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Editorial

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Welcome to our second edition of the refreshed *Australian Counselling Research Journal.*

This round of the Journal drew an incredible number of submissions showcasing specialised research from across the counselling and mental health professions. We're proud to present an edition complete with insights from trauma-informed study of the fawn response, cultural reflections on time and anxiety, to the use of Interactive Drawing Therapy in pediatric counselling. Each of the 10 papers offers new and engaging perspectives on our changing world, and the best way to support clients and practitioners, and improve counselling practices in a multitude of ways.

To begin, Tanya Tedesco-Malone's literature review of how at-risk youth in Western Australia's education system presents a clear and defining look on how the state's engagement with alternative settings can create meaningful changes. The use of trauma-informed interventions is particularly noted for helping students to engage with education and navigate socio-economic disadvantages across the board. This research gives insight into how government policy makers, clinicians and non-governmental organisations can effectively work together.

The advantages and pitfalls of the lived experience peer workforce are examined in an excellent piece by Carolyn Cousins, which takes into account the huge impact peer workers can have in therapeutic care – but also the need to properly support and sustain them in the mental health workforce. The role of supervision and reflective oversight cannot be understated, and this article highlights the urgent need for the sector to pay attention to – and enact changes in support of – peer support services and their workers.

Suicide prevention is an ongoing public health issue which affects everyone. Kelly Kaciuba's paper on self-harm and suicide in autistic youth is a detailed and compassionate look into how positive identity and early interventions can help a population that suffers acute and ongoing mental health issues. As the author outlines, rates of mental health co-morbidities within the autistic population are continually high, with autistic children particularly vulnerable to bullying and ongoing stress "in a world not built for neurodivergent minds". This research weaves together strands of international and Australian data in a clarifying call for clinical and policy attention.

Qualitative research from Monash lecturer and longtime counsellor Dr Anni Hine Moana rounds out this edition, with a study on the relationship between shame and alcohol use in Aboriginal women across Australia. This research is empathetic, grounded and is a resounding call for decolonising therapeutic practices through trauma-informed and deep listening. All practitioners, particularly those who work with First Nations communities, would benefit from engaging with this detailed and impactful work that highlights how systemic racism continues to shape so many lives today.

The ACA team extends our warmest gratitude to all our contributors, from the seasoned research professionals to those embarking on the initial stages of the academic calling – and a special thanks to our tireless peer reviewers who make sure each manuscript reaches its full potential.

The next edition of the *Australian Counselling Research Journal* is accepting submissions now, and will be published in June 2026.

With thanks,
The Editorial Board

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Author Biographies

Tanya Tedesco-Malone

Tanya Tedesco-Malone is a counsellor, counselling supervisor, educator, and researcher with expertise in mental health and postgraduate counselling education. She applies an evidence-informed approach to her counselling practice and is committed to supporting client wellbeing. In her academic role, Tanya teaches emerging counsellors, integrating contemporary theory with professional practice. Her research has a strong focus on student experience and future opportunity.

Carolyn Cousins

Carolyn Cousins is an accredited social worker with experience in the trauma and mental health sectors in Australia and the UK. She has a passion for ensuring practitioners survive the work well and receive the support they need. She provides individual and group supervision, as well supervisor training. Carolyn holds Bachelors and Masters degrees in Social Work, a Masters in Adult Education and recently obtained a Masters in Science (Applied Neuroscience) through Kings College, London.

Kelly Kaciuba

Kelly Kaciuba is a Senior Lecturer in Counselling, with over two decades of frontline and academic experience spanning mental health, trauma recovery, neurodiversity, and suicide prevention. She is a passionate advocate for identity-affirming care and early intervention, and the creator of MegaMind—a groundbreaking digital resilience program designed to support autistic youth through gamified, neuroaffirming connection. Kelly's work bridges evidence-based theory and real-world innovation, empowering the next generation of counsellors to think critically, compassionately, and creatively. Kelly's professional qualifications include Bachelor of Behavioural Science, Graduate Certificate in Psychology, Master of Counselling, Master of Education and HRD Candidate.

Dr Anni Hine Moana

In addition to her work as a counsellor and counselling supervisor, Anni is a lecturer at Monash University/ Turning Point in the Master of Addictive Behaviours. Prior to joining Monash, she has worked on participatory action research projects with Australian Aboriginal communities, most recently the Indigenous led project, Healing the Past by Nurturing the Future at the Indigenous Health Equity Unit, University of Melbourne.

Anni is a passionate teacher and counsellor who is particularly interested in changing the narrative around addiction, issues of power and privilege in the development of therapeutic relationships and trauma, specifically the effects of settler-colonisation on indigenous populations. She has presented papers at national and international conferences, appeared as a guest on the ABC program Life Matters and been a panel member at the Melbourne Writers Festival.

Natalee Martin

Natalee Martin is a counsellor, professional supervisor, and mindfulness and meditation facilitator. She holds a Master of Counselling from QUT and is a registered Level 4 practitioner and member of the College of Supervisors with the Australian Counselling Association. In her private practice, she works with individuals and couples, drawing on a trauma-informed lens shaped by years of experience in not-for-profit organisations and diverse community settings. At the heart of her practice is a commitment to fostering compassionate, mindful connection. Natalee aims to create a space where clients feel safe, seen, and validated—whether they're navigating challenges or celebrating growth. Her approach is steady, supportive, and grounded in the belief that each person holds the strength and wisdom to move forward with confidence.

Belinda Kippen

Belinda Kippen is a nurse, midwife, and counsellor who lives and works in Brisbane, Australia. She has spent much of her career working alongside women as they navigate key life transitions, such as pregnancy, birth, parenthood, and aging.

More recently, Belinda has been providing clinical supervision to nurses, midwives, and other professionals in the helping fields. This is where she first noticed joy emerging in her practice, sparking her curiosity about what factors contribute to joy in professional practice.

In 2024, Belinda completed a Masters in Counselling, focusing on collaborative and narrative approaches. She continues to offer clinical supervision in private practice and also offers counselling to women as part of a multidisciplinary team in a women's health practice.

She is interested in how "taking-it-back" practices might support practitioners in the helping professions to find joy in their work and prevent the emergence of burnout. She has noticed that joy is lingering in the work she does.

Vivian Baruch

Vivian Baruch M. Couns is in private practice as a relationship coach, counsellor, psychotherapist, and clinical supervisor specialising in relationship issues for singles and couples. She has been practicing since 1981, has been a psychotherapy educator at the Australian College of Applied Psychology & taught supervision to psychotherapists at the University of Canberra. In 2004 she trained with Dr. Scott D. Miller & has been using Feedback Informed Treatment (FIT) for 21 years, to routinely incorporate her clients' feedback into her psychotherapy & supervision work.

Christine Honor

Christine is a Sydney psychologist working in private practice with adolescents, adults and couples. With a strong foundation in depth psychology and informed by years of rich experience in the health, education and disability sectors; she brings a deeply thoughtful and in-depth approach to her therapeutic work and research activities. Christine has a special interest and experience working with individuals who may have been impacted by trauma of various kinds such as single incident, complex, developmental or intergenerational trauma.

Shalini Shaji

Shalini Shaji has over five years of experience working as an Audiologist and Speech Therapist at MOSC Medical College Hospital, India. Shalini's professional qualifications include Master of Audiology and Speech Language Pathology (MASLP), Bangalore University, and Master of Counselling and Psychotherapy (MCouns&PsychTh), The University of Adelaide.

Zoe Caldwell

Zoe Caldwell has five years of experience working as a Child and Adolescent Psychotherapist at Northern Area Community and Youth Services, Adelaide. Zoe holds a Master of Counselling and Psychotherapy (MCouns&PsychTh) from The University of Adelaide.

Simon Faulkner

Simon Faulkner, BSocSc (Psychology & Addiction) MCouns., is a leading practitioner in the design and delivery of evidence-based interventions utilising rhythm to assist with social and emotional health and the recovery from trauma. He is currently the director of Rhythm2Recovery and works internationally training practitioners in a model combining rhythmic music with cognitive reflection.

Simon has designed a wide number of programs for different populations, including the well-known Holyoake DRUMBEAT program, and continues to work with a range of different client groups in his clinical practice. He has a strong interest in supporting and learning from Indigenous peoples and has worked in 1st nations communities in Australia, New Zealand, Canada and the USA. He is based in Perth, Western Australia.

Issues of reconnection: Youth at Risk (YAR) in the Western Australia Education System

Tanya Tedesco-Malone

Keywords: *Youth at Risk, schools, educational support, mental health, developmental stages, child poverty*
Note: *In this paper, the terms "children," "adolescents," "youth at risk," and "students" are used interchangeably to refer to individuals aged 12–18 years*

Abstract

This literature review examines key issues affecting young people aged 12 to 18 years facing a range of complex and interconnected challenges impacting or rupturing their educational journey within Western Australia's (WA) education system. Students that are disengaged or disengaging from WA's education system are classed as Youth at Risk (YAR).

Disengagement in school education is complex and often cumulative and YAR in WA are often navigating multiple challenges such as mental health issues, substance use, domestic and family violence and socio-economic disadvantage.

Trauma informed and flexible alternative education programs with smaller class sizes and access to counselling support create safe meaningful opportunities for students to reconnect with learning. These settings promote healing, resilience and generate smoother pathways to future employment.

To support these successful transitions the use of trauma informed narrative therapy interventions that help students to reengage and reframe their stories, identify their strengths, rebuild and reestablish a sense of belonging and purpose are recommended.

Introduction

According to the latest figures released by the Australian Bureau of Statistics (ABS), Australia's population grew by 1.7 per cent in 2024 (Cho, 2025) with Western Australia (WA) being reported as having the fastest growing population tipping over the three million mark in 2024 (Polini, 2025). The ABS identifies vast differences in growth patterns between states and territories with WA reported as having the highest growth rate of 2.4 per cent versus Tasmania having the lowest growth rate of 0.3 per cent (Cho, 2025). In conjunction with this WA reported a 2.6 per cent increase in births totalling 292,400.

It is often said that "children are our future" (Hullinger, 2021). This literature review takes a deeper look at the younger population in WA and what supports are available, given the state's increasing population and the subsequent impact on the education system.

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There are approximately 652,890 children and young people currently living in WA, representing 22 per cent of the state's population (McGowan-Jones, 2025). While many thrive, a significant number face complex challenges that hinder their successful transition into adulthood (McGurk & Rowe, 2022). Over the past decade, WA has recorded the most substantial decline in Year 12 completion rates compared to other Australian states and territories, despite some gains in non-government school retention (Thompson, 2024).

Although approximately 476,000 children and young people were enrolled in formal education across WA in 2023 including around 113,000 in Years 7 to 12 government schools continue to struggle with retaining students through to Year 12. Alarmingly, the proportion of 15 to 24-year-olds fully engaged in education or work the year after leaving school dropped dramatically from nearly 78 per cent in 2022 to under 50 per cent in 2023, marking a near 30 per cent decline in just one year (McGowan-Jones, 2025).

This literature review explores the key factors driving disengagement among students aged 12 to 18, and the alternative educational pathways currently offered to support and sustain them in education. It also highlights initiatives supported by the Department of Training and Workforce Development (DTWD), including traineeships, apprenticeships, and short courses, as viable avenues to re-engage these young learners (Department of Training and Workplace Development, 2020).

Defining Disengagement

It is essential to define what it means for students to disengage from education as a multifaceted challenge. Disengagement includes students who are physically present at school but not actively involved in learning, as well as those who attend sporadically or drop out entirely (Department of Communities, 2022). In WA, students who are disengaging or already disengaged are often classified as vulnerable youth or Youth at Risk (YAR) (Department of Communities, 2022).

Several factors contribute to student disengagement, such as learning difficulties, mental health issues, trauma, and a lack of belonging within the school environment (McGurk & Rowe, 2022). These challenges may be compounded by social isolation and systemic barriers (McGowan-Jones, 2025). Research consistently shows that mental health challenges, social exclusion, and a sense of disconnection from school are among the leading causes of disengagement (Hancock, K. J., Christensen, D., & Zubrick, S. R., 2018). Socioeconomic disadvantage also plays a major role. For example, in WA,

105,000 children have been reported to live below the poverty line and Vadivel et al., (2023) states low "socioeconomic status" as the reason some children have had to leave their studies (McGurk & Rowe, 2022).

Mental Health, Substance Use, Violence, and Poverty

In addition, 51.5 per cent of young people surveyed in 2021 mentioned mental health as a key barrier to academic success (Mission Australia, 2024). Mental health challenges among young people aged 12 to 17 in WA such as anxiety, ADHD, depression, and conduct disorders have been extensively documented (Meadows et al., 2020). It is also noted that these issues often co-occur with other complex problems such as alcohol and drug use, aggressive and anti-social or risk-taking behaviours, self-harm, emotional regulation concerns, truancy and disengagement from support services (McGurk & Rowe, 2022). These issues often disrupt school participation, particularly when compounded by substance use and exposure to domestic or family violence (The Australian Institute of Health and Welfare, 2020). For example, reports in WA state that alcohol and drug use can exacerbate all mental health problems, while trauma from domestic violence may create ongoing emotional and behavioural issues that interfere with school life (Harris, 2017; Tran, 2020).

The cumulative effect of multiple adverse experiences such as domestic violence, poverty, and substance abuse can significantly impact a young person's educational journey. These outcomes confirm that WA's youth facing overlapping challenges are at heightened risk of emotional dysregulation, poor academic outcomes, and future disadvantage, (The (Australian Institute of Health and Welfare, 2020). In support of this the WA government's *At Risk Youth Strategy 2022–2027* stresses the need to address these compounding issues before they become entrenched (Department of Communities, 2022). If left unaddressed this cycle can also become intergenerational: disengaged young people may become adults with limited employment prospects or parenting capacities, perpetuating the same patterns of disengagement and hardship in their children (Commissioner for Children and Young People WA, 2023). Sadly, many of these statistics are not new and it can be all too familiar to read how school students are not "thriving" in the education system (Koelma, 2017). The WA government has recognised these issues and through the Department of Communities, leads a "whole-of-government" approach working in partnership with young people, the youth sector, community groups and across all levels of government. This approach aims to support and develop programs and initiatives that meet the diverse needs of young people aged 10 to 25 years (Beazley, 2025).

Alternative Education Models

Research has linked adverse experiences in childhood, such as exposure to family and domestic violence and/or physical abuse, to children or young people engaging in harmful behaviours (McGurk & Rowe, 2022). It is recognised that this in turn may impact their formative years (Peat et al., 2005) which may also rupture their education journey and lead them to experience negative life outcomes (Deng et al., 2022). Education plays an important role and can hold many advantages for young people supporting them to prepare or plan for work or pursue a higher education while graduating from university (Al-Shuaibi, 2014). There is no 'one size fits all' answer to the issues faced by our mainstream education in its current format (Raj, 2025) and having the option to gain education in an area of interest may be the key to helping a person think, feel, and behave in a way that contributes to their success (Al-Shuaibi, 2014). The Department of Training and Workforce Development (DTWD) recognises this and now offers alternative education options (Department of Communities, 2022: (DTWD, 2025a) in vocational education areas. Targeted funding enables participation in vocational qualifications, such as Certificate II and III programs focussing on employment outcomes. According to the DTWD (2025), Youth at Risk students must be unemployed, face barriers to mainstream education, and be referred by approved agents. Eligible participants must be between 15 and 24 years old (Department of Communities, 2022).

Adult education settings offer a different contrast to traditional schools. As we have already discussed, there are multiple reasons mainstream schools often struggle to meet the needs of students dealing with trauma, mental illness, or socio-economic disadvantage. Wiedermann et al., (2023) argue that a proactive, holistic approach to mental health is essential for building a resilient educational infrastructure. However, rigid structures, large class sizes, and academic content disconnected from students lived experiences can alienate young learners (Maynard BR, Farina A, Dell NA, Kelly MS., 2019) and therefore reinforcing the need for this cohort of students to have alternative arrangements or options is a 'must'. Wiedermann et al., (2023) goes on to explain that educational institutions can effectively leverage the expertise of diverse stakeholders to create targeted interventions by cultivating partnerships, which in turn is what DTWD has done by developing their alternative programs with many also incorporating work experience. Therefore, students learn what life is like beyond mainstream schooling and have agency over their learning, which fosters motivation and a sense of ownership. Smaller class sizes help create safer environments for students who have experienced trauma. These spaces emphasise practical and relevant learning, which in turn supports smoother transitions into employment or further education (Re & Capodieci, 2020).

Importantly, alternative education is not just a second chance at learning, it is an opportunity for healing and empowerment (Mills & Mcgregor, 2013). The WA government is focused on a collaborative approach to support at risk young people that include targeted initiatives to address health, mental health, education needs and training and employment pathways (McGurk & Rowe, 2022). Currently, DTWD conducts a range of funded programs across multiple Registered Training Organisations (RTOs) that are designed to deliver training that meets the skill needs of the state (DTWD, 2025c) including apprenticeships, traineeships, priority industry training and the participation programs (DTWD, 2025b).

The participation programs are designed to support youth at risk. As the Department has recognised potential barriers to accessing, engaging and completing mainstream training these programs have been developed so the RTO can offer additional support to students to support them to engage and retain them in training. Examples of support that RTOs can offer students include mentoring and counselling (DTWD, 2025b). In addition many RTOs offer opportunities for student counselling (WAA, 2025).

Despite the benefits of alternative education, significant challenges remain. For example, young people may experience communication difficulties with peers and teachers which can undermine their sense of emotional safety in the classroom (Re & Capodieci, 2020). Addressing these issues requires the implementation of trauma-informed teaching strategies that are grounded in empirical research (Watson & Astor, 2025).

Trauma informed teaching strategies are grounded in constructivist and socio-emotional pedagogical principles which recognise that student's past experiences significantly shape their capacity to learn (Brunzell et al., 2015). Therefore, by adopting a trauma-informed lens educators can create a safe and supportive environment where the students feel secure enough to

participate and develop (Brunzell et al., 2015). Considering YAR students generally have a history of some form of trauma it is important to incorporate forms of relationship-building strategies to support them in the classroom and enhance their engagement (Wilson-Ching & Berger, 2023), such as icebreakers to cultivate classroom belonging (J. M. V. Sasan et al., 2023).

Reauthoring Student Narratives

Disengagement rarely stems from a single issue. It often reflects the intersection of personal, social, and systemic barriers, particularly among students facing poverty, housing instability, family violence, trauma, or mental health issues (Commissioner for Children and Young People WA, 2023). We understand that students disengaged from mainstream education that are choosing to reengage in alternative education can be taking the first step of their journey to transition into employment or further education (Watson & Astor, 2025). Therefore the option to engage in mentoring and/or counselling at this time can be extremely supportive. Viewed through the lens of Narrative Therapy, this could be seen as supporting students to help them "reauthor" their stories. Rather than focusing solely on behaviour correction, this approach highlights students' values, commitments, and strengths and it can help young people externalise problems (such as, anger or anxiety) and explore their responses to these challenges (Thompson, 2024). One example would be the cognitive behavioural program "Talk Sense to Yourself" (TSTY) by Jeffrey Wragg that focuses on self-talk and emotional regulation (Saji, 2015).

Conclusion

This literature review has highlighted the multifaceted challenges faced by young people at risk of disengagement from education, including poverty, homelessness, domestic violence, trauma, and mental health concerns. While these issues are well-documented in psychological and social contexts, their nuanced effects on educational engagement remain underexplored. While this paper focuses only on WA there are clearly opportunities and recommendations for future research using a national lens to compare state-based policies and practices while tailoring interventions to the unique social, cultural, and economic needs of individual regions.

For counselling professionals, the findings emphasise the need for holistic strategies that acknowledge the complexity of disengagement. Supporting at-risk youth requires more than addressing immediate crises; it demands long-term strategies that reconnect young people to meaningful education and employment pathways. By providing trauma-informed, flexible, and youth-centred learning environments, educators and service providers can offer students not just an education but a renewed sense of agency, purpose, and belonging. Counsellors working in this space can consider multiple methodologies to support students' needs including options such as Narrative Therapy to invite students to reflect on the personal stories they tell themselves and explore how these narratives influence their actions and self-image. Short, structured sessions delivered one-on-one or in small groups can help students identify personal strengths and preferred ways of responding to challenges. A predictable and safe learning environment enhances the effectiveness of these interventions, as it allows space for self-exploration, growth, and confidence-building (Vanzin & Mauri, 2020).

For counselling professionals and educators, the findings demand a shift towards integrated, trauma-informed, and youth-centred approaches that prioritise not just academic outcomes but also a young person's sense of agency, belonging, and purpose. Practice recommendations include embedding trauma-informed pedagogy to provide safe environments where young people can rebuild trust and re-engage with learning. The implementation of narrative and strength-based interventions can support students to critically reflect on the personal stories they tell themselves, reframe limiting narratives, and help them to identify strengths that foster resilience and hope. Offering adaptable, personalised education and training pathways supports disengaged youth to reconnect with meaningful educational and employment opportunities.

For researchers, there is an urgent need to bridge the gap between psychological research and educational practice. Future studies should explore the long-term impacts of trauma-informed and narrative-based interventions, examine the role of cultural identity in engagement, and investigate how emerging technologies can enhance connection and learning for at-risk youth.

The challenge now is not simply to understand why young people disengage but to reimagine how education, counselling, and research can work together to keep them connected.

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Supervision and Support for the Lived Experience Peer Workforce

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Abstract

Employing peer workers alongside counsellors is increasingly bringing lived experience voices into therapeutic service provision in sectors such as mental health. This integration has meant considering how to best support peer workers in order to sustain them, without fully subsuming them into the system they are asked to challenge and change. This article will consider the importance of reflective supervision as one of the ways to support and revitalise lived-experience peer workers – those who have gained their expertise through their experiences as clients of the system, rather than through study or as employees. It will include consideration as to who is best placed to provide this supervision. It will argue that supervising the peer workforce requires additional knowledge and skills, whoever provides it, and that there are specific principles and values needing to be incorporated into the supervisory relationship.

Introduction

The supervision and reflective oversight of therapeutic work has long been recognised as important for professionals working in direct counselling and case management services. Supervision is also increasingly being recognised as important for non-clinical roles, where distressing material or systemic challenges may be faced. This paper suggests the sector needs to pay proactive attention to the specific supervision needs of lived-experience peer workers, who are increasingly part of the service offering and who have unique needs and risks. Literature around ensuring the longevity and inclusion of peer support workers within the mental health sector, who have had peer workers for some time, suggests that reflective supervision is a key component to addressing challenges experienced while implementing peer support services (Gates and Akabas, 2007; Delman and Klodnick, 2017). Counsellors and case managers are increasingly in roles where they are either providing such supervision or influencing its provision (Castles *et al*., 2023). There are a range of benefits for peer workers through the provision of supervision, including increased morale and improved retention, with assumed benefits also for the client or consumer. Research shows that supervision can also assist achieve the agency's objectives (Reddy, Wolf and Brown, 2020).

This paper uses the term reflective supervision to describe the time set aside between two individuals for examining practice in a reflective way, although it is recognised that the term clinical supervision is sometimes used interchangeably to describe this intentional interaction. It is recognised there is debate around these terms. The term "reflective supervision" has been chosen in this paper as the content proposed to be covered in the sessions goes beyond the remit of what some health and welfare professionals may consider clinical (i.e. client / case based discussion) to also include other areas of supervision, such as reflecting on organisational dynamics and mediating vicarious trauma.

Importance of supervision for peer workers

Literature around peer supervision (see Gates and Akabas, 2007; Fortuna *et al*., 2020; Reddy, Wolf and Brown, 2020) outlines many benefits of supervision common to a range of welfare and health disciplines, but also identifies unique challenges arising specifically for peer workers. There are important distinctions made between the line management oversight of peer worker roles, and the provision of reflective supervision.

Line management meetings are a process of administrative supervision that focuses on ensuring that the worker is meeting the obligations and requirements of their role within the organisation, and during which both parties can identify opportunities for development (Ashley-Binge and Cousins, 2020). Reflective supervision is a more contemplative and analytical process that focuses on growing the skills and capacity of the peer worker both within and beyond their employed role. This includes supporting peer workers in their ability to connect with others who have a lived experience and understanding of "what it feels like" to engage with health and welfare services, and to ensure peer workers are able to empower the clients and consumers they are working with to take the next steps in their recovery journeys.

Reflective supervision provides opportunities for problem solving and navigating role challenges, and it can provide the opportunity to unpack the challenges that come from "walking alongside" another consumer, whilst also supporting the peer worker to maintain their own wellbeing (Reddy, Wolf and Brown, 2020).

A particular focus should be the supportive and restorative functions of supervision, as studies have shown that peer workers can leave their roles due to not feeling understood and from facing challenges in the workplace that are unique to their specific role (Reddy, Wolf and Brown, 2020; Poremski *et al*., 2022; Prat Vigué *et al*., 2022). A small 2023 study interviewing peer workers described a range of personal and organisational strategies for optimising the workers effectiveness and well-being, including self-care, and professional development with participants highlighting that they appreciated having

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opportunities for peer mentoring and supervision. (Saad *et al*., 2023). For the supervision to be effective, this study reported it needed to be with a competent peer mentor, accessible regularly and contemporaneously, as well as promoted so that staff knew such support was available and what to expect of it.

The key expertise a peer support worker brings to their role is their own lived experience as a prior client or consumer of the service system. This experience is valued as having something to teach and add to the system – including for their professional colleagues. This means peer worker roles are unique in that they require the individual to utilise personal, and sometimes difficult or painful experiences and memories within their work. They will be faced with regular ethical choices about how, when and if they share their own experiences, as well as moments that may remind them of their own journey. They may also be witnessing others experiencing a journey not unlike their own, including experiences of discrimination and judgement. At the same time, peer workers may be routinely exposed to colleagues that observe them for signs of impending concern or "relapse". Added to this, peer workers may be carrying out their responsibilities in organisational cultures that stigmatise them as colleagues and individuals (Prat Vigué *et al*., 2022). These factors create some unique workplace dynamics with potential for harm. Therefore, peer workers need a space to discuss both the impacts of their lived experience expertise, and the workplace environment.

Reflective supervision for peer workers can provide a safe space to unpack frustrations, discuss difficult experiences and challenges, and consider how lived experience can be used in intentional ways in the work. This safe space, if achieved, can add legitimacy to the fact that peer workers need ongoing support to navigate how they can best use their own lived experience, whilst also allowing space to discuss ethical responsibilities and accountabilities. It recognises that the lived experience is both an essential tool of the work, but also an area of potential vulnerability, and encourages learning alongside the examination of challenges.

A 2023 scoping review (Castles *et al*., 2023) found a lack of clarity about both the definition and various purposes of supervision within the peer workforce literature, although there was general agreement supervision was needed. From an organisational perspective, there can be an intent through supervision to "socialise the peer worker" into understanding the professional systems; to ensure adherence to policy and procedural requirements; and to ensure a form of organisational risk management through the consideration of decision making and ethics. While from the view of the growing peer worker sector, reflective supervision can assist with adherence to the values and principles of peer work; allowing an opportunity for the peer worker to debrief and seek guidance, and to ensure there is not a drift toward more organisationally focussed approaches. Part of the role of a peer worker is to remain an advocate and agitator within the service system, to stand a little aside, and be able to critique and challenge as needed (See MHCSA, 2019). This is not an easy position to maintain. There is also an implied purpose within reflective supervision generally that it will improve practice and intervention for the client or consumer, although this assertion is untested in a fully evidenced way (Cousins, 2022). The definition of what is best for the client may at times be different for the peer worker as compared to the organisational or even the professional perspective, and supervision will be a place where these differences in opinion, and the goals of client work, can play out.

Who should provide peer supervision?

There are debates about who in the workplace should provide peer worker supervision, that are linked to differing views about the primary purpose of the supervision (Gates and Akabas, 2007; Foglesong *et al*., 2022; Poremski *et al*., 2022). If the purpose is primarily intended to be to socialise the peer worker into the ways of the broader therapeutic system, to help them understand the professional roles and boundaries so they can be better advocates, and to monitor this progress, then it can be concluded that reflective supervision can be provided by counsellors and professionals with skills in reflective practice and who bring a strong understanding of the sector. However, if the primary purpose is more to provide a reflective space to consider what it is like to be a peer worker and the associated challenges, then it is likely the supervisor should be a peer worker with additional training in how to provide reflective supervision. It could also be argued that either of these individuals can provide appropriate supervision to peer workers, if they themselves have appropriate training.

In a study of 837 supervisors of peer support workers in the USA (of mixed professions and backgrounds) (Foglesong *et al*., 2022) found that many peer workers wanted to be supervised by others with lived experience. However, the researchers also found peer workers who were supervisors shared that they were often asked to provide supervision with little to no training or even understanding of what they were supposed to be doing in supervision. Many supervisors reported being unable to find time to research or even read about what supervision is or should be.

This leads to the question of whether experience as a peer support worker in and of itself is enough to equip this peer worker to provide reflective supervision, especially if they have not experienced quality reflective supervision or had any training.

When the intentions of reflective supervision are unpacked, it becomes apparent that it is quite a complex task, facilitating and holding a space where the supervisee can experience a reflective space in which they can be both supported and challenged, pushed and encouraged, around some key topics and also principles (Murray, 2011). Reflective supervision is not a simple co-worker chat. Rather there are principles, ethics, dilemmas, and worker and organisational needs that are expected to be discussed and examined within this interaction.

The literature identifies specific challenges experienced by peer supervisors of peer workers (Gates and Akabas, 2007; Knox *et al*., 2011; Foglesong *et al*., 2022) that can be summarised as arising from:

- A lack of training and experience with providing supervision and instead offering a relationship based on friendship
- Not knowing how to advocate within the service system to bring about change
- A potential lack of knowledge by peer supervisors about peer principles and approaches
- A tendency to share their own experience than focussing on the supervisee

Tuija et.al. (Viking and Nilsson, 2022) suggest that peer workers should be supervised by other peer workers *with clear role delineation and training*, which they note would also provide a professional career path for peer support specialists. Backing this, Scanlan *et al*. (2020) found that peer workers who received supervision from a senior peer worker or peer team leader were more satisfied than those who did not (in Saad *et al*., 2023). However Tuija et.al. (Viking and Nilsson, 2022) note a significant challenge is that there are not enough senior peer workers ready, trained and skilled to offer this supervision support. This means other professionals will likely continue to be used in this space.

There are a range of challenges identified in the existing literature (Gates and Akabas, 2007; Reddy, Wolf and

Brown, 2020; Poremski *et al*., 2022) for non-peer experienced supervisors to overcome. These can be summarised as arising from:

- A lack of experience and working knowledge of peer practice and principles
- Narrow and / or traditional clinical approaches to how services should be delivered (approaches being challenged by the peer workforce)
- A risk of trying to "professionalise" or teach supervisees the "right" ways while eroding the agitator and critiquing intention of the peer worker role; and
- Feeling the need to monitor the well-being of the peer worker, and providing more of a clinical or counselling service to them than supervision

This would suggest that where supervision is provided by other professionals – such as counsellors and case managers in the workplace – they need to have a strong value for the role of peer workers and an understanding of the principles and practices of peer support. This would suggest they too may need some specific training, despite no specific training existing.

Specific challenges influencing supervision

Whether to establish peer work as a discipline

Asad & Chreim (2016) and Castle (2023) identify that there is debate about whether peer work should be establishing itself as a discipline or profession in order to gain the standing and professional respect that comes from this recognition. Arguments for more professional recognition include that it would lead to greater consistency in practice and role clarity for the peer workers, as well as the clinicians, managers and consumers they work with. Gillard *et al* (2013) state that "only when there is consensus about what constitutes a body of peer practice will Peer Workers have confidence to apply that practice in their work knowing that they will be supported and valued by colleagues and managers in doing so".

The provision of reflective supervision can be seen as part of the professionalisation of peer work toward gaining discipline status. However, some argue that moving toward peer work being a discipline or profession runs the risk of losing the essence of the consumer perspective and becoming regulated in a way that will compromise the principles of peer work. These proponents (Tisdale *et al*., 2021; Poremski *et al*., 2022) argue for a much less formal type of supervision that tends towards peer support, leaving the organisation to provide just line management supervision rather than a reflective space.

Lived experience as a knowledge base

Lived experience is the term used to specify knowledge "that is gained by personal experience, as opposed to learned via study or employment and elates to a personal experience" (Childs, 2021). Watson (2019) further describes a lived experience knowledge base as the combination of the peer worker's own personal lived experience and the knowledge gained from the broader consumer perspective framework, and emphasises that this includes the experiences and perspectives of other consumers and consumer workers. A consumer perspective framework is gained through reading research and literature, learning from peers and developing an understanding that the peer worker's own perspectives may not apply to all the people that the peer worker is working with. It is suggested this broader focus of peer knowledge, and being able to assess where the personal is useful to the client or consumer, and when it may be less useful, is an area for review in reflective supervision.

The interface with counselling

In reflective supervision, and even in line management, there can sometimes be a difficult boundary when discussing a personal matter that impacts work, and it has become too personal and is more suitable for counselling than supervision or a management discussion. It can be appropriate for all professionals to discuss in reflective supervision how a personal issue is impacting engagement with the team and/or clinical decision making, although not all supervisors feel confident in these discussions. Yet for peer workers, where their lived experience is the very essence of their professional knowledge, seeking clarity around this boundary seems crucial. The literature about supervision for peer workers appears to offer little to supervisors on how to navigate the ethics and boundaries of this complexity, other than to sometimes point it out as a dilemma.

In peer work, the supervisee and potentially supervisor are likely to have been in case counselling types of roles previously, as participant and provider, meaning this can be a familiar experience for them both, sometimes more familiar than the reflective supervision experience. This could lead to a replication of this role and dynamic within supervision if unexamined. It is suggested that further specific clarity around this issue is needed for the peer workforce and providers of supervision going forward.

Areas for focus within peer supervision

There are certain areas in peer work that need particular focus, while also appearing in other counselling related professions. Kadushin and Harkness (2002) identified three functions of supervision: administrative (promoting adherence to organisational policies and processes); educational (development of knowledge and skills); and supportive (providing practical and emotional support, in (Castles *et al*., 2023), while other models highlight a stronger focus on the client experience and decision making. All four functions, as described in Figure 1, are appropriate to supervision for peer workers. Each peer worker, however, will have particular needs, with the potential to focus more on the left hand quadrants of the restorative and organisational areas of supervision than with clinical teams, who are more likely to focus more heavily on the right. Figure 1 is offered to assist supervisors describe to peer workers the various functions of supervision and how these can be structured around a peer specific value set.

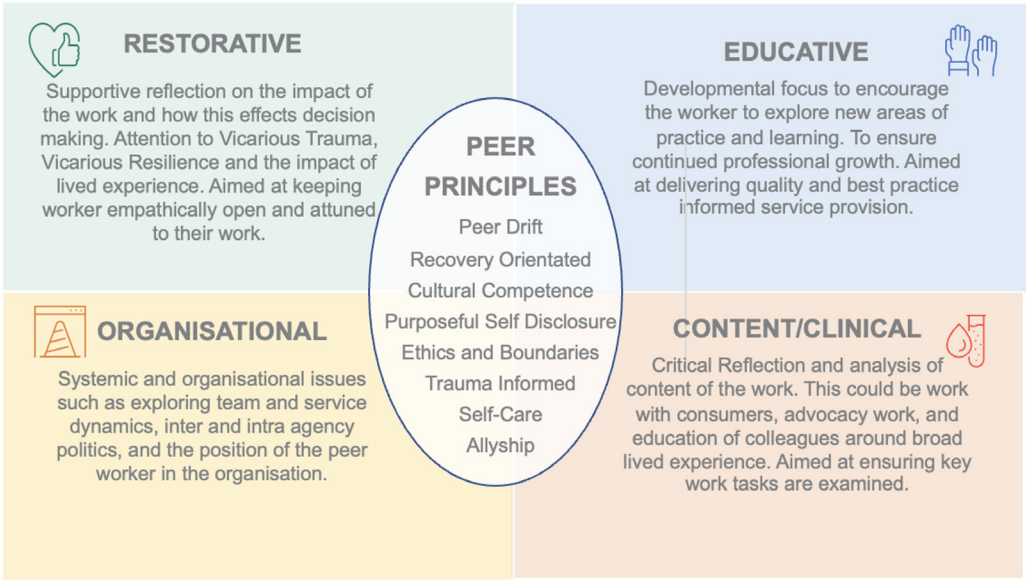

Figure 1: Suggested areas for focus (Author's own diagram)

It is suggested that reflective supervision is not value neutral in that it aims to help hold the worker accountable to suitable values and approaches specific to their role. With supervision for peer workers, it is suggested that the following values apply:

Peer drift

Peer drift is the term used in much of the literature for what can occur when peer workers begin to drift from core peer worker values (see for example Foglesong et al., 2022). This is potentially more common in services where a bio-medical model is dominant, or in teams where lived experience and/or the peer role is less valued.

When a worker has a strong peer or lived experience identity, they are comfortable with personal disclosure and will have self-confidence and pride identifying as a peer. These peer workers may not feel as much need to be accepted by other professionals as part of the rest of the team. They will feel safe to use their peer role to influence for change. However, where a peer worker is experiencing peer drift, they may feel uncomfortable or avoid sharing their personal lived experience, or fail to use opportunities to influence for change, wanting instead to be accepted as part of the treating team. The nuances of these pulls and this drift is a key area to cover and re-visit often in reflective supervision.

Trauma informed and recovery orientated practices

Peer workers use their personal lived experience of recovery to provide hope for other clients and consumers who may not currently have hope for a recovery journey themselves. This means peer workers are role-modelling their own recovery and that of others they have supported to show that a positive future is possible. Yet a lived experience of mental ill health, violence or oppression usually includes experiences of significant trauma. Because of this, peer workers may need a supportive supervisory environment in which to re-consider their own first-hand experience of trauma and adversity, with reference to potential triggers, to trauma informed principles and to recovery orientated practices. This is likely to be both an educative and restorative part of reflective supervision, exploring how to ensure trauma-informed principles and safety remain present in their work for themselves and those they are supporting.

Cultural competence

There are two types of cultural competence required by peer workers. The first is ensuring the peer worker can tolerate differences, reduce prejudice, and support others in using their voice, no matter what their cultural or ethnic background. This is cultural competence in the sense of being professional in all interactions and behaving with cultural humility (Zhang et al., 2022).

Depending on the life and work experience of a peer worker, they may already have a good understanding of the expected practices around inclusivity toward people from different cultural backgrounds from their own, or they may need assistance to understand these requirements and challenge their own prejudices through training and reflective supervision. It is suggested that identified First Nations peer roles should also be afforded cultural supervision as a separate and additional offering (Deroy and Schütze, 2019).

The second cultural competence is in understanding and negotiating the organisational culture in workplace systems. Reflective supervision can help develop competency around the culture of care systems, understanding how they operate and how to act within them as a colleague, rather than a client or consumer.

Purposeful self-disclosure

A key element of being a peer worker is being willing to share your own experience through purposeful self-disclosure. When a peer worker shares something from their own personal journey and recovery, it can provide hope for others in relation to their own recovery (Firmin et al., 2019). Childs (2021) outlines how "purposeful disclosure can help the peer practitioner to build connection or establish rapport, to be with the person where they are at, to validate the other person's experiences, to reduce stigma, to inspire hope and to demonstrate empathy".

Knowing when, why and what to disclose purposefully is an important aspect of the peer worker role. This includes being aware of and examining the purpose for each disclosure in the moment, and considering what the possible or likely outcomes may be. This is especially important when sharing traumatic or adverse experiences where it may be difficult for the peer worker to know what the impact of the self-disclosure could be. Purposeful self-disclosure includes making the decision not to share sometimes, because it may not benefit a client in that moment, and being able to assess that in real time.

Self-disclosure can assist the peer worker to build connection and establish rapport with the client they are supporting, as well as validate the other person's experiences. It can reduce stigma, inspire a sense of hope and offer empathy (Knox et al., 2011). Peer workers may also share a part of their personal lived experience with colleagues or management to educate them or inform their decision making, providing a firsthand perspective.

However there are risks with self-disclosure. It can be distressing or overwhelming for the client or consumer, and their reaction, as well as the potential reaction of colleagues, can re-traumatise the peer worker themselves. Self-disclosure can risk the client or consumer feeling like the conversation is no longer about them, or that they are being asked to support the peer worker in return (Balon, 2007). A further risk is that personal stories can also imply the client or consumer should follow the steps the peer worker undertook rather than finding their own path.

These complications suggest that peer worker's reflective supervision should allow them to explore the decisions they make around purposeful disclosure and its impacts. Reflecting on self-disclosure is crucial both for personal and professional development, and for ensuring trauma informed, person-centred practice.

Ethics and boundaries

The personal self-disclosure involved in peer work can leave the peer worker more open to boundary challenges than other professionals might experience, and peer workers need to ensure they demonstrate clear ethical behaviour to the service system. Reflective supervision can allow the peer worker to continually reflect on the ethical dilemmas in the decisions they need to make. This can build capacity for self-reflection and in the moment insight. A peer worker's life experience may not have exposed them to an understanding of the ethical standards that the care workforce takes for granted. Reviews of organisational policy and procedures, as well as the principles and expectations of peer workers in relation to boundaries, are important areas for exploration, especially early on in reflective supervision.

Self-care

As people with a lived experience of service provision, it would be hoped that peer workers will be aware of the importance of self-care and have skills and resources to maintain their own wellbeing. However all reflective supervision involves a restorative element of watching for signs of vicarious trauma, and this supervision is no different. A recent (2023) study found that self-care was a key strategy identified by peer workers as effective for remaining in the work (Saad et al., 2023).

Discussing the peer worker's well-being risks a sense of over-surveillance for the peer worker, given they were once a client or consumer, if this is not explicitly discussed as a standard part of reflective supervision. Supervisors need to be open to also being challenged if the peer worker feels there is over surveillance in this area.

Allyship

Reddy et al., (2020) highlight the importance of being an ally as a peer worker, being within the care system, but also advocating against it. This includes addressing "discrimination that can cause isolation and alienation within agencies and community" (Reddy, Wolf and Brown, 2020). For clients and consumers, having a peer worker gives them an ally with a greater voice, who can highlight stigma and discrimination and point out the "othering" in the system, while also elevating the voice of the client. Reflective supervision can examine how a peer worker can be an advocate and agitator in the system, whilst also building and gaining professional respect from fellow professionals. This requires mutual respect, and balancing advocacy with understanding.

Conclusion

Providing the peer workforce with reflective supervision is crucial to supporting those employed for the value of their lived experience to remain and thrive in their roles. Yet, there are nuances and areas of consideration different to those raised in supervision of other roles. Quality peer supervision can provide peer workers a space to reflect regularly on their complex roles and positioning within the care system, so they are best able to advocate for service provision which incorporates client and consumer perspectives. This paper has raised questions for further exploration about whether reflective supervision for peer workers is best provided by more senior peer workers or by counselling professionals and line managers, with benefits and challenges discussed for whoever provides the supervision. It has suggested that reflective supervision for the peer workforce requires some additional knowledge and skills. The paper has also outlined how the core functions of reflective supervision can be purposefully applied in supervision for peer workers, whilst suggesting specific principles and values – some that are unique to the peer workforce – for ongoing reference across the life of the supervisory relationship.

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From Masking to Meaning: A Neuroaffirming Approach to Suicide Prevention in Autistic Youth

Kelly Kaciuba

Keywords: *Neuroaffirming, suicide prevention, autistic, youth*

Introduction

A positive autistic identity and sense of belonging may protect young autistic people against the dangers of self-harm, according to emerging data and community insights (Cooper et al., 2017). Autistic youth face an alarmingly high risk of suicidal thoughts and behaviours, elevating the issue to an urgent public health concern. Recent analyses indicate roughly one in four autistic young people have contemplated suicide, and around one in ten have attempted it. Autistic individuals are several times more likely to experience suicidality than their non-autistic peers; one comprehensive review found autistic people have up to an eightfold increased risk of death by suicide compared to the general population (O'Halloran et al, 2022). Troublingly, this heightened risk emerges even in childhood. New data suggest suicidality can begin at very young ages in this population; for example, a caregiver survey in the US found that over one-third of autistic children aged 8 or younger had expressed a desire to die or kill themselves (Kennedy Krieger Institute, 2024). In other words, suicidal thoughts and feelings are not confined to late adolescence or adulthood in autism; they can surface in preadolescence, necessitating proactive intervention well before the teenage years. In short, the confluence of high prevalence and early onset of suicidality in autistic youth demands immediate scholarly and clinical attention.

This article examines the importance of neuroaffirming identity development as an upstream strategy for suicide prevention in preadolescent autistic youth. We discuss how fostering self-acceptance, community connection, and resilience in late childhood could reduce risk factors before serious crises occur. The autism suicidality crisis has many causes, such as a high mental health co-morbidity rate. Half to three-quarters of autistic people have a co-occurring mental condition, usually anxiety or depression (Lai, et al. 2019). These mood and anxiety disorders, which are common in autistic kids, are known risk factors for suicidal thoughts and behaviour in the general population and likely contribute to autism's increased suicide risk (Brown et al., 2024; Brynie, 2012). Autistic children also face severe social challenges that might harm their mental health. Principal among these is peer bullying and victimisation. A national survey in the US found 63 per cent of autistic children had been bullied, compared to 12 per cent of their non-autistic siblings (Kennedy Kreifer Institute, 2024; Park et al, 2020). This shows that autistic youth are bullied three times more, underlining their social alienation and mistreatment. Chronic peer mistreatment is connected to juvenile sadness, anxiety, and suicide (Maiano et al., 2016). Beyond bullying, autistic preteens often face sensory-overloading classrooms and social demands that overwhelm them, causing ongoing stress in "a world not built for neurodivergent minds." According to minority stress models, external stressors, including limited access to resources, unfavourable societal attitudes, and disability-related discrimination, produce a pressure cooker that worsens internalising symptoms. Many of the issues that lead to suicidal despair in autistic children arise from the mismatch between autistic people and a culture that does not accept them. The social model of disability holds that environmental constraints and stigma cause disability-related issues more than neurobiology (Oliver, 2013). Unfortunately, traditional support systems have often overlooked or underperformed in addressing these issues. Clinicians and educators may neglect bullying, exclusion, and low self-esteem in favour of addressing autistic symptoms or concomitant conditions. Few validated instruments exist to quantify suicidality in autistic youth, and mainstream suicide prevention initiatives rarely adjust risk assessments or interventions (Cassidy et al., 2021). Many vulnerable preteens lack understanding and immediate support due to this gap. Psychiatric vulnerabilities, social victimisation, and cumulative environmental stress explain why an autistic child may feel hopeless and why typical interventions generally fail to lessen this risk.

Autistic self-advocacy, sometimes under the neurodiversity movement, has promoted autism as a natural neurological difference and a legitimate identity within human diversity for the past decade. According to the social model, many autism challenges stem from societal issues like inaccessible environments and stigmatising attitudes, and acceptance, accommodation, and pride in one's neurodivergent identity are crucial (Kapp et al., 2013). More research demonstrates that helping autistic youth accept and understand their autism might boost resilience and mental health (Rivera & Bennetto, 2023). Participation in autism community organisations or neurodiversity-positive initiatives that celebrate autistic qualities instead of stigmatising them increases self-esteem and sense of belonging in autistic people (Hus & Segal, 2021). Confident autistic adolescents who see themselves as "different but not less" had better mental health than those who internalise negative stereotypes. Cooper et al (2023) suggest that feeling proud to be autistic and connected to an autistic community can protect against stress, much like other minority groups' strong identities protect against prejudice. Boosting self-esteem and group

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connection may help autistic youth cope with bullying, loneliness, and self-doubt. They become more likely to seek assistance from like-minded individuals and reject society's negative portrayal. Finally, there is hopeful evidence that an autistic child's self-perception as a worthwhile neurodivergent individual with a meaningful identity, rather than a faulty "defective" version of normal, can dramatically impact their mental health.

In contrast, when autistic youth develop a negative self-concept or feel pressured to hide their true selves, the impact on mental health can be devastating. Many autistic children receive implicit or explicit messages from an early age that their natural ways of being are "wrong." They might be told not to flap their hands, to "tone down" their intense interests, or to act less autistic to fit in. Over time, these messages can foster internalised stigma, where the child begins to view their autism as a shameful defect. Internalised autism stigma has been directly linked to reduced wellbeing and increased depressive symptoms (Cage & Troxell-Whitman, 2019; Botha & Frost, 2020; Perry et al., 2022). A child who believes they are fundamentally flawed or a burden is more susceptible to hopelessness, self-loathing, and suicidal thoughts. Additionally, a common way of coping with stigma is camouflaging or masking one's autism, suppressing natural behaviours and imitating neurotypical actions to avoid rejection. While masking might offer short-term social benefits (or at least reduce overt bullying), a growing body of research shows it has significant long-term mental health costs (Alaghband-Rad et al., 2023). The effort to constantly "play neurotypical" is draining and anxiety-provoking, often leading to burnout. Studies have found that increased habitual camouflaging is linked to higher levels of depression and suicidality in autistic adults. For example, one study showed that autistic adults who reported more frequent camouflaging had significantly higher odds of suicidal thoughts and behaviours, even after accounting for other factors (Cassidy et al., 2018). The psychological toll of masking, feeling one must hide one's true identity to be accepted, can erode self-worth and social trust. Over time, the gap between the "false self" shown to the world and the genuine self can lead to deep loneliness and identity confusion. In short, when autistic youth feel unable to be themselves, their mental health often suffers severely. This dynamic helps explain why traditional interventions that aim to make an autistic child seem more "normal" might inadvertently cause harm, even if well-meaning, by reinforcing the child's belief that something is inherently wrong with them.

Given these insights, an effective early intervention for suicide prevention in autistic youth is neuroaffirming identity development. By helping autistic children build a positive understanding of their identity and by creating environments that validate rather than suppress their neurodivergence, we may protect them from some of the worst mental health outcomes. Our discussion is grounded in relevant psychological theories (social identity theory, self-determination theory, resilience theory) and the social model of disability, linking each to the experiences of autistic youth. We also introduce an innovative program, the "MegaMind" digital intervention, as a practical example of applying these principles. Finally, we consider implications for counsellors and psychotherapists working with neurodivergent young people, offering concrete recommendations for practice. Throughout, the tone remains optimistic and proactive: by embracing neurodiversity and supporting autistic children's identity development, counsellors can help lessen suffering and even save lives.

The Case for Neuroaffirming Identity Development in Early Intervention

Classic social identity theory (Tajfel & Turner, 1979) suggests that strong, positive group ties boost self-esteem and protect against external threats. This implies that when an autistic child views their neurotype as a desirable social identity rather than a source of shame, it can help them overcome stigma. A 2023 review by Rivera and Bennetto found that autistic individuals who identify with the autistic community have higher self-esteem and wellbeing and experience fewer adverse effects of minority stress on mental health. This highlights the importance of community belonging for autistic youth. Generally, feeling connected protects against youth suicide, but it is especially vital for autistic youth who find it hard to fit in. These children may not feel accepted or understood in conventional peer groups, so autistic social clubs, camps, mentorship programs, and online communities can support them in building connections. Research shows that autistic children who spend time together in inclusive environments often develop a deeper understanding of each other and feel relief from social pressure. Autistic-led peer programs report higher social enjoyment and lower anxiety compared to neurotypical therapist-led social skills groups (Shea et al., 2024). One study found that autistic youth said being with other autistic individuals helped them "finally relax" and stop worrying about being judged, which boosted their confidence (Crompton et al., 2020). Offer opportunities for autistic youngsters to meet and bond with their neurokin in person or online to strengthen their sense of shared identity. They can celebrate their interests, share experiences, and tackle problems with people who "get it". This friendship and collective identity can help individuals overcome feelings of estrangement.

Self-determination theory (Ryan & Deci, 2000) states that wellbeing blossoms when autonomy, competence, and relatedness are fulfilled. Traditional autistic treatments often disrupt these needs, such as harsh behavioural regimens that focus on conformity or tell children they must change to be accepted. Neuroaffirming identity interventions aim to meet these needs. Involving the child in support decisions and respecting their choices – such as letting them speak or type – can support autonomy. Encouraging a child's passion for computers or art and framing it as an opportunity to build competence is beneficial. The child might develop relatedness by having mentors or classmates who appreciate them. Early therapies should promote autistic youth to self-determine and feel capable and respected. Clinicians should replace conformity-focused goals like "make eye contact for X seconds" with more meaningful ones such as "identify your feelings and communicate them in a way that works for you" or "engage in a hobby with a friend." Giving autistic children a sense of control and recognising their mastery – even in unconventional areas – fulfils resilience-building psychological needs. Building resilience involves fostering a child's self-determination, helping them feel in control of their story and capable of growth. This aligns with evidence showing that self-advocacy and independence therapies can reduce sadness and improve coping in autistic teens, such as letting youth set objectives or make decisions.

The aim of resilience theory is to develop protective factors that help young people recover from hardship. Family support, school involvement, and other protective elements for autistic adolescents may require a neurodivergent perspective. For a student who feels alienated in a mainstream class, "school connectedness" may seem different, but connecting them with a scientific club mentor who shares their passion can be a similar experience. Developing a positive autism identity is like minority youth building a strong cultural identity to guard against discrimination. Resilience research suggests neurodivergent-friendly methods to promote protective processes, such as having a supportive adult, coping skills, and finding meaning or purpose. Counsellors may serve as the helpful adult who truly "sees" and accepts the young person. Learning coping skills might be framed as a "power-up" for a child who loves superheroes. The idea that "my brain is different and that's

what makes me an amazing artist/robotics builder" can give an autistic 11-year-old dignity and purpose. Besides reducing risk, resilience fosters strengths and hope. A neuroaffirming approach highlights strengths and prepares young people for challenges. Teaching an autistic preteen how to self-advocate for sensory breaks builds resilience: it helps them navigate a confusing world without giving up. The child learns "I can survive hard things, I have people who support me, and I have ways to cope that don't require me to pretend to be someone I'm not." These micro-interventions build resilience. This outlook might be the best defence against suicide.

Before showcasing an example program, it is important to recognise that embracing neurodiversity does not mean overlooking genuine struggles. Instead, it involves addressing these challenges in a way that respects the individual's identity. For example, suppose an autistic child experiences extreme anxiety. In that case, a neuroaffirming therapist will undoubtedly work on easing anxiety – but they will frame it as "let us find tools that help you feel better" rather than "let us fix your autistic behaviour". While this distinction may seem subtle, it is deeply significant for the child. One approach pathologises their autism, whereas the other supports them as a whole person. Research on clinical interventions increasingly acknowledges this difference. Murray et al. (2022), for instance, highlight the adaptation of cognitive-behavioural therapy for autistic youth by integrating special interests and visual techniques, both of which respect identity and enhance outcomes. Ultimately, mental health support for autistic youth should be additive (building new skills and supports), rather than subtractive (trying to remove core aspects of who they are).

MegaMind: A Digital Intervention Model

To illustrate these principles in practice, consider the "MegaMind" program, an early-stage digital intervention designed to promote resilience and positive identity in neurodivergent preadolescents. MegaMind is an 8-week program that operates in a Minecraft sandbox virtual environment. Why Minecraft? For one, Minecraft is a popular special interest for many kids, including those on the spectrum, and it offers an open-ended, creative space. MegaMind uses game-like activities to teach social-emotional skills. Players create an avatar and explore a virtual world, undertaking resilience-themed missions and challenges such as recognising stress and finding a "chill zone". Neurodivergent-friendly adjustments are made to the environment. Visual stimuli can be toggled to prevent sensory overload in the game, and children can communicate using text or emoji instead of voice chat.

MegaMind actively promotes children's individuality. MegaMind allows students to connect on their own terms, unlike typical social skills groups that teach eye contact or "appropriate" greetings. The game lets one child's avatar flap its wings or spin in circles, which is similar to stimming. The software celebrates each avatar's abilities in stories. A child who likes trains may build an avatar with a train suit and lead a group "train adventure" quest, turning a common autistic interest into leadership and pride. This is different from previous intervention strategies (like some ABA programs) that judged success by how similar the autistic child was to peers. MegaMind measures success through psychosocial growth, confidence, friendships, mood, and creative problem-solving. The program reduces real-world learning demands by providing a safe virtual space for autistic kids to be themselves. Early feedback from kids and parents shows that children feel "accepted" and "understood" in the game, maybe even making their first real friend.

MegaMind also includes peer mentoring, where older autistic teenagers or young adults trained as moderators act as "guides". Mentors share stories about their own experiences, gently demonstrate coping strategies (e.g. taking a break in a quiet virtual room when overwhelmed), and most importantly, affirm the younger participants' feelings. Based on social learning theory, children learn from somewhat older peers. MegaMind mentors show that "it's okay to be autistic; I've been where you are, and it gets better". Feeney et al (2021) found that near-peer mentoring can increase participation and reduce anxiety in autistic adolescent programs because mentees relate more easily to mentors than to adult therapists. A child may speak more openly in MegaMind if they know the mentor enjoys Minecraft or has struggled at school. These interactions help build a sense of community.

MegaMind innovates clinically by altering the environment, not the child. It aligns with the neurodiversity concept by creating a micro-environment that adapts to autistic youth rather than forcing them to adapt to a stressful reality. This modified setting aims to help them build confidence and skills that they can later apply in real life with counsellors and parents. The game features an AI "emotion coach" character that will gently check in if a child's avatar has been inactive or is typing repeated sad words in chat and ask, "I see you are quiet, want to use the mood spinner to convey how you feel?" For kids who struggle with open communication, a private in-game tool allows them to choose an emoji or colour to represent their emotions, providing facilitators with insight into who may need extra support. Digital augmentation supports findings that some autistic youths are more comfortable opening up to virtual agents or prompts than to doctors (who can unintentionally frighten or overwhelm them).

MegaMind is a prototype for a new wave of acceptance and strengths-based therapies, but such programs are still undergoing research and refinement. In limited samples, MegaMind (in-house) pilots demonstrated reductions in self-reported anxiety and improvements in "self-concept clarity" (the clarity with which participants view themselves and their traits) following the 8-week session. The programme represents a shift in autism intervention from compliance training to mental health promotion and identity support. It has great potential but requires technological resources, facilitator training in counselling and gaming, and careful customisation to each child's needs (not all autistic children like video games). We will soon examine practicalities and limitations. We begin by exploring what counsellors can incorporate from these techniques into their everyday practice.

Implications for Practice

Psychotherapists and counsellors who work with autistic children and adolescents can improve outcomes by adopting a neuroaffirming, identity-focused approach. This involves shifting from a pathology-based to a strength-based, collaborative paradigm. Practical implications and strategies for professionals include that therapists should focus on measuring mental health and skill development rather than on how "normal" an autistic young person becomes. Success might mean enhanced self-esteem, decreased suffering, or greater engagement with others on the child's terms, rather than merely trying to suppress autistic behaviours. Instead of attempting to eliminate hand-flapping or scripting, a therapist may encourage the child to use these behaviours strategically (such as flapping to calm down) or creatively. This reframe supports recent criticisms that masking autistic traits is unethical and ineffective (Botha et al., 2022). The goal is to help the child thrive as their true self, not to change them.

Encourage positive autistic discussion in therapy. This could involve teaching a young person about prominent autistic role models, reading age-appropriate books that celebrate neurodiversity, or openly discussing the child's own experiences with autism. Therapists may comment, "Your brain works a bit

differently, and that can be really cool – you notice things others miss!" Counsellors help reduce depression-causing internalised negativity by normalising and promoting neurodiversity. Some clinicians use identity mapping exercises, where the child creates a chart of things they like about themselves (such as "autistic," "honest," or "good with animals") and things they find difficult. Then, the therapist helps them see how many positives are connected to their autistic way of thinking.

Autistic children often think visually or benefit from structure. Visual aids in counselling improve communication and emotional understanding. For example, instead of relying solely on conversation therapy (which can be difficult for children who struggle with rapid language processing or introspection), a counsellor might use emotion cards, thermometers, or drawing exercises to help the child identify feelings. They could make a visual calendar or checklist for coping strategies (literally drawing "calm breathing," "hug a pillow," "play music" as options the child can pick). These techniques respect the child's communication style and lower the demands that can cause shutdowns.

Research shows that such augmentative assistance can significantly enhance emotional regulation in autistic children, as they feel understood on their own terms rather than failing to meet an all-verbal adult-centric approach. Using the child's interests in therapy is an excellent way to engage them. According to MegaMind, harnessing a child's passions, such as Minecraft, trains, astronomy, or anime, is a straightforward path to motivation and enjoyment. A counsellor might use a train analogy to discuss staying "on track" with coping skills or role-play with a favourite superhero to practise social skills. Content is less important than the message of respect: your interests matter. Therapy can use "circumscribed" interests to connect rather than pathologise individuals. The child becomes the expert in the room when talking about their subject, which can empower a child who feels incapable in other areas. Clinically, engaged and content children are better equipped to learn new coping strategies and perspectives. ills and views.

Support from peers can have a profoundly positive impact on someone's life. Counsellors should consider providing autistic clients with group activities or peer meetups. This could include organising a small social group for autistic preteens to play games in the therapy space or linking a family to autism community events. Even in one-on-one sessions, a counsellor can replicate some peer connection benefits by adopting a more collaborative approach, such as encouraging the child to teach them something, shifting the power dynamic, to foster a sense of equality. Where possible, involving autistic adults or older youth as co-facilitators or guest speakers can serve as sources of inspiration and comfort for young clients. Imagine a 10-year-old autistic child meeting a successful autistic university student who says, "I used to get really anxious in school too, here is what helped me." These connections provide hope and practical advice to enhance the therapist's support.

Bullying, sensory overload, and social failure traumatise many autistic youngsters. Additionally, they can experience "autistic burnout", a state of extreme exhaustion from prolonged masking or stress. Counsellors should view meltdowns, withdrawal, and regression as trauma or burnout symptoms, not random "problem behaviours". Trauma-informed sessions empower children with choices, create a sense of safety (perhaps by softening the lights or allowing breaks), and validate their emotional responses ("That noise hurt you, I see why you got upset" rather than scolding). It also involves teaching self-advocacy as a coping strategy: for instance, helping the child practise a word or signal to use when feeling overwhelmed, so adults can adjust the environment. Recognising autistic burnout may include convincing parents that a child who remains calm all day but erupts at home is overwhelmed. Counsellors can assist families in preventing crises with accommodations like a peaceful decompression hour after school. Seeing the autistic child's difficulties through a trauma and stress lens makes therapies more compassionate and effective, reducing blame and focusing on healing.

The success of MegaMind demonstrates that digital tools can improve therapy. Counsellors should be willing to incorporate apps, games, and other technologies to engage young clients. Use an autistic-friendly mood-tracking software or suggest a moderated online forum where the young person can practise social skills safely. Some autistic teenagers found telehealth services, which became popular during the COVID-19 pandemic, helpful because they could open up at home, often off-camera or via chat. Clinicians can offer such formats when suitable. Meeting the child where they are is essential. If a client enjoys texting, try therapeutic text check-ins between sessions. If they find face-to-face communication stressful, perhaps use a shared Google doc to "talk". Many games and applications teach emotional awareness, social problem-solving, mindfulness, and more in enjoyable ways. Professionals should evaluate these technologies for quality and use them to complement human interaction. However, a child's comfort with digital media can increase engagement and transfer therapeutic benefits into daily life.

Therapists and counsellors must also be open to learning from autistic people and updating their techniques. Neurodiversity-affirming practice is a relatively new paradigm, and it challenges several standard practices. Clinicians should learn about autistic culture and the Double Empathy problem, which turns social communication challenges into a two-way gap in comprehension. Importantly, autistic people can contribute valuable insight as teachers, advisors, or first-person accounts in literature. This teaches practitioners and models the collaborative mindset we aim to portray to clients ("I value autistic voices, and I'm not the sole expert here"). Traditional therapeutic methods like forced eye contact and punishment-based behaviour modification are increasingly considered harmful or ineffectual for long-term health. Keeping up with research and listening to autistic self-advocates helps one's practice benefit clients. Therapists should recognise neurodivergent clients as a minority group with genuine experiences and adjust their methods to be culturally competent.

These tactics can help counsellors build a holistic, flexible, and powerful therapy space for autistic youth. Nurture, not fix, takes precedence. Early research suggests that such an approach minimises negative outcomes like suicidality and actively promotes positive growth like confidence, self-knowledge, and hope, which are essential for long-term mental health.

Conclusion

As professionals in counselling and psychotherapy, we are uniquely positioned to influence the developmental path of autistic youth at risk of suicide. Research clearly shows that risk factors emerge early, but so do opportunities for prevention. By prioritising neuroaffirming identity development during preadolescence, we can address some of the underlying causes of despair, such as feelings of alienation, low self-worth, and ongoing stress caused by having to pretend, before they become ingrained in adolescence. Grounded in social identity theory, self-determination theory, resilience research, and the social model of disability, this approach reminds us that health is not just the absence of illness but the presence of positive connection and self-esteem. Initiatives like the MegaMind program demonstrate how we can creatively apply these principles, combining psychology, technology, and community-building to support young people in ways that are engaging and authentic to them. Although such

programs are still evolving, they offer a glimpse into a future where an autistic 10-year-old might confidently say, "I like who I am," and genuinely mean it; an outcome that could, quite literally, save their life. For practitioners, the challenge is to incorporate these insights into everyday practice: to be that counsellor who not only treats a child's anxiety but also affirms their right to be different; to guide families in not just accommodating autism but celebrating it; and to advocate for systemic changes in schools to become more inclusive and understanding. It involves supporting our clients beyond therapy, perhaps consulting with a teacher about bullying issues or assisting families in finding neurodiversity-affirming support groups. The small practical steps we take today in clinics, schools, and community spaces can help build a safety net of acceptance around these young individuals. In essence, preventing suicide among autistic youth demands a fundamental shift in how we approach early intervention. It's not enough to solely target problematic behaviours or co-occurring symptoms in isolation. We must proactively foster protective factors, especially a secure sense of identity and belonging. This preventive approach recognises autistic children not as fragile beings needing correction, but as resilient individuals who can thrive when provided with the right supports. It's about acknowledging their humanity and individuality, which in turn helps them imagine a positive future for themselves. Suicide prevention in this context is therefore about more than crisis response, it's about nurturing strength and pride from an early age. By igniting that spark of self-acceptance and connection, we can help ensure that neurodivergent youth not only survive but flourish, feeling valued and understood. This is both the challenge and the promise of embracing neurodiversity within our future mental health strategies. It's a challenge we, as a professional community, must urgently meet, and a promise we can deliver through empathy, innovation, and collaboration with those who matter most: the autistic young people themselves.

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Listening to the Silence: Shame, Storytelling, and Healing with Aboriginal Women

Dr. Anni Hine Moana

Keywords: *Aboriginal; Women; Narrative; Cultural; Settler- Colonisation*

Abstract

This article explores the relationship between shame and alcohol use among Aboriginal women in Australia, drawing on qualitative research conducted with women who have experienced alcohol problems and the Aboriginal counsellors and community workers who support them. The findings highlight the impact of trans-generational trauma, systemic racism, and gendered oppression on the development and maintenance of alcohol problems. The use of narrative therapy emerged as a culturally congruent and effective approach, enabling women to reframe their experiences and reconstruct positive self-identities. The article discusses the implications for counsellors, particularly the need for culturally safe, trauma-informed, and narrative-based practices that validate lived experience and support justice-seeking. It calls for a shift in mainstream counselling services to better meet the needs of Aboriginal women through deep listening, acknowledgment of historical harms, and decolonising therapeutic approaches.

Introduction

Since settler-colonisation, the experiences of Aboriginal women in Australia have been profoundly impacted by its associated policies and practices which have been described as the Australian Genocide (Tatz, 1999, 2001).

Most Australian Aboriginal people have experience of systemic racism, ongoing systemic discrimination by the trauma of forced child removal policies and have been affected directly or indirectly by this, and the resultant dislocation from culture (Dudgeon, Rickwood, Garvey & Gridley, 2014). Such experiences are known to contribute to a range of harms associated with social and emotional wellbeing, including a heightened vulnerability to alcohol and other drug (AOD) problems (Bennett, 2013; Bessarab & Crawford, 2013).

Shame, a deeply internalised response to social stigma and marginalisation (Goffman, 1963), has also been identified as a significant risk factor in the development and maintenance of substance use issues (Dearing et al., 2005; Potter-Efron, 2002).

This article draws on qualitative research conducted with Aboriginal women who have experienced alcohol problems, as well as Aboriginal counsellors and community workers who support them. It explores the implications for counsellors working in mainstream services, particularly the need for culturally safe, trauma-informed, and narrative-based approaches to therapy. The findings underscore the importance of listening—deep, uninterrupted listening— as a therapeutic act that validates lived experience and facilitates healing (Bacon, 2007, 2013).

The Power of Story: Dorrie's Narrative

The research began with a story: one that crystallised the emotional and ethical imperative of the work. 'Dorrie', an Aboriginal woman interviewed for the study, shared a harrowing account of her life marked by child slavery, forced separation from her children, and systemic neglect. Her life, which began in a western Victorian town in the mid 1950s, bears witness to the enduring legacy of settler-colonial violence and its impact on Aboriginal women's wellbeing.

Dorrie described being taken in by a non-Aboriginal family who subjected her to physical abuse and forced labour from a young age. Each of her children was taken from her at birth and raised by the same family, with the complicity of local authorities. "It was all allowed," she said, recounting how the police failed to intervene when she tried to reclaim her children. The trauma of these experiences led to alcohol use as a form of self-medication. "I reckon it was after losing that first baby. Heartbreaking it was," she said.

Her narrative, shared from a sparsely furnished ministry unit in Melbourne, was punctuated by grief, loss, and a desire for truth-telling. "I want you, Anni, to tell people what happened to me," she said. "Most people don't know about all this going on." Dorrie's story exemplifies the kind of lived experience that is often silenced in mainstream therapeutic contexts yet holds profound implications for counsellors seeking to support Aboriginal women (Hine Moana, 2022).

Understanding Shame in Context

Shame is a self-conscious emotion responding to the feeling that one's social identity is flawed due to perceived failures to meet societal expectations or internalised standards of worth (Goffman, 1963). For Aboriginal women in Australia, shame is often rooted in experiences of systemic racism, gendered oppression, and historical trauma (Drahm-Butler, 2015; Wingard & Major, 2015). These intersecting forces create conditions in which shame becomes not only a personal burden but a social and political construct that reinforces marginalisation.

The women interviewed in this study described shame as a pervasive and cyclical experience. It was linked to being Aboriginal, to being female, and to being perceived as "drunk" or

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"unworthy." One participant noted, "Blackfellas are perceived [by white people] as alcoholics anyway," highlighting the racialised stigma that compounds the emotional toll of substance use. This internalised shame often led to self-silencing, isolation, and a reluctance to seek help—factors that exacerbate the risk of harmful alcohol use.

Research has shown that shame thrives in secrecy and loses its power when exposed in the presence of an empathic listener (Brown, 2012). For Aboriginal women, the opportunity to share their stories in a safe and respectful environment is not only therapeutic but also a form of resistance against dominant deficit narratives . By externalising shame and situating it within a broader socio-historical context, women can begin to reconstruct their identities and reclaim their voices.

The concept of "misogynoir," coined by Bailey (2010) to describe the intersection of racism and sexism experienced by African-American women, was adapted in this study to reflect the unique configuration of racialised misogyny confronting Aboriginal women in Australia. Jackie Huggins' (1998) metaphor of "two folds of the cloth" similarly captures the dual oppression faced by Aboriginal women: both as Indigenous people and as women within a patriarchal society.

Counselling Implications

The findings of this study have significant implications for counsellors working with Aboriginal women, particularly in the context of alcohol and other drug (AOD) services. Despite Aboriginal people comprising one in seven clients of mainstream AOD services, many of these services fail to provide culturally appropriate therapeutic responses. Non-Aboriginal counsellors often struggle to listen without interrupting, a practice that can be experienced by Aboriginal clients as dismissive or invalidating ((Vickery & Westerman, 2004).

Aboriginal counsellors and community workers emphasised the importance of creating conditions in which women could tell their stories without interruption. This approach aligns with Indigenous healing practices such as deep listening, or dadirri, which prioritise presence, patience, and respect. For mainstream counsellors trained to direct sessions and dispense remedies, adopting a non-interruptive stance may require a fundamental shift in therapeutic orientation.

Narrative therapy emerged as a particularly effective modality in this study. It supported women to explore the context in which their alcohol problems developed and to challenge the dominant narratives that positioned them as deficient or broken. Through storytelling, women began to "look at their own history books," as described by Aboriginal AOD counsellor/educator and elder,Aunty Suzanne Nelson, and to recognise that their alcohol use was not a personal failing but a response to systemic harm.

To this end, counsellors working with Aboriginal women must move beyond symptom-focused interventions and engage with the broader social, historical, and cultural dimensions of their clients' experiences. This includes acknowledging the legacy of the Stolen Generations, validating experiences of racism and misogyny, and supporting justice-seeking as part of the healing process As the women in this study demonstrated, feeling heard, having injustices witnessed, and being supported to reframe their narratives are critical components of effective counselling (Tamasese & Waldegrave, 2003; Tamasese & Leban, 2003).

Narrative Therapy as Resistance

Narrative therapy, as employed by Aboriginal counsellors and community workers in this study, provided a culturally congruent and empowering framework for addressing alcohol problems among Aboriginal women. Rather than pathologising the individual, narrative approaches position the "problem" within a broader social, historical, and political context—one shaped by settler-colonialism, racialised misogyny, and trans-generational trauma (White & Epston, 1990; Wingard & Lester, 2001).

The women interviewed described how narrative therapy helped them to reframe their experiences and challenge deficit-based discourses. Through storytelling, they began to see their alcohol use not as a personal failure but as a response to systemic harm. This reframing was described by one participant as "looking at your own history book," a metaphor introduced by Aunty Suzanne Nelson. It reflects a shift from internalised shame to externalised understanding—a process that supports the reconstruction of a positive self-identity (Denborough, 2008, 2011; White, 2005; White & Epston, 2005).

Narrative therapy also facilitated the emergence of alternative stories—stories of resilience, strength, and courage. These counter-narratives disrupted the dominant stereotypes that have long defined Aboriginal women in Australia and opened up new possibilities for healing and self-determination. As Bacon (2007) and Wingard & Major (2015) argue, narrative approaches are particularly effective in contexts where identity has been shaped by oppression and marginalisation.

Importantly, the therapeutic value of narrative work was not limited to the individual. It also served a communal function, validating the lived experiences of Aboriginal women and contributing to a collective process of truth-telling and resistance. In this way, narrative therapy intersects with Indigenous healing practices and supports the broader goals of social justice and reconciliation.

Voices of Counsellors and Community Workers

The Aboriginal counsellors and community workers who participated in this study provided critical insights into the structural and emotional dimensions of alcohol use among Aboriginal women. They described the debilitating effects of trans-generational trauma, stigma, discrimination, and ongoing racism—factors that contribute to feelings of shame and serve as barriers to help-seeking.

Their narratives echoed those of the women they supported, reinforcing the link between racialised misogyny and harmful alcohol use. Themes that emerged from their accounts included the relationship between racism and shame, anxiety about public visibility, feelings of unworthiness, and the impact of historical and ongoing trauma. These professionals emphasised that alcohol problems must be understood within the context of systemic oppression, not as isolated or individualised issues.

The counsellors also highlighted the importance of culturally safe practices, including deep listening, validation of lived experience, and the use of narrative approaches. They described how these methods helped women to feel heard, have their injustices witnessed, and reframe their alcohol use in light of their lived realities as Aboriginal women. These practices not only supported behavioural change but also facilitated the reconstruction of a positive cultural identity.

A significant finding of this study was the extent to which racialised misogyny—what Bailey (2010) terms "misogynoir"—has shaped Aboriginal women's self-perceptions. This insight, voiced consistently by both counsellors and clients, underscores the need for therapeutic approaches that address the intersection of race, gender, and trauma. As Huggins (1998) noted, Aboriginal women experience "double oppression"—a reality that must be acknowledged and addressed in counselling practice.

Key Findings and Recommendations

This study found a significant relationship between the self-conscious emotion of shame and the development of alcohol problems among Aboriginal women. Shame was not only a personal experience but a social and political one, shaped by trans-generational trauma, systemic racism, and gendered oppression. The narratives collected revealed that shame often led to self-silencing, isolation, and a reluctance to seek help—factors that perpetuate harmful alcohol use.

Narrative therapy emerged as a powerful intervention, enabling women to reframe their experiences and challenge deficit-based discourses. By situating their alcohol use within a broader socio-historical context, women were able to reconstruct their identities and develop a more positive self-account. This process was supported by Aboriginal counsellors and community workers who employed culturally safe practices, including deep listening, validation, and justice-seeking.

The implications for counsellors are clear. Mainstream AOD services must move beyond symptom-focused interventions and engage with the lived realities of Aboriginal women. This includes:

- **Creating culturally safe spaces** where women can share their stories without interruption.
- **Acknowledging historical and ongoing injustices**, including the legacy of the Stolen Generations and the impact of racialised misogyny.
- **Employing narrative and storied approaches** that support identity reconstruction and healing.
- **Validating lived experience** and supporting justice-seeking as part of the therapeutic process.

These recommendations are not only supported by the voices of Aboriginal women and their counsellors but also align with broader calls for decolonising therapeutic practice and promoting social justice in mental health care (Brady, 2012; Waldegrave, 2012; Wingard & Major, 2015).

Reflection and Call to Action

The testimonies of Aboriginal women and their counsellors underscore the urgent need for systemic change in how counselling services engage with Indigenous clients. To address the disparities in health and wellbeing between Aboriginal and non-Aboriginal Australians, service providers must develop a deeper understanding of the historical and structural factors that contribute to these disparities.

Healing requires more than individual therapeutic work—it demands collective acknowledgment of past and present harms.

As the research participants made clear, justice-seeking must be supported and validated within therapeutic contexts. This includes recognising the role of settler-colonialism in shaping Aboriginal women's experiences and committing to practices that honour their resilience and strength.

Counsellors must listen—not just to the words, but to the silences, the histories, and the truths that have long been ignored. In doing so, they can support Aboriginal women not only to move away from harmful alcohol use but to reclaim their stories, their identities, and their futures.

Limitations of the Research

This study does not claim to represent the experiences of all Aboriginal women across Australia's diverse communities. Each narrative is unique, shaped by individual memory, context, and interpretation. As Antze and Lambek (2016) suggest, "Memories are produced out of experience and, in return, re-shape it." From a therapeutic perspective, this limitation is also a strength: counselling can help reframe memories by introducing new interpretive lenses, such as understanding how dominant discourses have positioned Aboriginal women and their alcohol use through racist and sexist stereotypes.

The narratives shared by participants reflect deeply personal and painful experiences. The trust placed in the researcher by Aboriginal women, counsellors, and community workers was both a privilege and a responsibility. The study sought to honour this trust by positioning participants as co-researchers and employing a culturally respectful, potentially decolonising methodology.

Conclusion

The experience of shame, cited as a risk factor in the development of alcohol problems, is a significant issue for many Aboriginal women. Shame is linked not only to trans-generational trauma resulting from the Stolen Generations and other colonial policies, but also to ongoing experiences of misogynistic racism, stigma, and discrimination. These intersecting oppressions contribute to harmful alcohol use and create barriers to help-seeking.

Mainstream AOD counselling services that focus solely on substance use without addressing underlying trauma and systemic harm do not provide appropriate therapeutic responses for Aboriginal women. Culturally safe, narrative-based approaches are essential. These approaches support women to feel heard, have injustices witnessed, and reframe their alcohol use in light of their lived experiences.

Narrative therapy intersects with Indigenous healing practices and supports the deconstruction of oppressive discourses. It enables Aboriginal women to re-story their lives, reclaim their identities, and resist deficit narratives. For counsellors, the imperative is clear: listen deeply, validate lived experience, and support justice-seeking as part of the healing journey.

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Be Here Now: Journey into Therapeutic Presence through Co-Creation

Natalee Martin

Keywords: *Therapeutic presence, collaborative therapy, intentionality, social constructionism, autoethnography.*

Abstract

Despite extensive research on the therapeutic relationship, the role of therapeutic presence, considered a fundamental aspect of effective therapy, remains underexplored, with its distinctions, applications, and the nuanced experiences of counsellors not fully understood.

This paper explores the author's journey as a counsellor, examining the value of intentionally cultivating therapeutic presence within the therapeutic relationship. This autoethnographic study investigates how therapeutic presence is cultivated and maintained, and whether the counsellor's presence holds more value than technique. From a social constructionist perspective, which advocates for a collaborative approach to therapy, the study considers the possibility of an alternative view on the role of counsellor presence. Data collected over a 10-month period through reflective journals and vignettes inform the research text, drawing on the author's experiences in a counselling clinic working with individuals and couples, and comparing those experiences to existing literature.

Key findings highlight a shift from individualistic understandings of presence toward a relational, co-constructed perspective, one that unfolds dynamically within the counsellor–client interaction. Additionally, cultivating a flexible balance between presence and process appeared to support more attuned and collaborative therapeutic experiences.

Introduction

I believe Maya Angelou's words, "People will forget what you said, people will forget what you did, but people will never forget how you made them feel", capture the essence of my personal and professional orientation. They resonate deeply, guiding me to believe that empathy, kindness, and genuine connections can profoundly impact emotional well-being. This approach shapes my professional and personal life, influencing my interactions with colleagues, clients, supervisees, friends, and family. I consider my way of being with others as intimately tied to the concept of presence.

Growing up along the east coast of Australia as a white Australian woman, with formative educational experiences both locally and overseas, I was shaped by frequent relocations and exposure to diverse environments and relationships. These early experiences fostered adaptability, relational sensitivity, and present-moment awareness, and laid the foundation for my evolving cultural lens and therapeutic stance.

I bring to my research a perspective informed by coastal urban life, varied learning contexts, and the lived experience of a blended family, qualities that continue to shape my values and professional identity. My work as a counsellor, professional supervisor, and mindfulness facilitator is grounded in extensive community sector experience supporting individuals and families from diverse cultural and socio-economic backgrounds, a foundation further enriched by postgraduate study that reshaped and refined my professional orientation. These experiences have informed both my therapeutic approach and the direction of this inquiry, fostering a deep appreciation for therapeutic presence as a way of being.

Presence, according to Rogers (1957), involves a wholehearted attentiveness, being mentally and physically anchored in the here and now, allowing for authentic, meaningful connection with others. Similarly, therapeutic presence involves the application of this concept in a counselling setting. It includes active listening, empathy, and creating a safe, non-judgmental space for clients (Howes, 2014).

To better understand the concept of presence, I turned to the literature on therapeutic presence, which reveals its depth, complexity, and varied interpretations across modalities. Therapeutic presence is considered a rich, multifaceted concept (Geller & Greenberg, 2012), with origins tracing back to tribal times when community members offered counsel (Field, 2022). Carl Rogers introduced "therapeutic presence" in the 1940s, emphasising empathy, unconditional positive regard, congruence, and counsellor presence (Rogers, 1957; 1980; Schmid, 2002). Early pioneers like May (1967) and Bugental (1976) underscored its importance in creating a healing environment, while later studies by Hycner (1991) and Erskine (2015) reinforced its relevance.

Research shows that therapeutic presence significantly impacts the healing process, focusing on empathy and creating a compassionate space (Vinca & Hayes, 2007; Geller & Porges, 2014; Cain, 2019; Norcross & Lambert, 2019). Cross-cultural studies reveal that cultural norms influence the expression and reception of therapeutic presence (Zhao, Li, & Chen, 2022; Jin et al., 2022), challenging the notion of a one-size-fits-all approach (Sue & Sue, 2016). Counsellor presence is purported to enhance therapeutic relationships and outcomes, fostering deep connections, building trust, and co-constructing meaning with clients (Gergen, 2009; Anderson, 2012). It is considered crucial for forging genuine connections and sparking meaningful dialogue (Tannen & Daniels, 2010).

Despite its foundational status, counsellor presence remains nuanced and interpreted differently across approaches. Ratner (2017) highlights its ongoing evolution and complexity. Hartley (2002) notes debates on its role and implementation

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in therapy. Emotion-Focused Therapy (EFT) emphasises attunement to the client's emotional and bodily experiences (Greenberg et al., 1993; Greenberg, 2007). Existential and Gestalt therapies focus on the here-and-now (Bugental, 1987; Perls, 1970; Schneider & May, 1995). Psychodynamic and relational approaches highlight the healing relationship, nurturing a safe space for clients to explore their inner landscapes (Mitchell, 2000; Stern, 2004; Stolorow et al., 1987; Gelso, 2010). Given such varied interpretations and implementations of counsellor presence, one might wonder if the counsellor's nuanced experiences with presence remain understudied because the experience and role of presence differ depending on the approach adhered to, underscoring the need to examine presence within the context of the therapeutic model.

Origins in counselling practice

Beginning my internship at the Queensland University of Technology (QUT) counselling clinic, a final-year requirement of my Masters program, I was optimistic. I assumed my full presence and natural relational style would smoothly blend into this setting, allowing me to follow a counselling process while being present with my clients and the counselling conversation. I was naive! A reality check came swiftly. The unique clinic setting, being observed behind a one-way mirror by peers, was far from a typical occurrence. I became fixed on performing well, eager to apply the counselling techniques I was learning. Noting that my focus on technique often overshadowed my presence with the client, and the flow of our conversations, as I clung rigidly to a solution-focused therapy framework. I felt a wave of confusion and uncertainty when the client responded in ways that did not quite fit the structure of my approach, leaving me to wonder if the client felt equally disoriented and lost.

Reflecting on my early counselling sessions, I realised my divided focus had a significant impact. By rigidly sticking to a therapy model, as Keeney & Keeney (2012) highlight, my ability to be fully present and therapeutic was hindered. This created disruption and impacted my effectiveness, noting my struggle to actively listen or ask meaningful or relevant questions of the client. As Anderson & Gehart (2022) maintain, tuning into the unfolding conversation and co-construction can spark more relevant and engaging questions and comments.

The interplay between presence and structured therapeutic processes is a key area of debate. Keeney & Keeney (2012) argue that strict adherence to therapy models can diminish a therapist's ability to be fully present, leading to a sense of disconnection and inauthenticity. They suggest that embracing the uncertainties and mysteries of change allows for a more genuine therapeutic presence. Conversely, some scholars emphasise the necessity of clear theoretical frameworks for navigating relationships and crafting tailored treatment plans (Lombard & Ditton, 1997; Tomlinson, 2019). This tension is further complicated by the argument that some level of structure is necessary to ensure consistency and predictability in therapeutic practice (Malet et al., 2022).

So, there it was, my lightbulb moment about the vital role of counsellor presence. While this concept was not covered during my Masters program explicitly, my own experiences underscored its importance for me. Fostering meaningful connections with others has always been central to my approach, so it felt natural that early in my clinic year, I became intrigued by the idea of counsellor presence. An intrigue that led me to wonder if cultivating my presence should be an integral part of my method. This introspection prompted me to question whether presence was indeed more imperative than process, and whether upholding my preferred present and relational way of being meant abandoning structured processes altogether. Equally, I found myself pondering, if I choose to follow a structured process, should intentionally cultivating presence become an integral part of my approach, both prior to and during a counselling conversation. This reflective tension gave rise to my research, which seeks to understand how presence can be cultivated within structured therapeutic practice. Rather than positioning presence and process as opposing forces, I began to explore how they might inform and enrich one another.

Co-creating languages of connection

My evolving counselling lens increasingly aligns with social constructionist approaches, particularly collaborative conversations. Social constructionism emphasises how our interactions and relationships shape our understanding of the world (Anderson & Gehart, 2007). This perspective values the co-construction of new understanding and respects uniqueness, offering diversity and empowering others to shape their lives (Anderson, 2012). In practice, this has prompted a subtle yet impactful shift in my approach: rather than applying techniques prescriptively, I have begun to engage with clients in ways that honour their language, values, and unfolding narratives. As Anderson & Gehart (2007) suggest, therapeutic change emerges through dialogic relationships and mutual responsiveness.

My journal entries and vignettes illustrate how this stance, marked by presence, curiosity, and shared meaning-making, can foster deeper insight, emotional resonance, and therapeutic momentum. Appreciating multiple viewpoints within this framework has allowed me to explore how presence and process intertwine in my evolving practice, offering a relational space where meaning is co-created.

Journal entries, documented throughout my clinic year, became a key source of reflection and analysis, helping me trace the development of therapeutic presence in practice. Upon reviewing later journal entries, I noticed several instances where my increased presence seemed to align with collaborative meaning-making. This heightened presence involved being more attentive, engaged, and emotionally connected during interactions. As a result, these interactions appeared to foster more meaningful and productive collaborations with clients, where we could co-create meaning and share understanding.

After observing these particular instances of heightened and collaborative meaning-making, I began questioning whether cultivating presence is a solo responsibility or something that organically unfolds within the collaborative relationship. This latter perspective is supported by Geller and Greenberg (2012), who argue that while individual presence involves the counsellor's attunement and mindfulness, the co-creation of presence emerges from mutual, interactive processes in which both counsellor and client contribute to the therapeutic experience.

Therefore, this study is rooted in my journey with presence and my experiences as an evolving counsellor who values genuine connections. I hope to explore the significance of presence in fostering collaborative relationships and scrutinise the factors influencing its efficacy. Initially, I wondered if cultivating and sustaining presence should be an intentional pursuit in counselling conversations. As I delved into the literature and reflected on my practice, my research questions began to take shape: How is presence intentionally cultivated, both individually and within collaborative relationships? What barriers might exist to sustaining presence? Is presence more valuable than specific techniques in creating meaningful connections?

To further understand these questions and how they intersect with my own experience, relevant literature on therapeutic presence; presence versus process, presence and intentionality, and the co-construction of presence will be examined in the sections to follow.

Methodology: Auto-ethnographic research

Autoethnography, as explained by Ellis et al. (2011), is not just a research and writing method; it is a transformative approach that delves into personal experiences within sociocultural contexts, boldly challenging conventional research techniques while asserting that research is an inherently political and socially aware endeavour. It is an autobiographical genre that intricately weaves personal narratives with contextual meaning-making (Ellis & Bochner, 2000). As a postmodern methodology, autoethnography invites the researcher to inhabit the tensions between personal narrative and cultural discourse.

Spry (2001) and Fine (1998) underscore the vital importance of the researcher's voice in this process. Autoethnographic narratives can manifest in diverse forms, including introspective journals, compelling stories, or expressive poetry, all aimed at illuminating personal revelations and transformative moments. Furthermore, this approach offers the opportunity to test tightly held beliefs and assumptions, demonstrating that autoethnography can be evocative, emotional, and rich in description. As Ellis et al. (2011) suggest, it is through layered reflexivity that we begin to see how our stories are shaped by, and in turn shape, the cultural landscapes we move through.

Despite the initial challenges and the vulnerability that comes with self-exploration, I found the opportunity to engage deeply in both reflexive and reflective thinking very rewarding. This methodology, though new to me, offered invaluable insights that I came to appreciate during my contemplations. I soon settled into the opportunity to engage in self-dialogue, examine my existence, and understand my experiences through autoethnography. It became a chance to place myself at the heart of my story (Finlay, 2002), and to critically assess my biases, firmly held beliefs, and appreciate diverse viewpoints.

To ensure methodological rigour, I grounded my reflections in established autoethnographic practices, drawing on academic literature, theoretical frameworks, and transparent analytic processes (Adams et al., 2015; Chang, 2008). My approach was intentionally structured to explore the relational and cultural dimensions of therapeutic presence, rather than relying on anecdotal narrative. This process aligns with the view that autoethnography, when thoughtfully applied, offers a credible and richly contextualised lens for exploring lived experience within therapeutic practice (Chang, 2008).

This exploration reflects my journey as I engage with personal experience and literature, specifically examining the significance of therapeutic presence as a relational, context-sensitive phenomenon. It lays the foundation for deeper inquiry into how presence is cultivated, sustained, and experienced within structured counselling practice.

Methods

Data was gathered from journal entries over a 10-month period of reflection. These entries documented my experiences as a counsellor, a member of a reflecting team, and during post-session debriefs. I also reflected on conversations with clinic supervisors, counselling clients, mentors, and peers. The journal entries delved into my reflections on the intentional cultivation of therapeutic presence, how I nurture and maintain this presence, its co-constructed nature, and its value relative to technique or approach.

Throughout the journaling process, I engaged in ongoing reflection, noting emotional responses, theoretical insights, and client interactions as they emerged. These entries later formed the basis of my data analysis, where I reviewed moments that highlighted the impact of therapeutic presence. Key themes included deep client connection, challenges in sustaining presence, and the balance between presence and structured processes. I also observed how increased presence facilitated collaborative meaning-making, with clients and I co-constructing insights during our interactions. These patterns informed a narrative that explores the dynamic interplay between presence, relational depth, and therapeutic structure.

Helps (2017) posits that scrutinising our thought processes reshapes how we engage with our thoughts, opening us to alternative perspectives and explanations. Over the past 10 months, my journal reflections have been a constant source of self-questioning. By examining these entries, I was able to identify patterns and insights that informed my understanding of therapeutic presence and its role in fostering meaningful connections and collaborative meaning-making with clients.

One reflective account revealed a moment of therapeutic tension that appeared to be shaped by the client's culturally embedded understanding of self and emotional experience. This insight highlighted how therapeutic presence must be attuned not only to relational dynamics, but to the cultural frameworks that shape how clients make meaning. These reflections illustrate how cultural contexts emerged not only as theoretical considerations, but as lived, relational dynamics within practice.

To shed light on my experience, I offer four vignettes that chronicle my journey with therapeutic presence, intentionality, and process. These vignettes aim to explore the subtleties of therapeutic presence, its influence on the therapeutic relationship, and the deliberate use of this intervention. Through reflection and analysis of these vignettes, I sought to gain a deeper understanding of how therapeutic presence contributes to a meaningful and effective therapeutic encounter. These vignettes capture my own musings and reflections, rather than detailing observations of clients and their reactions (Humphreys, 2005).

Therapeutic Presence in Practice: A Reflexive Exploration

Presence Versus Process

Balancing presence and process has been a continual challenge for me. While structured processes like narrative and solution-focused therapies provide a useful guide, true presence has at times required stepping away from rigid frameworks (Norcross & Guy, 2007; Hayes et al., 2011). My journal entries often reveal the tension between following a structured approach and being authentically present. I recall specific instances where deviating from a strict process led to more meaningful and impactful sessions, underscoring the importance of presence in my therapeutic work (Geller & Greenberg, 2012). Similarly, adhering strictly to a process at times hindered my presence. I noted my struggle to follow the unfolding conversation while maintaining a clear process such as solution-oriented or narrative therapy (Anderson & Gehart, 2007; Shamoon et al., 2017).

My journal reflections mirrored my evolving understanding of presence, aligning with early pioneers like Rogers, May, and Bugental, and my own clinical experiences. These sparked the realisation while presence allows for genuine connection and adaptability, a structured process also provides necessary guidance during sessions. Therefore, finding a balance where presence and process work together felt crucial, ensuring the therapeutic environment remains flexible and responsive to clients' needs while providing a structured framework (Norcross & Guy, 2007; Hayes et al., 2011; Geller & Greenberg, 2012). During my clinical experience, I shared my interest in exploring how to achieve this, wondering if mastering a balance would apply to all counselling conversations, a transferable skill that could enhance various therapeutic approaches (Anderson &

Gehart, 2007; Shamoon et al., 2017). Approaching therapy from a collaborative perspective, as advocated by Anderson (2012), supported me in feeling that I had, at times, found this balance. Collaborative therapy emphasises co-constructing meaning with clients, fostering a therapeutic alliance that allows for both structured guidance and genuine presence. This perspective aligns well with my experiences and reflections on balancing these two essential aspects of therapy.

Geller and Greenberg (2012) suggest that balancing the counselling process with nurturing the therapeutic relationship is a delicate endeavour, requiring a mix of guiding the process and being genuinely present. Gergen & Ness (2016) add that this balance is inherently co-constructed, emerging from shared relational dynamics. Every client's unique needs and context demand a tailored therapeutic approach, emphasising the dynamic and collaborative nature of therapy where meaning and outcomes are co-created – delicate balancing act indeed.

Presence and Intentionality

Reflecting on my early counselling conversations in the clinic, I often felt constrained by rigid adherence to processes and doubting my abilities. Internally, I grappled with self-doubt, and feelings of stress, and externally, I was challenged by the unique clinic setting and strictly adhering to a therapy process (Shamoon et al., 2017). Norcross & Guy (2007) and Hayes et al. (2011) argue that sustaining presence throughout a counselling conversation involves overcoming such challenges. Geller & Greenberg (2012) argue that counsellor intentionality is vital to maintaining therapeutic presence, encompassing mindful preparation, attunement during sessions, and post-session reflection.

I vividly remember moments of deep connection with clients, where I was fully immersed in our conversation and feeling attuned to their experience. Conversely, when I experienced a feeling of less presence, it did seem to coincide with more shallow connections and missed opportunities for deeper insight and engagement (Cooper & McLeod, 2011).

This prompted me to seek strategies to bolster my presence, such as mindful breathing and body scans, which are recommended to stay present, reduce distractions, and fully engage with clients (Brown, 2012). Grounding myself with breath became a pivotal practice, allowing me to observe my thoughts without being hijacked by them. My curiosity further grew as I noticed how such practices enhanced my presence, notes I shared with my clinical supervisor.

Mindfulness-Based Stress Reduction (MBSR) and Acceptance and Commitment Therapy (ACT) link counsellor presence to mindfulness practices, enhancing emotional regulation and deepening therapeutic work (Harris, 2009; Geller & Greenberg, 2023). These approaches helped me appreciate how intentionality and embodied awareness can support therapeutic presence.

While I found these strategies supportive, Gergen (2009) cautions that focusing solely on individual practices risks overlooking the relational and contextual dimensions crucial to therapeutic presence. He argues that internal states such as self-doubt are influenced by broader social contexts, suggesting that reflective practices should consider both individual and relational aspects (Gergen & Ness, 2016). Anderson (1997) concurs, suggesting these challenges often arise within the therapeutic relationship.

Similarly, external challenges can also be shaped by social and cultural contexts, such as adhering to a clear process, or environmental distractions are more reflective of broader societal values (Anderson & Gehart, 2007). This understanding led me to reevaluate my solo approach, to consider aspects of relational and socially aware practices and to foster ethical and collaborative client engagement (Anderson, 2012).

Integrating these insights, I began to appreciate that sustaining therapeutic presence involves a dynamic interplay between individual practices and relational contexts. By acknowledging and addressing both, could I create a more inclusive and effective therapeutic environment?

Presence and the Co-Construction

Geller & Greenberg (2012) highlight that while individual presence focuses on the therapist's attunement and mindfulness, co-constructed presence arises from mutual, interactive processes between therapist and client. As an evolving counsellor, my practice framework emphasises staying true to my authentic way of being (Fife, 2014). Overlooking the relational and constructed nature of presence contradicts my developing practice within a social constructionist framework, where meaning is co-constructed and shared collaboratively.

Delving deeper into my journal entries, I began to see how meaning and presence can be co-constructed through conversations and mutual influence (Gergen, 2009). Noticing my increased presence often coincided with collaborative, co-constructed meaning-making with clients. Anderson (2012) argues that collaborative practice respects each person's uniqueness and values their knowledge, creating new understanding together. He terms this process "with-ness", working together, sharing perspectives, and collectively building understanding (Anderson & Gehart, 2022). Instead of imposing answers, collaboration involves curiosity and mindful questioning to help clients explore and expand their life stories (Gehart, 2022; Dickerson, 2010). Counsellor presence is seen as crucial for fostering such collaboration, distinct from merely applying techniques (Tannen & Daniels, 2010; Keeney & Keeney, 2012).

Postmodern approaches, such as narrative and solution-focused therapies, emphasise presence in co-constructing meaning (Anderson, 1997). The presence of the counsellor is key in collaborative conversations (White, 2007; Fromme, 2011), making therapy more inclusive and responsive (Schon, 1983). Attuned counsellors help clients resist oppressive narratives and construct new stories of resilience and hope (White & Epston, 1990; Morgan, 2000; Freedman & Combs, 1996). Malet et al. (2022) describe this as "attentional receptivity" to the client's unfolding experience.

I noted the alignment of postmodern approaches with full engagement and attentive listening to the client's narrative (White & Epston, 1990). This led me to consider the dynamic interplay between presence and counselling process, particularly within social constructionist approaches like narrative, solution-oriented, and collaborative therapies.

The following four vignettes are drawn from my autoethnographic journal, supervision notes, and reflecting team discussions. As part of the data collected over the 10-month research period, they offer brief contextual glimpses into my evolving relationship with therapeutic presence.

Vignette One: Be Here Now

During an early clinic experience, I had the chance to be the primary counsellor in a session, with my peers and our clinic supervisor observing behind the mirror. I felt optimistic that my natural way of being and my full presence would seamlessly integrate into this setting, allowing me to be fully attentive and present with my client. This optimism was soon challenged as I began, eager to impress my peers and supervisor, and skillfully apply a narrative therapy technique. Partway through the initial conversation with the client, I found myself trying to externalise their identified problem—a key narrative therapy method where the problem is seen as separate from the person (White & Epston,

1990). Yet, the client responded by questioning the separation of their anxiety, which they saw as very much a part of their identity.

In hindsight, I began to wonder whether the client's response reflected a culturally embedded understanding of self, one in which anxiety was not something to be separated, but rather integrated into their identity and lived experience. Narrative therapy's emphasis on externalising problems may not have aligned with the client's worldview, which could have been shaped by cultural norms around emotional ownership, personal responsibility, or holistic identity. This moment highlighted for me how therapeutic presence must be attuned not only to relational dynamics, but to the cultural frameworks that shape how clients make meaning.

At other moments in the conversation, when the client similarly offered responses that veered away from my process, I found myself feeling confused and unsure of how to proceed. Finding myself resorting to a check-in felt like the only viable option, asking the client something like, "Is this a useful direction for us to go?" The degree of relief I felt after our conversation came to an end, was surprisingly significant.

During my debrief with the reflecting team after the session, I mulled over why the conversation had felt so awkward. Why had I missed chances to collaborate or ask relevant questions? Why was it so hard to keep track of where we were going? Was it my anxiety about being observed by my peers and supervisor? Or the process? Had my strict adherence to this overshadowed my presence and the natural flow of the conversation? Keeney & Keeney (2012) warn that rigid adherence to a therapy model can stifle a counsellor's ability to be fully present and effective. They argue that embracing uncertainty, focusing on clients' situational contexts, and shedding theoretical attachments can foster a dynamic, adaptive therapeutic process driven by ongoing, reciprocal interactions. Noting my lack of presence seemed to create a disconnect, and acknowledging my own confusion, I wondered if the client had felt the same, highlighting the need for a more genuine engagement (Rogers, 1957).

This realisation marked the beginning of my research into the importance of counsellor presence, sparking my curiosity about the interplay of presence and process.

Vignette Two: A Matter of Balance

As the primary counsellor mid-way through the clinic year, I had the opportunity to work with a client couple. I went into the session with a clear intention to cultivate and maintain my presence by grounding myself throughout our conversation. I was also excited to experiment with a new approach,the Solution Focused Brief Therapy Diamond developed by Connie & Froerer (2023). I had decided to ask fewer questions, to hold the process a little lighter, and to create more distance between my questions, to hopefully offer the clients time enough to fully consider them.

Settling into my new approach, I noticed at times unhelpful inner chatter creeping in. I found myself doubting the "space" that we sat in after some of my questions, questioning myself on the relevancy of my inquiry, or if the clients appreciated the reflections they were encouraged to make. On recognising my inner chatter, I consciously decided to acknowledge it and let it pass without being fully taken away or disrupted by it, refocusing my attention on the clients and their responses.

During my post-session reflections with my clinic supervisor, I reflected on what had transpired. I shared my ability to acknowledge my doubt and let it go. I further acknowledged that the space did seem to support deeper reflection, as I had intended, most evident perhaps from the insights the clients shared afterward. I also noted how adopting a slower, more measured pace supported a new balance between following a process and being present. This felt like a crucial development in my practice. Was I more than just a good conversationalist? Was I becoming what Michael White (2007) referred to as influential, in actively listening and asking insightful questions to uncover the client's unique knowledge and abilities? I finally felt I had maintained a balance between my presence and my approach, in a way that felt effective.

In my later journal entries, I likened this experience to a therapeutic dance, where presence and process complemented each other, much like dancers needing both rhythm and technique. I noted times when I felt more present and attuned, following the client's lead, listening deeply, holding space, and asking questions relevant to their experience. This collaboration feels comparable to a well-timed dance, moving in sync with purpose and rhythm, elegantly navigating the therapeutic space together. Conversely, when I am in the room but not fully present or attuned, it feels comparable to stepping on the clients' toes instead of mutually flowing together. I imagine a waltz where one partner is distracted, out of sync, or preoccupied those missteps disrupt the dance. Let's dance!

Vignette Three: The Individual and the Co-construction

Toward the end of the clinic year, I aimed once again to experiment with a more collaborative approach. Instead of rigidly sticking to following a process, I again planned to ask fewer but more impactful questions and let the client's story unfold naturally. Anderson (2012) champions this approach, noting that collaborative practice respects individual uniqueness and values the knowledge born from collective creation.

During one session, my client was trying to share a significant life event but was at a loss as to how they could. I invited them to use a metaphor to express their feelings, and they compared their journey to a river, sometimes serene, sometimes turbulent. The client's metaphor became our shared language, guiding the rest of our conversation and fostering a deeper mutual understanding. Angus and McLeod (2004) suggest that metaphors in counselling help co-construct meaning by providing a common language, making complex emotions easier to express. This shared language can nurture a richer, more nuanced connection between counsellor and client, ultimately leading to narratives that truly resonate with the client's lived experiences (Angus & McLeod, 2004).

During discussions with my clinic supervisor afterward, I noted how the use of a metaphor had facilitated a more collaborative and organic process, allowing the session to flow naturally with meaning unfolding through our shared metaphor and mutual understanding. The client had my full attention, and I was reminded of the importance of flexibility, responsiveness, and co-constructing meaning in counselling, an approach that I have found can often lead to deeper insights and more meaningful engagement.

Gergen et al. (2019) view therapeutic presence as a relational and co-constructed phenomenon, emphasising the importance of interactions and shared experiences between counsellor and client. Reflecting on this, I acknowledged my previous assumptions about presence from an individualistic viewpoint, as solely my responsibility to cultivate and maintain. This perspective had led to feelings of challenge and frustration. Perhaps therapeutic presence is not just the counsellor's sole responsibility to cultivate and sustain. Is it possible it is also co-created? Could presence also unfold moment-to-moment within the collaborative effort between counsellor and client?

Vignette Four: Presence and Process as a Collaboration

In the final weeks of the clinic year, I became increasingly curious about presence as something co-created: less a quality I delivered, and more a shared phenomenon shaped in the space between myself and the client. I wanted to explore how presence and process might work together in more flexible, responsive ways. My intention for one session was to experiment with a narrative therapy frame, but to hold it lightly, allowing space for the client's unfolding story to shape the direction.

During one session, my client spoke of their discomfort with "the unknowns" describing it as standing inside a vast, bottomless space where little felt certain or solid. Their metaphor struck me deeply. Rather than following the expected arc of narrative therapy, thickening alternative storylines or locating unique outcomes, I asked how they had navigated uncertainty in the past (White & Epston, 1990). Their response was rich and evocative, revealing strengths I had not anticipated.

In that moment, I shifted. Rather than staying with narrative scaffolding, I responded with a question more aligned with solution-focused practice, inviting them to consider how those past strengths might support them now (de Shazer & Dolan, 2007). It wasn't a conscious technique switch; it was an instinctive, collaborative move, guided by what was emerging between us.

During post-session reflection and peer discussion, I noticed how my presence became more attuned not by adhering to process, but by letting process follow presence. I had moved between models, not out of confusion, but out of care, guided by the client's language, needs, and unfolding insight. What resulted felt like a shared authorship: a conversation that honoured the client's strengths, made space for uncertainty, and co-constructed new meaning in real time.

This experience further shifted my understanding of presence from something internal and preparatory to something dynamic, relational, and shaped by mutual responsiveness. My therapeutic presence was not static, but rather emergent, an expression of trust in the process and in the relational field. It reminded me that the heart of collaborative work lies not in choosing the "right" technique, but in being fully available to what arises, together (Gergen et al., 2019).

Discussion

Reflecting on my clinic experience and journal entries, I identified the significant theme of counsellor intentionality, deliberate and conscious efforts to maintain presence in sessions through mindful preparation (Anderson, 1997), attunement during interactions (Geller & Greenberg, 2012), and post-session reflection (Schön, 1983). Recognising this intentionality highlights the counsellor's active role in creating a meaningful and dynamic therapeutic environment that resonates with clients' unique narratives (Anderson & Gehart, 2007; Tannen & Daniels, 2010). This level of engagement also brought with it some important tensions. As Barnett (2019) highlights, being deeply engaged in a session can sometimes blur boundaries, compromise confidentiality, or emotionally impact the counsellor. Reflective practice and supervision, as suggested by White and Epston (1990), supported me to stay grounded, particularly in emotionally demanding sessions, and allowed me to show up in ways that felt both real and considered.

While mindfulness and self-reflection are considered beneficial, I began to notice that they sometimes overlook the relational aspect, the experience of presence as something that unfolds in dialogue. This realisation led me to embrace Anderson's (2012) concept of with-ness alongside presence, viewing presence as more dynamic; an interactive process evolving through mutual engagement between counsellor and client. Noticing how my presence increased during the co-construction of meaning with clients supported this position.

At times, it felt like stepping into an uncertain but hopeful space, less about performing a role and more about showing up with my whole self, available to what might emerge. There was a shift when I stopped focusing on "being present" as something internal to manage and instead, began noticing what was happening between us in the room. A perspective aligning with social constructionist ideas that knowledge and reality are co-created through social interactions (Burr, 2015).

For example, when a client offered a reflection and I responded, not with interpretation, but with curiosity about their experience, it felt like we were walking together, building meaning step by step. In those moments, I was not separate from the process; I was in it with them.

I have come to understand this as staying curious during a session, remaining attentive to what's unfolding, rather than anticipating what should happen next. For me, that meant slowing down internally, letting go of the urge to "respond well," and instead asking simple, responsive questions like, "What's that got you thinking?" or "Is this helpful?" It wasn't about doing more but doing less with more awareness. I also found it useful to reflect afterward on what felt mutual or co-created, what moments surprised me or shifted the energy, and to return to those reflections as a learning space.

Yet even this shift raised new considerations. In recognising the co-created nature of presence, I became more attuned to the need for cultural sensitivity and relational transparency. Approaching each encounter with an openness to the client's values, beliefs, and ways of being became central to ensuring our work remained collaborative and respectful (White & Epston, 1990).

Sustaining presence presented challenges. Reflecting on my journal entries, I noticed how internal challenges like self-doubt, and external challenges such as adhering to a clear process and the unique clinic setting, often disrupted my focus. Anderson (1997) suggests that internal challenges arise within the therapeutic relationship; however, it is also argued they are shaped by broader social and cultural contexts (Gergen & Ness, 2016; Anderson & Gehart, 2007). Keeping such perspectives in mind led me to consider reflective practices that address both internal states and relational contexts. Self-placed pressure to perform well heightened my self-doubt and frustration when things did not go as planned. However, reminding myself of the relational nature of presence helped ease this pressure, acknowledging the client's active role in co-creating the experience. Seeking supervision and engaging in reflective inquiry became vital for navigating these tensions with clarity and steadiness (Barnett, 2019).

Finding a balance between counsellor presence and the process has been a continual challenge. I found myself wondering how I can sustain my presence while adhering to my process and wondering too, if mastering this would apply to all counselling conversations, across approaches (Anderson & Gehart, 2007; Shamoon et al., 2017). The research and my experience demonstrated to me that while presence allows for genuine connection and adaptability, having a structured process provides necessary guidance during sessions (Stober & Grant, 2006). I discovered it is potentially less about choosing one over the other and more about finding a balance where presence and process work together, ensuring the therapeutic environment remains flexible and responsive to the client's needs (Stober & Grant, 2006). A balance, as argued by Gergen and Ness (2016), that is co-constructed, arising from mutual relational dynamics.

Much like a dance, they feel inextricably linked. Presence brings emotional depth and connection, while process provides structure and direction. It seems to be a delicate

balancing act, where both elements enhance and support each other in the co-creation of a meaningful therapeutic experience (Cooper & McLeod, 2011). In my own reflections, this balance also touched on questions of safety and containment, particularly for clients navigating uncertainty. The ability to move between presence and process, depending on client needs, felt like an important part of creating a therapeutic experience that was not only dynamic but ethically attuned (White & Epston, 1990).

Approaching presence from a collaborative perspective, as advocated by Anderson (2012), supported me in feeling I can, at times, find this balance. Collaborative therapy emphasises co-constructing meaning with clients, fostering a therapeutic alliance that allows for both structured guidance and genuine presence. This is consistent with my journal entries, which explored my preference for an egalitarian approach to client work, one that feels jointly collaborative and empowering. As Harrison (2013) notes, an intense focus on presence may unintentionally reinforce imbalances between counsellor and client. It was in those emotionally resonant sessions, where my presence felt most impactful, that I became especially mindful of this dynamic. Working with an awareness of power dynamics, both subtle and overt, supported my intention to engage in ways that felt honouring of the client's agency and autonomy (White, 2007; Harrison, 2013).

Reflecting on my experiences and journal entries, my previous assumptions about counsellor presence were challenged by the perspectives of Gergen (2009) and Anderson (2012). This highlighted to me that both individual practices and the counsellor–client interaction are essential to sustaining counsellor presence. For me, presence is more than a technique, it is a foundational aspect of my work, fostering genuine connection and engagement.

My journal entries explored presence as both something cultivated within and shaped between and underscored the importance of mutual engagement and shared responsibility in crafting meaningful therapeutic experiences. Maintaining that kind of presence, I found, depends not only on practice and preparation but on awareness, of power, of pace, of what is said and unsaid, and a willingness to keep showing up as thoughtfully and responsively as I can.

Conclusion

This auto-ethnographic journey has explored my developing relationship with therapeutic presence. As an evolving counsellor, understanding the role of presence in my practice and its impact on the therapeutic process has been important. Reflecting on diverse viewpoints challenged my assumptions and highlighted the crucial role of intentionality, not just in being present but in adapting to clients' needs (Gergen & Ness, 2016; Anderson, 2012). Recognising barriers to sustaining presence prompted reflective practices addressing both relational and contextual factors (Gergen & Ness, 2016; Anderson & Gehart, 2007).

Key learnings included the cultivation of presence both individually through mindfulness and self-reflection, and collaboratively through engagement and mutual influence (Anderson, 2012). Insights challenging earlier assumptions I held about presence residing solely within the counsellor, proposing instead that presence is a relational, co-constructed phenomenon, shaped by both counsellor and client. This re-conceptualisation invites a shift beyond self-focused embodiment toward mutually responsive engagement.

My research suggests that presence and process can complement each other, with presence fostering genuine connection and techniques providing structure. A balance I view as akin to a dance, where emotional depth and structure work together in a context-dependent manner. Embracing this co-constructed dynamic has alleviated pressure, allowing me to be more genuine and connected in my practice. My belief in the power of presence was reaffirmed as an essential element of the therapeutic relationship. Moving forward, I feel committed to refining this balance, ensuring that my presence and my process harmoniously create a therapeutic environment where clients feel seen, heard, and supported with their unique stories and presentations.

While these insights emerged from my personal journey, they may hold relevance beyond my own practice. For counselling educators, the reconceptualisation of presence as relational and co-constructed invites a pedagogical shift, from teaching presence as a static skill to fostering it as a dynamic, responsive capacity shaped within the therapeutic relationship. Practising counsellors may find value in reflecting on how presence emerges not only from within, but through attunement to client cues and mutual influence. Theoretically, these insights challenge individualistic framings of presence and align with dialogical, intersubjective models of practice. Rather than offering definitive conclusions, I hope this work encourages others to reflect on their own evolving relationship with presence and the ways it is shaped, shared, and sustained in the therapeutic space.

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Journeying to Joy: The Key to Reducing Burnout?

Belinda Kippen

Keywords: *Counsellor Well-being; Burnout; Joy in Practice; Collaborative Practice; Personal and Professional lives*

Abstract

This paper examines the idea of joy in professional practice, aiming to uncover what makes joy possible. Extensive research addresses burnout, including its causes, effects, and mitigation but limited research explores the interplay between counsellors' personal and professional lives, particularly what counsellors themselves gain from their work.

Using an autoethnographic approach, this study draws on multiple sources, including a reflective journal kept over 10 months as a trainee counsellor. This involved working as a counsellor and as part of a reflecting team in a university counselling clinic. Additional sources include literature reviews and discussions from supervision.

The study explores the transformative potential of counsellors adopting a collaborative stance and recognises the role of clients in fostering joy within professional practice. It asks: What if we consider how clients and their stories impact us? This opens possibilities for rethinking burnout, suggesting that joy may be a key factor in its reduction.

Introducing the Emergence of Joy

"Joy: the emotion of great delight or happiness caused by something exceptionally good or satisfying; keen pleasure; elation" (Dictionary.com, n.d). In the spirit of post-structuralism, Burr (2003) notes that language is always contestable, open to interpretation, and context dependent. In the professional context, my definition of joy is best described using metaphor. I imagine being on a journey in a sailing boat—it's raining, the seas are rough, and every effort seems to be met with resistance and struggle. During this struggle, I feel doubt, confusion, and anxiety. At some point, the sun shines, the sea calms, and my efforts align, allowing me to sail effortlessly across the water. I'm working together with the boat and the elements. It feels intuitive. I'm relaxed, my mind is open to possibility, and I feel joy.

My professional journey started as a nurse and midwife, where I first felt joy in my work through approaches that centred the client as the expert and positioned me as a collaborative partner. Joy resurfaced when I transitioned from being an employee to working autonomously in private practice, supporting nurses and midwives with clinical supervision. Most recently, joy has resurfaced in my life with greater intensity and endurance. This sense of joy has emerged through my work as a trainee counsellor, coinciding with a period when I was encouraged to explore and articulate the philosophical framework that underpins my unique practice.

I resonate with liberalism's emphasis on individual freedom and social constructionism's relational view of knowledge. Although these philosophical positions differ in their perspectives on knowledge, values, and societal structures, there are points of intersection. Both emphasise individual agency and share criticism of power structures that marginalise others. They both reject the essentialist view of identity and truth and highlight the value of dialogue. Liberalism is through the free exchange of ideas and social constructionism in the co-construction of meaning. (Hansen, 2004; Anderson, 2007; Mounk, 2023). These points of intersection suggest a common commitment to challenging dominant discourses and welcoming multiple perspectives. This research is conducted through a philosophical lens underpinned by social constructionist and liberal ideas.

This research unfolds during my professional journey as an emerging counsellor completing a Master of Counselling. I am part of a therapeutic team at the Queensland University of Technology counselling clinic, where I serve as a primary counsellor and a member of a reflecting team (Anderson, 1987). I am an outsider witness, listening closely to the client's preferred stories and values while observing from behind a one-way mirror. I offer my reflections to the client, inviting them to consider alternative perspectives that may support a more preferred story of their life (Carey & Russell, 2003; White, 1995; White, 2007).

As joy began to emerge and linger in my role as counsellor and reflecting team member, my curiosity grew. Why was joy persisting in this setting, where previously it had been absent, elusive, or fleeting at best? The following vignette captures reflections from my journal, after being witness to conversations in the clinic and my initial glimpses of joy.

Vignette One: Glimpsing Joy

One of the team members observed that I appeared energised and enthusiastic when discussing ideas related to outsider witness practices. I noticed that this way of practising felt intuitive and comfortable, and the more I engaged with it, the more I loved it. This led me to reflect on times when others noticed something about me that stood out to them, prompting them to make a change based on my words or actions. These moments were powerful and certainly put a skip in my step at the time. Have these experiences helped me reconnect with my preferred story, and has this influenced my preference for this approach?

Midway through the research year, I began to lean into a collaborative approach, valuing individuals' expertise in their own lives and recognising their capacity for change. I viewed therapy

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as a relational process shaped by stories and interactions with others (Dickerson, 2010; Hansen, 2004; Anderson, 2007; D'Arcy & Holmes, 2020; McCashen, 2017). Yet, I remained uncertain about what specifically brought me joy in this way of working.

This study was inspired by my desire to identify the elements of joy within my practice, offering a roadmap of sorts to navigate towards future experiences of joy. Reflecting on the potential impact of this research, I began to consider whether sustained joy in practice could enhance my professional experience and inspire others to uncover new possibilities in their work. During conversations about these ideas, I recall one particular instance where the topic of burnout was raised, and there was curiosity about whether exploring joy could provide an alternative to traditional approaches for preventing burnout. Until then, I had not considered joy in the context of burnout: is there a connection? As I delved into the literature and reflected on my practice and counselling framework, my research question began to take shape: *Journeying to Joy: The Key to Reducing Burnout?*

Autoethnography: Navigating the Personal-Professional Boundary

Many researchers note the relational aspect of counselling and emphasise the value of bringing the person of the therapist into practice (White, 1997; McLeod & McLeod, 2014; Proctor, 2014). I agree, and it has always seemed unethical to turn my back on or set aside the essence of who I am in my practice – something I had previously felt obligated to do in past roles. The counselling training program I was engaged with emphasised collaborative learning, providing philosophies and theories while encouraging us to develop our unique ways of working.

As such, there appeared to be no better way to bring myself into practice than through autoethnographic research. This qualitative research method aims to produce meaningful research grounded in personal experience (Ellis et al., 2011). It involves retrospectively writing about and analysing personal learnings or epiphanies (Ellis et al., 2011).

Heath et al. (2022) describe autoethnographic research as a method where the author is part of the story, aiming to "show rather than tell" (p. 28). In this study, "showing" emerges from data collected through weekly journal entries over 10 months. The entries capture my reflections on working within a therapeutic team, offering counselling and supervision to individuals, couples, and families. My thoughts focused on conversations as a counsellor and as a member of the reflecting and debriefing team. While the research focus was initially broad, over time, my entries became centred on the presence of joy in my practice.

The journals were structured using Kolb's experiential learning cycle, which supports learning by reflecting on experiences (Trottier, 2024). The process involved documenting reactions and observations, connecting them to values and societal discourses, supporting findings with literature, and planning how to apply the learning (Trottier, 2024). The analysis involved reading through journal entries to identify themes, which over time started to reveal various elements that were, or were not, present when joy was experienced.

Additionally, "the showing" will be further illustrated using vignettes. Humphrey (2005) describes vignettes as vivid portrayals of everyday episodes based on reflections captured after field experiences. In this study, the vignettes consist of reflections on my experiences, aiming to situate myself within the research and invite readers to engage with my journey. These thoughts are layers of my reflections rather than observations about clients. Heath et al. (2014) note that in-the-moment storytelling in autoethnographic research "places the reader in the mind and the heart of the therapist" (p. i). While these reflections on joy are my own, I hope that others will resonate with them and find further meaning through reading my work, in a way that might contribute to joy in their practice.

This exploration of personal reflections and storytelling led to a critical examination of the broader narrative in caregiving professions, particularly the tendency to frame burnout as an individual failing—an idea captured in the notion that "the person is the problem". This marks the starting point of the research journey.

The Person is The Problem

When examining the understanding of joy in the literature, particularly within the context of the counsellor's personal life, the concept of "burnout" seemed to be in the way. Miller et al., (2015) reference an article in *Scientific American Mind* that declares job satisfaction to be in a very fragile state, with between 21 and 67 per cent of workers experiencing high levels of burnout. A qualitative study on job satisfaction and burnout among those who do "people work" suggests that reducing burnout levels can lead to highly satisfied and blissful practitioners (Rosales et al., 2013). Burnout is a term I have heard often in my professional life. I was interested in this idea of burnout that seems to obstruct joy, job satisfaction, and bliss.

The conceptualisation of burnout, along with related conditions including compassion fatigue and vicarious trauma, emerged in the 1970s. Many agree that burnout occurs when chronic stress is not managed (Geldard, Geldard, & Foo, 2022; Squellati, R., & Zangaro, 2022). Burnout is often characterised by emotional, physical, and mental exhaustion, leaving individuals disconnected and unmotivated (Geldard, Geldard & Foo, 2022; Mathieu, 2022; Miller, 2015). Burnout has been reported to have several effects on the lives of people working in caregiving roles, including growing rates of absenteeism, high job turnover, anxiety and depression, and diminished spirit and passion for the job (Collette et al., 2024; Mathieu, 2022; Miller, 2015; Rosales, 2013). The impact of diminishing passion led me to question the potential role of joy in reducing burnout.

A brief review of the literature notes a recurring theme that burnout is widely regarded as a potential hazard of working with other human beings. Much of the focus is on how practitioners can mitigate the risks of burnout through self-care strategies and resilience programs (Mathieu, 2022; Geldard, Geldard & Foo, 2022; Collett et al., 2024). However, alternative research challenges the emphasis on the individual to reduce burnout, particularly the popular recommendations of self-care and coping strategies. Bober and Regehr (2005) conducted a cross-sectional study to assess the effectiveness of these commonly recommended forms of prevention. They found no evidence to support an association between devoting time to these coping strategies and reduced stress levels, noting that these strategies unduly individualise the problem.

Evidence of these effects of individualising the problem can be found in much of the literature. For example, an article titled "Eight Ways Nurses Can Manage a Burnt-Out Leader" (Squellati & Zangaro, 2022) places responsibility on nurses to recognise the signs of burnout and practice mindfulness and other methods to decrease burnout. Similarly, in *Revisiting Burnout*, Miller et al. (2015) discuss counsellors' experiences of feeling pressured to do more to support their mental health and well-being. They express scepticism about the effectiveness of these strategies and the guilt associated with the perceived ethical duty to care for themselves. It is interesting to consider other inconsistencies and contradictions that may be evident in this dominant story of burnout. Are there other narratives?

Re-authoring: The Membership of Life

Michael White, an Australian social worker and psychotherapist best known as a co-founder of narrative therapy, introduced the idea that "the problem is the problem; the person is not the problem" (White, 2007). Many agree on the benefits to clients in a counselling context when viewing problems in this way, including identifying the client's skills and resources, highlighting what may be important to them, and giving clients the agency to live the life they hope for (D'Arcy & Holmes, 2020; Morgan, 2000; Madsen, 2007). Considering these ideas in the context of burnout in the helping professions seemed relevant.

In his work examining the narratives of counsellors' lives, White (1997) notes that, alongside the nature of the work and institutional structures, burnout is often attributed to the individual, as found in the research by Bober and Regehr (2005). Practitioners are sometimes offered the notion that they are "not cut out for it" (White 1997, p. v). This perspective places the problem firmly with the individual, suggesting deficiencies or flaws predisposing them to burnout. White (2007) argues that this approach to problems shapes how efforts to resolve them are made and influences people to believe certain "truths" about their character, relationships, and those around them.

Michael White offers alternative ideas about relational practice that may help reduce burnout (1997). He speaks openly about experiencing joy in his work. This joy does not arise from professional expertise, but rather from the knowledge he has gained through the "membership" of his own life. The "membership of life" refers to the knowledge gained through our personal histories of living in this world and interacting with others (White, 1996). These ideas resonate strongly with me and contrast with the discomfort I've felt in systems that discourage practitioners from sharing aspects of their personal history.

Building on Michael White's ideas about relational practice and the "membership of life," the concept of meaning-making within a social constructionist framework further highlights the collaborative and relational nature of constructing personal meaning. It acknowledges the impact of cultural and social contexts, highlighting the role of language in shaping understanding through relational conversations (Anderson, 2007; Bird, 2000; White & Epston, 1990). Jonella Bird (2002) describes how singing often evokes strong emotions and memories. She suggests that within a post-structuralist conversation, where one human spirit connects with another, there is potential for "talk that sings" (Bird, 2002, p. 30), implying that both the client and counsellor may benefit from the shared experience of the conversation. I began to notice evidence that both I and the client were benefiting from conversation.

In the clinic, I observed that outsider-witness practices, where I listened for what was implicit in clients' stories and then offered reflections, created opportunities for clients to expand their preferred story (Carey & Russell, 2003; White, 1995; White, 2007). Hearing their stories reflected from other perspectives seemed to deepen their sense of agency and foster hope for a preferred future (Beaver & Gardner, 1995; Carey & Russell, 2003; White, 1995; White, 2007). Invigorated by these experiences, I began to extend these ideas beyond the reflecting team, integrating them into my role through the use of therapeutic letters addressed to the client. This approach seemed to allow me to draw on my own "membership of life" to foster meaningful, collaborative exchanges.

Therapeutic Letter Writing: Thickening the Story of Joy

Therapeutic letter writing offers a valuable means to highlight overlooked aspects of client stories — effectively "thickening the story" to extend the therapeutic conversation beyond the session (White & Epston, 1990). This narrative therapy practice involves counsellors writing letters after each session, capturing reflections on themes, strengths, and values expressed by the client. These letters are shared with the client to support further reflection and are retained as part of the client's records, providing an ongoing, meaningful account of their therapeutic journey (Morgan, 2000; White & Epston, 1990).

I started to notice that I was drawn to Michael White's (2007) four categories of inquiry in outsider witness processes. These categories guided how I listened and offered my reflections in person and when writing therapeutic letters. The focus is on what expressions stand out to the listener, what images of people's lives these evoke, and what these images suggest about their values and purposes. The listener considers how the story resonates with their own life and how they have been moved as a witness to the conversation (White, 2007; Carey & Russell, 2003). White suggests, this process can "contribute in significant ways to rich story development for clients" (Denborough, 2008, p. 56).

In discussing Meyerhoff (1986) in *Re-Authoring Lives: Interviews and essays*, White (1995) describes how an "outsider witness" provides people with an opportunity to be seen as they wish to be seen. This process amplifies and validates their preferred self-view, supporting a sense of agency and expanding their awareness of options for shaping their lives. These ideas resonated with my experiences of others noticing my preferred story. In an article discussing reflecting Teamwork as a Definitional Ceremony, White also notes that deconstructing comments within personal experiences helps to counter power imbalances and foster a more egalitarian stance (1995).

Reading this article at a particular moment felt strikingly significant, a flag waving for my attention. I wrote the following journal entry in response.

Vignette two: Egalitarianism

Although I have read about outsider-witness processes, and perhaps even this specific article, many times before, the meaning resonates more at this point in my journey, particularly the emphasis on fostering an egalitarian approach. This theme has often surfaced in my journals, reflecting my belief that all individuals, regardless of background or circumstance, deserve equal opportunities and the chance to thrive. I've also noticed that when others position themselves as authorities over me, it leaves me disempowered and unseen. This feels like a significant and powerful realisation.

My reflections on my experience of working in this way seemed to amplify my curiosity about what makes joy possible, a theme woven throughout my journal entries and shared in the following vignettes.

Vignette Three: Creativity

Being witness to conversation and an author crafting therapeutic letters seems like a creative expression. It requires me to suspend judgment, lean in, be curious, and wonder. In my personal and professional life, I appreciate the excitement of uncertainty, not knowing exactly how things will progress or where they will end up. I've noticed a tendency to resist prescribed methods, often feeling discontent when creativity is absent. When I practice from a position that centres me as the expert, creativity tends to vanish, leaving me bored and unsatisfied.

Vignette Four: Foundations of Joy

Could it be that narrative and collaborative approaches within a social constructionist framework nurture creativity and support an egalitarian stance, which, in turn, has allowed joy

to emerge? Is it the framework that makes joy possible? I feel compelled to use a metaphor here. There was a show in the 70s called "The Dating Game," where contestants asked questions to three mystery bachelors or bachelorettes hidden behind a door. The goal was to select one person based on their answers, with the mystery dates revealed at the end. Have I chosen an approach that aligns with my values and how I see the world, which supports my journey to joy?

Vignette Five: Taking it Back

But wait, there is more. It seems that the client also plays a vital role in facilitating joy for the counsellor within the therapeutic process. In describing the two-way account of therapy White (1997) that notes "the life-shaping nature of this work" (p. 131). In being witness to conversations and deconstructing comments within my personal experience, I have felt joy, and agree with White that it has been life-shaping. White describes "taking-it-back" practices, where counsellors share with clients what they have learned working in the therapeutic relationship, positioning clients as knowledgeable contributors. When I look at the joy I have felt, I realise that much of this joy stems from the act of taking-it-back.

This concept of taking-it-back feels both valuable and slightly risky, as it implies that something is taken from the client, a notion not often emphasised in traditional perspectives on the counsellor-client relationship. However, as I work through my journals and read through my retellings of client stories, I am reassured that I have been able to re-deliver to clients the things they value, in a way that may have resonance for them, and can contribute to rich story development (White, 2007). The following are some examples of what I have been able to take- back to counselling and supervision clients.

I noticed the client valued agency and resonated with the story of being misunderstood. This had me taking back an appreciation of how I might use transparency in both my personal and professional life.

I noticed the client valued capability and resonated with the story of being fearful of not having the right skills during a period of transition. This had me taking back a different perspective on change and a curiosity about dominant ideas of professionalism, wondering if these are okay or not.

I noticed the client valued relationships and resonated with the idea of presence and "being enough." This had me taking back an appreciation for times in my life when I could acknowledge that being present may have been enough.

It is interesting to consider these ideas in the context of counsellor effects. What impact do these practices have on the personal and professional lives of counsellors? How might participating in or facilitating these reflective practices contribute to a counsellor's sense of meaning, well-being, personal and professional growth, and joy?

Redefining Boundaries: Ethics, Joy, and Collaboration in Practice

It's becoming clear that the core of these reflections is the value I place on relationships in both personal and professional contexts, and the belief in the personal being the professional—the two cannot be separated. Both Anderson (2007) and George & Wulff (2007) expand on this idea, proposing that collaboration is more than a technique; it is a lifestyle. Anderson describes this as a philosophy of life, reflecting a natural rhythm in how one shows up in the world and across all roles in life. George and Wulff (2007) add that "operating from a collaborative stance allows us to feel good about what we do". Could this sense of "feeling good" be interpreted as joy? And when this outcome is achieved, where is burnout?

This research has prompted me to rethink the strict professional boundaries I've encountered throughout my career. White (1997) observes that when we step into the professional realm, we're often encouraged to set aside our personal histories, which become marginalised in favour of prioritising professional knowledge. White suggests that sharing our personal and professional histories can foster the sharing of values and beliefs that enrich meaning-making. Reflecting on my experience with boundaries, a metaphor comes to mind: In a scene from The Lord of the Rings, Gandalf is on the narrow Bridge of Khazad-dûm, blocking the way of the fiery Balrog, firmly declaring, "You shall not pass." The Balrog lashes out, ultimately causing Gandalf to fall into the dark abyss, an illustration of how rigid boundaries can sometimes feel perilous and isolating.

White (1997) critiques the tendency in many counselling approaches to maintain one-sided conversations, where the counsellor is positioned as a neutral observer. He argues that conversations become "problematised" when this one-way ideal is disrupted, particularly when counsellors bring parts of themselves into the dialogue, as if daring to cross that narrow bridge invites confrontation with the Balrog. This reflects my own experiences early in my career, where I felt constrained by these strict boundaries, often confusing this rigidity with a confirmation that I wasn't doing a good job. I agree with White's suggestion that when counsellors share their own experiences, it fosters a more egalitarian dynamic, allowing both the counsellor's and client's lives to be integrated into the conversation (1995). This two-way model encourages counsellors to engage in their own acts of meaning-making, enriching their work and shaping their professional identities (White, 1997).

McLeod and McLeod (2014) highlight the value of the "constructive use of self" in therapeutic relationships but caution that counsellors must prioritise client outcomes over their happiness. Interestingly, they also note that self-disclosure can strengthen relationships, provide alternative perspectives, and potentially equalise power dynamics in therapy. Contrary to McLeod and McLeod's (2014) caution about prioritising client outcomes over counsellor happiness, White (1997) frames the two-way account of therapy as an ethical commitment, enriching both the lives of clients and engaging counsellors in the reauthoring of their own lives and their work. This perspective aligns with Fife et al. (2014), who advocate for a "both-and" approach, integrating the way of being with techniques and the therapeutic alliance in their meta-model. Similarly, Anderson (2014) underscores the transformative potential of a collaborative way of working, which ethically influences and benefits both the client and the counsellor through shared interaction.

I've noticed a sense of lightness and perhaps even relief in understanding where joy has emerged, particularly how it flourishes when boundaries are redrawn, allowing for a collaborative practice where client and therapist are interconnected (Anderson, 2007). From my perspective, this creates an environment that would be difficult for burnout to flourish. I'm curious about what others might think. Some consider the idea of counsellors gaining or taking anything from their clients to be radical (McLeod & McLeod, 2014). In this context, where this approach questions traditional assumptions about how counsellors should practice and invites a shift in perspective, I agree that it may be radical, and I'm okay with that.

In commitment to radical ways of working, my final offering to you, dear reader, is an invitation to reflect on these ideas and consider how they might resonate with you in your practice.

Implications and Conclusions – A Letter to People Working with Other Humans

To those working in one of the many fields under the banner of the helping professions, this letter is for you. While it would be presumptuous to assume your reasons for choosing this career path, I can reflect on why I entered this arena. I hoped to care for and nurture others and was motivated by a desire to work closely with people. I wanted to do meaningful work that made a genuine difference in the lives of those I encountered. It was important for me to do a good job. Is this comparable to your reasons?

As a young nurse, however, I quickly became convinced I wasn't very good at my job. I was distracted by conversation, often prioritising time spent with patients and their families over other tasks. This was where I was first introduced to the concept of boundaries and expert positioning. I learned that bringing myself into the professional alliance was considered risky and unprofessional, and my role was to be the "holder of knowledge". My expertise, I believed, was what people needed; I was in a position to help by sharing my knowledge with them. Yet, I felt uncomfortable in this expert role and felt pressure to "be better". The more I worked, the heavier this burden became. I'm curious if this speaks to your experience.

The pivotal moment came when I was introduced to a collaborative approach that positioned me as a partner with the client, removing the weight of needing all the answers. It offered a different approach that valued egalitarianism and creativity- two things I realise now have always been important to me. This is the moment joy first emerged in my work. What are your experiences of joy in your work?

As an emerging counsellor, working from a social constructionist and liberal framework, I started to experience joy on a more regular basis and wanted to know why. My research has taken me to unexpected places, most surprisingly, the barrier of burnout and what potentially gets in the way of practitioner joy. It seems that people who do "people work" are feeling burdened and overwhelmed, not just by the work, but by the pressure to do better when it comes to self-care. Does this resonate with you?

My research has been influential in uncovering the sources of joy in my work. While I eventually arrived at a clear understanding, the journey was far from straightforward and led to unexpected discoveries. Initially, I hypothesised that working congruently with my way of being would naturally bring joy into my practice. What I discovered, however, was both more complex and, surprisingly, simpler.

It was the collaborative, philosophical stance that allowed me to bring Belinda, the person, fully into the therapeutic space (Anderson, 2007). The relief of no longer feeling pressured to leave the essence of who I am at the counselling room door- but instead being invited into the room, was pronounced.

You might be thinking, but isn't this risky? Are you suggesting therapists bare everything to their clients? Far from it. Michael White's concept of "two-way" therapy invites counsellors to thoughtfully deconstruct their personal experiences to contribute to the rich story development of those consulting them (White, 2007). In this approach, counsellors share how a client's story has moved them, shaped their lives, and led them somewhere unexpected. White emphasises that these responses are not grand or self-serving but powerful in positioning the client as a knowledgeable contributor. This final element has become the most surprising source of joy in my practice. The act of taking-back what I have gained as a result of sharing in conversation with another human being has brought immense joy.

If, like me, you've entered this work with a desire to make a genuine difference in the lives of those you meet along the way, consider this: what if the people we work with, care for, and support can also make a difference in our own lives? What do you think about that idea? This research has helped me appreciate that a collaborative and philosophical stance supports me in working in alignment with my values, specifically creativity and egalitarianism. These values, in turn, allow me to bring myself into the work, resulting in a profound sense of joy. I'm interested to know how this approach, or way of working, might change how others view burnout. Could joy indeed be the key to reducing burnout?

Warmly
Belinda

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Here to help: A therapist's journey into Feedback Informed Treatment (FIT)

Vivian Baruch

Keywords: *Feedback Informed Treatment, therapeutic outcomes, client engagement*

Abstract

Using a case study and meta-analytic data, this article makes the argument that routinely using Feedback Informed Treatment (FIT), is a robust way to improve outcomes and alliance in counselling. This method simultaneously centres our clients' voices, provides quality assurance, prevents worsening symptoms in clients at risk of poor treatment outcomes, and enhances professional development and accountability.

Here to help: A therapist's journey into Feedback Informed Treatment (FIT) by Vivian Baruch

Since entering the behavioural health field in 1981, I have been driven by the aim to be of help. This article depicts my journey towards knowing when and where I am actually helping. Decades of meta-analytic data provides ample evidence that psychotherapy is effective with an effect size (ES) of 0.8. Sadly, this ES has not changed in over 50 years, irrespective of the specific problem being addressed, the therapeutic method employed, the years of experience the therapist has or even the complexity of the client's issues – except for severe biologically based disturbances.

My guiding motto in 1981 was and still is Here to help. I went to graduate school full of hope, ready to learn how to be an effective therapist – and learned much. I loved the experience, my teachers, my peers. But despite acquiring key therapy skills and deepening my knowledge, something was missing.

I kept asking myself: *Am I actually helping? How do I know if what I'm doing works?*

Drowning in options, searching for certainty

As I began practicing, I found myself overwhelmed by choice—psychodynamic, behavioural, humanistic, existential. Should I specialise? Should I focus on individuals, couples, or groups? Anxiety? Depression? Trauma? Sexual dysfunction? CBT, EMDR, systemic, trauma-informed, more? There were endless possibilities. I kept training, reading, and attending workshops in pursuit of a more confident answer to those questions. Still, despite feeling more competent over time, the doubt lingered.

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Like many others, I coped by seeking more supervision, reading more, and attending training after training. I wasn't alone in this. When I spoke to colleagues, many admitted—privately—that they, too, felt uncertain. Publicly, however, we projected confidence. It felt like we were living double lives: one voice full of doubt, the other confidently assuring our clients (and ourselves) that we knew what we were doing. These fundamental questions kept gnawing at me.

Professional emails and journals offered countless new techniques and models, each promising better client outcomes and becoming a more skilled therapist. I believed them—why wouldn't I? After all, I wanted to be better.

Turning to the research

Eventually, I focused my practice on couples therapy, but the doubts persisted, especially when sessions were difficult or clients dropped out unexpectedly. Desperate for answers, I turned to the research—not summaries or commentaries, but the studies themselves.

It was tough going. I wasn't trained for this level of critical reading. But slowly, patterns began to emerge and they made me profoundly uncomfortable.

I initially rejected the findings. *This can't apply to me, I thought. My models are evidence-based!* My peers reacted similarly. When I shared the studies, they responded with disbelief, even hostility. I understood. We'd all been told the same thing: more training, new models, and supervision would lead to better outcomes.

But the data told a different story—and it forced me to reckon with hard truths.

What the research actually shows

Here's what I discovered from solid meta-analytic research. It challenged many of the assumptions on which our field is built:

- All bona fide therapy models work about the same (Wampold & Imel, 2015)
- Supervision doesn't reliably improve outcomes or therapeutic alliance (Norcross & Wampold, 2019)
- Personal therapy for therapists doesn't make us more effective (Haikal, 2022)
- Therapists don't improve with time and experience (Germer et al., 2022)
- Post-graduate training beyond the basics doesn't enhance client outcomes (Okiishi et al., 2006)
- Psychotherapy outcomes have not improved in over 50 years (Miller et al., 2020)

Let me be clear: psychotherapy is effective. Studies going back to Smith & Glass (1977) show that the average client receiving therapy, when they're engaged in the work, fares better than 80 per cent of untreated individuals. That's a remarkable effect size (ES ≈ 0.8)—comparable to coronary bypass surgery or four times the effect of fluoride in preventing cavities (Milton H. Erickson Foundation, 2014; Duncan et al., 2022).

But what shocked me was this: the effect size hasn't changed in decades. It doesn't vary based on the therapist's experience, the complexity of the problem, or the model used—except for severe biological disorders. Compare this to the progress seen in fields like science, medicine, technology, education, athletics, music and chess, where performance has dramatically improved over time (Ericsson, Prietula, & Cokely, 2007).

Despite feeling more confident than I did earlier in my career, the research made it clear: most therapists believe they're improving, but actual client outcomes don't reflect that. The data show we don't reliably improve unless we're actively measuring our effectiveness. And most of us aren't.

Cognitive bias and the illusion of growth

This disconnect between perceived and actual improvement is well-documented. For example, Goldberg et al. (2016) found that therapists tend to plateau early in their careers, even as their confidence increases. A follow-up study (Germer et al., 2022) replicated these findings, confirming that more experience doesn't equal better outcomes.

Even more provocatively, studies show that paraprofessionals with just six weeks of training can get results comparable to those of licensed psychologists five years post-PhD (Goldberg et al., 2016). Instructors' outcomes often don't exceed those of their students (Witkowski, 2020). And in underserved communities, non-specialist workers using manuals like *Where There Is No Psychiatrist* (Patel, 2003) frequently deliver effective mental health care.

The culprit, it appears, is cognitive biases. Like anyone else, therapists are prone to the Dunning-Kruger effect (Duignan, 2019): the tendency to overestimate our own abilities. But what do we do with this knowledge?

Finding Feedback Informed Treatment (FIT)

In 2004, I came across an article in *Psychotherapy* in Australia introducing an idea that changed everything: Feedback Informed Treatment (FIT). It *wasn't* a new therapy model—it was a framework for routinely tracking outcomes and the therapeutic alliance from the client's perspective, to assess whether therapy was helping.

I attended a training with Dr. Scott D. Miller titled, *"How to Improve the Effectiveness of Your Clinical Work by 65% Without Hardly Trying"*. I was skeptical, but curious. What I learned was simple and radical: ask clients for feedback in every session and use that data to guide the process.

FIT uses two brief, standardised tools:

- The Outcome Rating Scale (ORS) at the beginning of each session, to track life changes and levels of distress and functioning between meetings.
- The Session Rating Scale (SRS) at the end of each session, to assess the client's experience of the session.

The simplicity and accessibility of these tools—they're available in 20+ languages, and adaptable across age and literacy levels—makes FIT widely applicable, especially with Culturally and Linguistically Diverse (CALD) and economically disadvantaged clients. Before private practice, I'd worked extensively in underserved communities, so I saw how empowering it was for clients to have a voice in their care.

Using FIT changed everything. It helped me let go of rigid treatment plans and focus instead on what clients needed to feel better. I learned to prioritise their theory of change—not mine—and use their feedback to adapt. It was humbling and liberating. Why hadn't anyone taught me this before? Clients started to feel more engaged, and I felt more aligned with my core value: being of help.

Streamlining the data

After several years, I began using a digital platform for administering and tracking the ORS and SRS measures. Doing so not only expedited the process, but allowed me to aggregate client feedback over time, compare my work to global therapist benchmarks, and quickly spot clients at risk of dropping out or deteriorating.

It was confronting. The data showed that I wasn't helping as many clients as I'd thought. I was pushed to challenge my thinking and adapt on the fly, working hard to help in those instances where I wasn't helping. In short, I was being challenged by the feedback.

The case that convinced me to stick with FIT

The case that solidified my commitment to Feedback Informed Treatment (FIT) was, not surprisingly, a couple. Nicholas (not his real name) had cheated. Diane naturally was hurt and wondering whether to stay or leave. What unfolded over four sessions demonstrated how routine outcome and alliance tracking not only saved the therapy but reshaped its direction.

Session 1: Contrasting realities

Diane's ORS scores are represented by the black dots in Figure 1. The ORS measures her therapeutic progress while asking about her level of distress and functioning. Hers was above cutoff, the solid black line, indicating she was functioning well despite his affair. Internally I thought "This is strange. Why is she here?" She stated that she was coping well with life in general. The SRS is represented by the grey dot and measures the therapeutic alliance. She scored on the solid grey line. indicating her satisfaction with the session.

In contrast, Nicholas's ORS score (Figure 2) fell below the clinical cutoff, showing distress. The international benchmarks aggregated by MyOutcomes (2025), show that clients who score below 25 on the ORS are distressed in various domains. Nicholas was in the red zone, and was struggling in himself, in their relationship and socially. His SRS was also low, showing he wasn't happy with the service. I was genuinely surprised! I thought the session had gone well and mistakenly "sensed" that I had an alliance with both of them.

If SRS scores are below the cutoff, my FIT training taught me to spend the last few minutes of the session exploring what was missing and what could have been done differently. He said he wanted to work on healing the affair and reconnecting as a couple. This was his theory of change which the research recommends therapists explore and honour. I suggested we start there in the next session. If I had not checked with him, I doubt they would have returned for a second session.

Figure 1

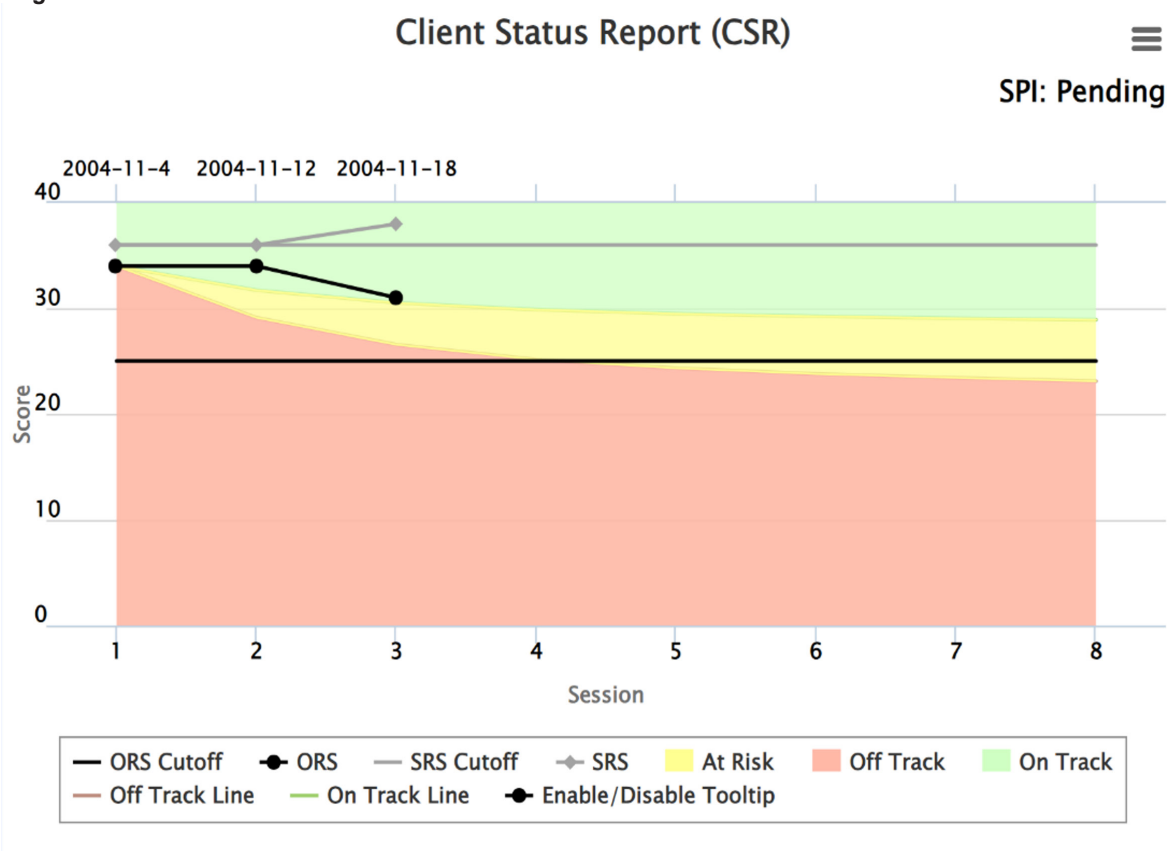
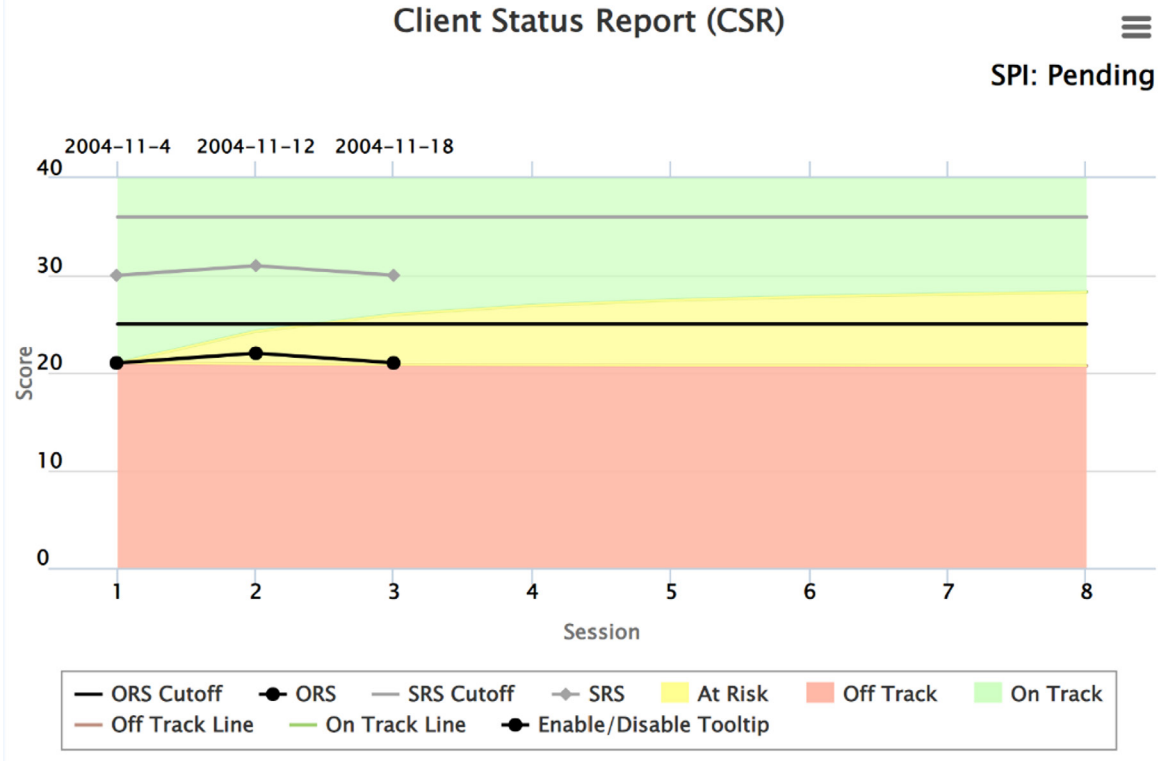


Figure 2



Session 2: Mixed signals

Diane's on track ORS was exactly the same. She was still feeling good in herself, despite his affair. She wasn't saying it, but I wondered if she had already decided to leave. We had agreed to start work on reconnecting them as a couple. I struggled on whether this was the right call, based on two intuitions. One part of me saw it as a good sign that they came back so we could do the "recommended" therapy when dealing with an affair (Dupree et al., 2007). Another part internally nagged me to pay attention to what her ORS and SRS scores were actually saying.

Seeing Diane coping so well kept Nicholas's ORS in the distressed zone. He said she was evasive at home and in session. They chose to explore her staying or leaving. At the end of this session, his SRS was still below the cutoff. He stated that he wasn't getting what he needed in our sessions. When I asked what was missing for him, he declared he wanted Diane to speak up about her plans.

Session 3: Emerging truths

Diane's ORS dipped because she'd told Nicholas that she had doubts about staying in the marriage. Was she now ambivalent? Was she worried about causing him pain by speaking her truth? They chose her worry about his reaction to her truth as the focus of this session. Her increased SRS represented her relief at being more authentic.

Nicholas's ORS dropped, showing we were stuck. He said Diane had expressed her doubts and he was not feeling better in between sessions and was not being helped by our work. Diane told him why she hesitated to state her truth. Even though this was their chosen session focus, his SRS also dropped. I was concerned. Despite my impression that progress was being made, his scores said otherwise. Something was missing and his scores helped me to catch and discuss it early.

If I hadn't been tracking their feedback, I may not have seen that their alliances with me were not aligned. Her scores told me she was engaged, his scores showed me he wasn't, and that he was in danger of dropping out of therapy. In discussing what needed to happen in our next session to make it more worthwhile for him, he said he wanted clarity about Diane's intentions. I asked her if she was prepared to do that, and she left us all in doubt, answering "I'll think about it until we next meet".

Session 4: Clarity arrives

Diane's increased ORS in Figure 3 showed her feeling clearer and stronger. She had told Nicholas she wanted to separate. Unpacking this big revelation was their focus for this session. Her explanation of her similarly increased SRS was that our work helped her communicate more directly to Nicholas "without giving him false hope".

Nicholas's ORS in Figure 4 finally rose to the clinical cutoff. Surprisingly, he said he was feeling better outside of therapy. He felt relief because Diane had finally said she wanted to end the marriage. He'd been feeling this all along, as I had. Their chosen focus for this session was processing their perspectives on ending the marriage. His SRS also improved, reflecting a stronger alliance as he "dealt better with tangibles than the unknown".

They continued therapy for a few more sessions to create a respectful separation plan for their children.

Figure 3

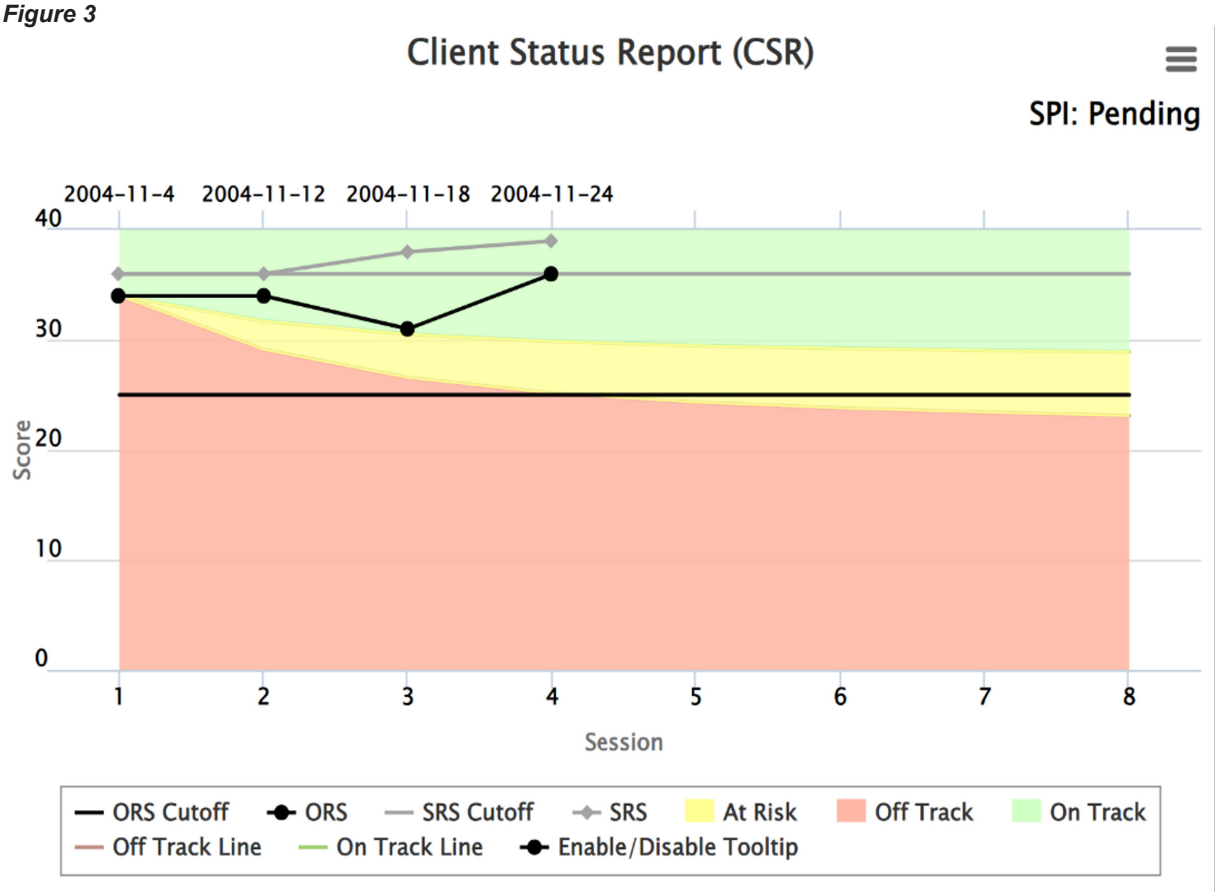
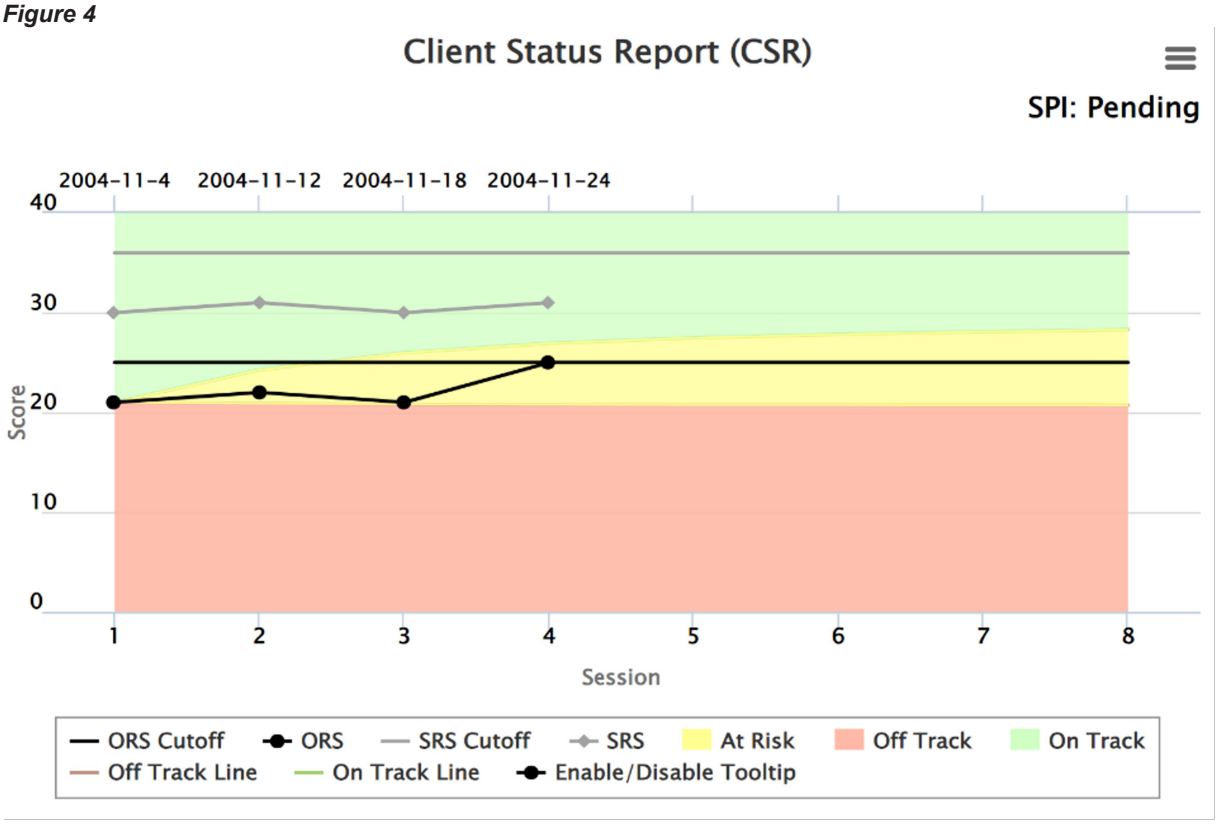


Figure 4



Why this case mattered

Thanks to the graphs and open discussions, what I thought was progress wasn't always aligned with their experience. Their feedback shaped the sessions and protected the alliance. This case became the turning point in my understanding of FIT and its application to broader counselling.

Without FIT, I likely would've misread their reactions and misdirected the therapy. Diane's early scores signalled her disengagement before she said a word. Nicholas's low SRS alerted me that he wasn't connecting with the process—contrary to my perception.

Their graphs told me what words didn't:

- That the alliance was uneven
- That Nicholas was at risk of dropping out
- That my own impressions could be misleading

Their real-time feedback helped me adapt. It gave the couple a clearer sense of their own progress and gave me a grounded answer to my long-standing question: Am I actually helping?

Their data, not just their words, shaped the path forward. That clarity is why I've used FIT ever since.

What I've learned

Twenty-one years of using FIT have taught me that:

- Measuring outcomes matters more than models
- Clients rarely care about our theoretical orientation—they care whether they feel better
- Therapists improve not by working longer, but by measuring their impact and adjusting accordingly

As I grew more confident with the system, my focus shifted. I started looking more closely at the margins—at cases where I wasn't helping and asking why. The data helped me become more responsive, to quickly pivot when therapy wasn't working, and to address drop-out risks early. Instead of waiting for failure, FIT helped me anticipate and adapt.

My mentor Scott D. Miller calls this *practice-based evidence*, and it's now supported by regulatory bodies too. It's not about adherence to a model but about using client feedback measures to guide clinical decisions. It even supports ethical endings. When therapy isn't working, FIT gives both therapist and client the clarity to explore better alternatives.

In Australia, exciting changes are happening in the field of counselling and therapy. The Psychology Board of Australian Health Practitioner Regulation Agency (AHPRA) recently updated its competencies to recommend purposeful and deliberate practice by using outcome data to guide learning. These changes will eventually impact all counsellors and Allied Health practitioners. This marks a shift in our field—away from assumption, toward accountability and quantitative professional development.

Final reflections

I've heard colleagues say they have no need for FIT because they already get feedback. Yet the Anker study (2009) showed that while half of the time therapists received feedback, half the time they did not. When they did get feedback from clients, couples were far more likely to be helped and less likely to separate or divorce at follow-up. This finding has now been replicated multiple times (Brattland, 2019). The bottom line is, no matter what we therapists believe, we are more likely to be helpful when we ask for and receive formal feedback.

FIT resonates with me because it returns the power to the client. They are the experts in their own lives. My job is to listen, adapt, and help them reach their goals—using whatever methods that requires. FIT gives me the freedom to use clinical judgment, to adapt session by session, and to stay focused on the one thing that has always mattered most to me: helping. The research is clear: routinely measuring outcomes and alliance is the only proven way to reliably improve both (Lambert & Kleinstäuber, 2019).

It's not always easy; in particular, seeing where I fall

short can be uncomfortable. But it's also clarifying, empowering, and deeply respectful of the client's role in the therapeutic process.

If you're looking to grow and improve your work, I recommend starting with two excellent resources:

- *Better Results* by Miller, Hubble, Chow & APA (2020)
- *The Field Guide to Better Results* by Miller, Chow, Malins & Hubble (2023)

These books outline the research and practical tools needed to evolve—one session, one client, one datapoint at a time.

After all these years, I finally have an answer to the question that once kept me up at night:

Am I actually helping?

Now, I know. And that makes all the difference.

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Embedding Fawning: A Feminist Grounded Theory of Trauma Survival in Clinical Practice

Christine Honor and Dr Lynlee Howard-Payne

Keywords: *counselling; education and training; fawning; grounded theory; meaning-making; postmodern feminism; trauma responses*

Abstract

Dominant trauma theory emphasises fight/flight (and freeze), overlooking "fawning" (appeasement) as a response to traumatic events or experiences. This constructivist Straussian grounded theory (GT) study explored how five experienced Australian mental health practitioners interpret fawning in counselling practice in the absence of formal training. Using repeat semi-structured interviews analysed via the constant comparison from a postmodern feminist lens, we identified three categories: (1) *Contextualising Fawning as an Adaptive Survival Response*; (2) *Transforming Shame through Meaning-making*; and (3) *Structural Barriers to Recognition*. Findings reveal that practitioners develop sophisticated ecological frameworks to recontextualise fawning from individual pathology to contextual adaptation. This reframing enables rapid transformation of survivor self-concept from shame to self-compassion through what participants described as profound "aha moments" of recognition. However, gendered socialisation patterns, training gaps, and epistemic exclusion within mental health professions continue to marginalise these responses. Our findings highlight implications for counselling education, such as inclusion of appeasement responses in curricula, explicit attention to power and gendered socialisation, and transparent, context-sensitive assessment. We argue that integrating these elements can strengthen trauma-informed practice and improve support for survivors whose responses have been marginalised.

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Introduction

The evolution of trauma theory reveals a persistent tension between expanding empirical understanding and entrenched theoretical frameworks that limit recognition of diverse survival responses. Cannon's (1932) foundational fight-or-flight model emerged from laboratory studies of male subjects and animals, establishing a binary conceptualisation that continues to dominate clinical understanding despite mounting evidence of its limitations (Taylor et al., 2000; Bracha et al., 2004). Selye's (1946) general adaptation syndrome theory reinforced this model by focusing on physiological stress responses without accounting for the social and relational dimensions of threat.

This androcentric foundation created systematic blind spots that postmodern feminist scholars have increasingly challenged. Taylor et al. (2000) directly confronted the masculine bias in stress research by proposing the "tend-and-befriend" model, demonstrating that affiliative responses represent biologically grounded adaptations rather than deviations from "normal" stress responses. Their work revealed a fundamental contradiction that while fight-or-flight theory claimed universality, it described responses more typical of men under specific conditions.

Porges' (2009a, 2009b) polyvagal theory further challenged binary thinking by introducing neurobiological foundations for understanding immobilisation and social engagement as adaptive responses. However, a critical gap persists between Porges' neurobiological insights and Taylor et al.'s social-behavioural observations, as neither explicitly addresses how power dynamics shape which responses are available or adaptive in each context. This gap is precisely where fawning (also known as appeasement) responses become theoretically significant.

Recent scholarship has begun to address this gap through explicitly political analyses. For example, Bailey et al. (2023) formally proposed replacing the stigmatising term "Stockholm Syndrome" with "appeasement", grounded in polyvagal theory. This shift reframes such survival responses from psychological pathology to neurobiological adaptation. However, Bailey et al.'s focus on neurobiology, while valuable, does not fully account for the socio-political contexts that determine when appeasement becomes necessary.

Postmodern feminist trauma theorists provide the missing political dimension. Herman's (1992) analysis of how women's trauma responses have been systematically pathologised connects directly to contemporary debates about epistemic injustice (Fricker, 2007). Herman showed that excluding women's experiences from trauma theory was not accidental but

reflected power structures that delegitimised "feminine"-coded responses. This insight gains currency through scholars like Thompson (2021) and Johnstone and Boyle (2018), who argue that trauma theory must explicitly incorporate the socio-political contexts of oppression.

The convergence of these theoretical developments reveals three critical insights that prior literature has not fully integrated. First, neurobiological research (Porges, 2009a, 2009b) and behavioural research (Taylor et al., 2000) both challenge binary trauma models, but neither adequately addresses power dynamics. Second, postmodern feminist analyses (Herman, 1992; Thompson, 2021) provide crucial contextual understanding but require integration with contemporary neurobiological insights. Third, recent attempts to legitimise appeasement responses (Bailey et al., 2023) remain primarily focused on individual-level mechanisms rather than the systemic factors that shape their expression and recognition.

These theoretical gaps translate into practical limitations in mental health education and practice. While evidence increasingly supports the prevalence and adaptiveness of fawning responses in interpersonal trauma (Pill et al., 2017; Cromer & Smyth, 2010), clinical training continues to emphasise individualistic frameworks that may inadvertently reproduce victim-blaming narratives (Narruhn & Clarke, 2020). This disconnect between emerging theory and practice creates an implementation gap where practitioners are often left without adequate frameworks for understanding and responding to fawning behaviours.

The present study addresses this implementation gap by examining how experienced practitioners make meaning of fawning in the absence of formal theoretical guidance. By focusing on practitioner meaning-making processes, this research provides empirical insight into how theoretical integration might occur at the practice level, potentially informing broader efforts to update trauma education and clinical frameworks.

Methods and Procedure

Following ethical clearance from the institutional Human Research Ethics Committee (HREC), participants were recruited via targeted advertisements on social media. A modest honorarium of AUD$50 was offered to compensate participants for their time and insights, in line with ethical guidance to avoid coercion (Lynch, 2014). Inclusion criteria required participants to have at least five years of clinical experience working with individuals who have experienced interpersonal trauma, proficiency in English, membership in a professional organisation with an ethical charter, and availability for repeat interviews (approximately one hour each) given the cyclic data collection and analysis in a Straussian GT study. Recruitment paused after five participants (meeting these criteria) responded to our adverts. They were provided written informed consent after reviewing key documents including an information sheet, initial interview schedule, support resources, consent forms, and a debriefing protocol.

From our initial partial literature review (an exploratory engagement with literature to sensitise researchers without imposing a *priori* theories), we developed a semi-structured interview schedule to explore how participants conceptualised fawning as a trauma response in their practice. The schedule comprised 12 core questions with prompts, for example: *"How do you understand the concept of fawning?", "What is your professional experience with trauma responses and the concept of fawning?", "How do you think the fawning response is represented in counselling/psychological theory? Is it underdeveloped or underrepresented in training?"*, and *"What would you like the broader field to understand about this phenomenon?"*. These guiding questions evolved over time as emerging findings informed subsequent interviews.

We conducted repeat one-on-one interviews via Zoom. Each interview was recorded and transcribed verbatim, and transcripts were returned to participants for accuracy checking (member checking). Upon confirmation of accuracy, the recordings were deleted. All transcripts and related materials were stored securely (password-protected cloud storage) in accordance with ethics protocols, to be retained for five years before destruction.

Anonymity and privacy were maintained by using pseudonyms for all participants and redacting any identifying details (workplaces or specific locations). All five participants identified as women. Data collection continued until we reached data saturation (Strauss & Corbin, 1998) after approximately 11 hours of interviews (including follow-up sessions and member checks). Table 1 summarises key demographic information for each participant, including age range, professional qualifications, areas of practice, and years of relevant experience. All names are culturally appropriate pseudonyms.

Table 1. *Demographic Information of Sample*

Name	**Joy**	**Anne**	**Em**	**Karen**	**Jane**
Age	45-50	66	34	47	50-60
Professional Qualification	Bachelor Criminology, BPsych (Honours), Resource Therapist, EMDR Therapist, Graduate Diploma (Systemic Couple Therapy)	Master of Art Education/Art Psychotherapy Grad Dip Art Therapy, Diploma of Fine Art	Social Work Degree, Psychology Degree, Clinical Mental Health Social Worker, Emotion Focused Therapist	Bachelor of Social Work (Honours), Post Graduate Loss Grief and Trauma Counselling, Somatic Experiencing Training	PhD Politics Grad Dip Psychotherapy

Trauma Work Type	Victims of domestic and intimate partner violence/childhood abuse/neglect	Victims of abuse (children), War veterans, Perpetrators and victims of Domestic violence, Adult survivors of childhood sexual abuse / childhood trauma, Institutionalised childhood sexual abuse	Complex trauma, Family violence, abuse, exploitation and neglect. Historical trauma (i.e. Institutionalised sexual abuse, forced adoption, people that are living with disability and historical sexual abuse, sexual assault survivors and women in the sex industry	Sexual assault/ domestic violence (children) War trauma and torture (Refugees), Domestic violence (women) Prison counsellor (men)	Complex Trauma, Dissociative Disorders Adult survivors of complex childhood trauma
Educational Development/ Training	Drug and Alcohol Interventions, Relationship counselling, Educator/Trainer	Visual Art Art Therapy Psycho-analytically Oriented Art Psychotherapy	Complex trauma training, somatic approaches to trauma (i.e. Bessel Van Der Kolk, Babette Rothchild, Janina Fisher, Dan Siegal, Dr Rick Hanson). Somatic alongside Verbal approaches, Mindfulness, Neuropsychology, Neuroplasticity	Somatic Experiencing Training, Childcare (early childhood)	Cert 4 in Workplace Training and Assessment
Years of Related Work Experience	20	40	11	6	20

Analytic Strategy

This study employed a constructivist Straussian GT approach, which differs from classic Glaserian GT in several keyways. Straussian GT permits initial literature engagement to sensitise researchers to relevant concepts while maintaining analytical openness (Strauss & Corbin, 1998). Our constructivist orientation acknowledges that data and analysis are co-constructed between researchers and participants rather than "discovered" as objective truth (Charmaz, 2014). In practice, this meant we approached the data recognising that meaning emerges through interaction and interpretation, which is well-suited for exploring practitioners' subjective sense-making around fawning. This stance also emphasises researcher reflexivity and theoretical sensitivity (awareness of concepts from prior knowledge) while maintaining rigour through systematic procedures (Howard-Payne, 2019).

Data analysis followed Strauss and Corbin's (1998) multi-stage coding process. We began with open coding, which is a line-by-line examination of each transcript to identify and label key concepts in the data. Next, we engaged in axial coding, relating categories to their subcategories by exploring properties and dimensions of each concept and looking at how they interconnect. Finally, we employed selective coding, integrating the major categories and subcategories around a core category (the central phenomenon of interest). Throughout these stages, we used the constant comparative method as the analytic backbone, continuously comparing data segments, codes, and categories across interviews to identify patterns, variations, and evolving theoretical relationships (Glaser & Strauss, 1967; Strauss & Corbin, 1998). The constant comparative method operates through four key processes: 1) Comparing incidents applicable to each category, 2) Integrating categories and their properties, 3) Delimiting the theory, and 4) Writing the theory (Howard-Payne, 2019).

This iterative process ensured analytical rigour by requiring us to continually question and refine emerging interpretations in light of new data, leading to progressively more refined theoretical understandings. We also employed theoretical sampling during data collection whereby our early analysis guided adjustments to subsequent interview questions and the recruitment of any additional participants or follow-ups to further develop emerging categories. We determined that data saturation was achieved once the fifth interview yielded no new properties or insights for the core categories (Strauss & Corbin, 1998).

Throughout analysis, we kept analytic memos to document our decision-making and reflexive thoughts. This audit trail captured how our feminist positioning and prior experiences may have influenced interpretations, thereby increasing transparency. Verbatim quotations from participants are presented in the findings to illustrate each category and its dimensions; we use ellipses and bracketed clarifications where needed for readability. Internally, we noted each quote's transcript page and line number to ensure traceability of data, reinforcing the transparency and trustworthiness of our analytic process.

Findings and Discussion

Our analysis revealed that practitioners construct meaning around fawning through an ecological lens encompassing individual, relational, and structural dimensions. Three main categories emerged, reflecting how participants navigate the absence of formal training by drawing on alternative frameworks to validate fawning as a contextually appropriate survival behaviour.

Category 1: Contextualising Fawning as Adaptive Survival

Dimension 1.1: From Pathology to Adaptive Strategy

Participants consistently emphasised the importance of reframing fawning from an individual pathology into an adaptive survival strategy. This recontextualisation required them to move beyond traditional, individualising frameworks toward a more holistic, biopsychosocial understanding of trauma responses. As Jane explained: *"Fawning is an unfortunate term, but it fits well within the three F's … Prior to that utilisation, if we talked about fawning on someone, it almost implied a sort of obsequious, you know, a lack of self-respect – a pejorative term, really, fawning. But of course, in the trauma context it's really anything but [weak]. We're talking about a survival response … really linked to coping mechanisms and [it] can be quite strategic."* Jane's reflection shows how reconceptualising fawning as an adaptive, contextually driven response challenges the tendency of dominant frameworks to label it as a character flaw.

Participants described the profound relief clients experienced when fawning was reframed in this way. Em shared, *"I can just picture so many women [who have] had those 'oh, this all makes sense' moments … there's sort of a letting go of, 'there's something wrong with me. I'm crazy, I'm defective, I'm to blame'."* In these moments, what had been internalised as personal weakness was reinterpreted as an understandable coping strategy in context, which greatly reduced survivors' self-blame.

Dimension 1.2: Biological and Neurobiological Foundations

Participants also demonstrated a sophisticated understanding of fawning as a biologically and neurologically embedded response. Joy described humans as *"creatures with a physiological arousal response … our nervous systems are hard-wired to take care of us without thinking."* She and others saw fawning as occupying an intermediate state in the arousal spectrum. *"One's the accelerator on and one's the accelerator completely off. I think fawning fits in between that, as a more learned helpfulness"*, as Joy said, comparing it to states of hyper-arousal (fight/flight) and hypo-arousal (freeze/collapse). Karen elaborated on the physiological complexity of sustaining a fawn response: *"If you are consistently hypervigilant but also trying to fawn, it's like trying to drive a car with the accelerator and the brake on at the same time. It's exhausting, I notice a lot of clients have chronic health issues."* These insights align with contemporary neurobiological trauma theories that locate appeasement behaviours within our evolved threat-response systems (Porges, 2009a). In other words, participants recognised that fawning has a grounding in our autonomic nervous system's social-engagement circuitry. It is not a chosen weakness, but a hard-wired adaptive option that can come at a physiological cost when chronically engaged.

Category 2: Transforming Shame through Meaning-Making

Dimension 2.1: Disrupted Assumptions and Self-Blame

Participants identified how fawning responses often shatter survivors' fundamental assumptions about themselves and the world, leading to intense shame and self-blame. Many survivors hold an implicit "just world" belief, which is the notion that good things happen to good people and that one can control outcomes by behaving "correctly". When trauma violates these assumptions, survivors may irrationally blame themselves for what happened. Fawning can be especially hard to reconcile with notions of agency and resistance. Joy shared a powerful example of a male client in his 60s who had experienced childhood sexual abuse: *"There's a lot of self-blame, you know. Horrible … 'why did I do this? Why didn't I say [when my caregiver asked] "Is he [sexually assaulting you]?" Cos he kind of got found out'."* The client's retrospective self-interrogation of *"Why didn't I cry out? Why did I comply?"*, illustrates how survivors can internalise responsibility for abuse, especially when their trauma responses (like freezing or fawning) are misinterpreted as passive consent or weakness.

Participants lamented how often the systems around survivors inadvertently compound this shame. Jane observed systemic therapeutic failures: *"Therapy has tended to be 'what can you do to make your situation better?' Now for someone who is a victim of relational trauma, that's just incredibly shaming and completely missing the mark. So, the idea of what can you do fits into a just-world [belief] – bad things shouldn't happen to good people. If you'd done X, this wouldn't have happened."* In Jane's view, traditional therapy paradigms too often locate the problem (and solution) in the individual, reinforcing the notion that the survivor "should have" acted differently. This outlook, however well-intended, can reinforce survivors' guilt by implying they had control or choice during the trauma.

Participants also discussed how institutional betrayals and societal denial exacerbate survivor shame. Jane noted, *"We've had all these royal commissions and they come out with great recommendations. But actually implementing them – there are all these interests and stakes in them not being implemented."* These systemic failures to protect and validate survivors (in churches, schools, care systems) can lead to re-victimisation and a deepened sense of personal defectiveness. Em described the pervasive survivor guilt she encounters: *"Sitting with survivors who feel immense guilt and shame because they allowed it to happen. Because they didn't run away. Because they didn't say no loudly enough."* This internalised responsibility reflects assumptive world theory (Janoff-Bulman & McPherson Frantz, 1997) where, in an effort to make sense of trauma, survivors may rewrite the narrative to assume they had control *("If only I had done X, it wouldn't have happened"*), thereby preserving an illusion of justice or order at the expense of their self-worth.

Dimension 2.2: Integration and Meaning Reconstruction

Despite these challenges, participants described profound therapeutic transformations when fawning is openly named and contextualised. Meaning-making within a supportive therapeutic relationship helped turn shame into compassion and insight. Em reflected on witnessing these shifts: *"I just love seeing women go on [this journey]. It's just amazing seeing them shift from being sort of a shadow of themselves, to being full and connected, powerful, powerful human beings."*

Crucially, this transformation required explicit attention to both personal and structural dimensions of trauma. Em emphasised: *"You need to name it, validate it, believe the victim. You need to place it within its systemic context. You need to highlight the sexism and oppression and the inequality; that's all part of the healing journey."* This approach moves beyond individual symptom management toward developing the survivor's critical consciousness of the social conditions of their trauma. It aligns with Herman's (1992) stage model of recovery – establishing safety, remembrance and mourning, reconnection – but extends it by explicitly integrating political analysis into the healing process.

Participants recounted specific "aha" moments when clients reconceptualised their fawning response. Em described many clients having: *"Those 'oh this all makes sense' moments and you can just see the overwhelming relief and emotion that comes with it, because there's a letting go of 'I'm crazy,*

I'm defective, I'm to blame'." In these moments of meaning reconstruction, survivors often experience a flood of relief as the weight of self-blame is lifted. What changes, participants noted, is not the factual memory of what happened, but the interpretation of those actions: from "I failed" to "I did what anyone might do to survive an impossible situation."

While acknowledging the value of somatic trauma therapies (which often de-emphasise narration of the trauma story), participants advocated for a more comprehensive integration that includes narrative and systemic elements. Em critiqued purely body-focused interventions: *"Van der Kolk … his approach is just, you don't have to talk about what happened. And I agree to an extent – you don't need to articulate the abuse. But…"* She argued that healing also requires putting the experience into words and context when the survivor is ready: "You need to name it, validate it … place it within its systemic context." In other words, bodily processing of trauma is essential but insufficient if the survivor's socio-political reality is not addressed. Participants' approach to integration thus marries the somatic with the narrative-political. This integrative meaning-making aligns with Herman's (1992) emphasis on meaning in recovery, while also echoing postmodern feminist and decolonial critiques that urge naming of oppressive structures in the healing journey. By doing so, participants felt they were not only reducing individual distress but also empowering survivors to reclaim their stories from pathologising or victim-blaming cultural narratives.

Category 3: Structural Barriers to Recognition

Dimension 3.1: Gendered Socialisation and Double Binds

All participants highlighted how gendered socialisation creates complex double binds that both shape fawning responses and impede their recognition in practice. Karen, drawing on her experience working in prisons, described intense masculine social pressures: *"It's not safe [for men] to be seen as weak. I wonder if for men that fawning equals weakness. Like, if you go along with what's going on … that fight response is a better option for them than a fawning response, because of what they've been told."* From boyhood, many men are conditioned to believe that submission or appeasement is shameful; thus, if they do fawn under threat, it may deeply conflict with their identity, and they may later deny or reframe it.

Conversely, women are often expected to appease as a default social role yet paradoxically are also punished if they fail to do so. Karen noted, *"What I noticed with men, and maybe some other women as well, is that when women don't use that fawning response on social media, they are seen as bitches or, um, hardcore feminists."* In other words, women who refuse to "play nice" or appease, even in everyday situations, can be socially penalised. This creates a bind where women learn appeasement as a safety and likeability strategy, but then, in a trauma context, that same response might be judged as "weak" or "passive".

Participants distinguished between everyday people-pleasing and trauma-driven fawning. As Jane explained, *"Women are very socialised to be people-pleasing, but people-pleasing doesn't begin to speak to what fawning in a trauma sense is, which is literally trying to adapt to survive by not igniting the source of threat, by trying to fit in around them, by pre-empting what [the abuser] wants and keeping safe by trying to protect oneself."* This distinction is critical as fawning is not just "being nice" or conflict-avoidant by choice; it is a fear-driven survival manoeuvre. Gender socialisation lays the groundwork, teaching women to prioritise others' needs and teaching men that compliance equals weakness, and trauma then exploits that groundwork in life-or-death situations.

Participants also pointed out a telling paradox, which is that appeasement is openly taught and valued in certain sanctioned contexts, yet pathologised in personal trauma contexts. Jane gave the example of crisis negotiation: *"You have police negotiating… you don't antagonise and make demands of the person who's taken someone hostage. There are great attempts to get on their good side strategically."* In hostage situations, "fawning" by negotiators is considered a smart strategy to avoid violence. But when an individual (especially a woman) uses similar appeasement strategies with an abusive partner, it is often misunderstood or stigmatised as "co-dependency" or lack of assertiveness. Recognising this double standard, Jane argued, broadens understanding: *"The more we can say that men are utilising this response in different contexts, the more it starts to broaden understanding. It's not just women, even though it's used in quite a gendered way."*

Ultimately, participants saw the marginalisation of fawning as tied to the broader devaluation of responses coded as "feminine" within traditionally masculine-oriented frameworks. Jane remarked, *"It's interesting that fawn is passive and yet it's been less attended to… and it's connoted [with] femininity. But it is a creative, innate coping strategy that makes absolute sense in context."* Her point underscores that fawning's lower status in trauma theory mirrors the lower status historically accorded to traits associated with women (passivity, submission) in a patriarchal system.

Dimension 3.2: Professional Training Gaps and Epistemic Exclusion

All participants identified a profound disconnect between what they were formally taught and what they encountered in practice regarding fawning responses. Several admitted they initially had no language or framework from training to identify what some clients were doing. Em's reaction upon first hearing of the concept was telling, *"Gosh, I had never heard of it!" and Anne similarly said, "I do think it's underrepresented in professional training and in other sectors. And the reason I say this is because… not until I heard of this research, I hadn't really come across it."* This illustrates that standard curricula in counselling, psychology, and social work may omit appeasement as a trauma response altogether. As a result, practitioners only come to recognise and understand fawning through on-the-job experience, independent study, or in this case, through participating in research.

Participants linked these training limitations to broader epistemic exclusions in mental health professions. Jane observed that despite movements toward more relational and trauma-informed care, an *"individualistic hangover"* persists in the psy-disciplines: *"Despite all our emphasis on relationality, I think it's still strong. There's still a fallout of kind of individualising, privatising problems… seeing them as characterological rather than about the context the person is operating in."* From this perspective, the marginalisation of fawning is not just an oversight but a symptom of a larger bias in the field that favours internal, individual explanations over contextual ones.

The political dimensions of these exclusions were explicitly recognised by participants. Jane noted that awareness is – slowly – growing: *"Now we're so much more aware of the social/cultural/political context of mental health and certainly trauma too… but it's still a late realisation for a lot of clinicians."* She tied this shift in part to broader social movements: *"With #BlackLivesMatter and #MeToo, everyone's belatedly realised you cannot keep politics out of mental wellbeing and psychological health."* In other words, recent cultural reckonings with systemic injustice have begun to penetrate trauma practice, highlighting the need for frameworks that acknowledge power and context.

Participants even framed their engagement in this study as a form of political advocacy. Em expressed hope that this research would prompt structural change: *"You've [the*

researchers] highlighted something that needs to be expanded on more… I would hope that any expansion into that area that psychology or social work or counselling takes really takes a structural lens. To understand not only the micro fawning that occurs but the systemic fawning… and how they're inseparable. And we need social change, ultimately. You can't expect women to change fawning behaviour if the system around them doesn't." Here, Em is extending the idea of fawning beyond individual behaviour ("micro") to how entire systems or institutions demand appeasement ("systemic fawning"). This comment reiterates a core feminist principle, that the personal is political. Helping individual clients cannot be fully separated from advocating for social conditions that no longer coerce or punish appeasement responses.

Finally, participants warned that decontextualised interventions (however well-meaning) can be dangerous. Jane gave a clear example, where teaching a survivor to "just be more assertive" without considering their power context can backfire: *"Trying to be assertive in an unequal power relationship can be a very dangerous thing, so it can make sense that the fawn response is utilised."* This underlines why practitioners in this study felt it was crucial to validate fawning as making sense in context, rather than hastily trying to extinguish it. Instead of urging clients to change their behaviour in isolation, the onus shifts to practitioners and systems to change how they interpret and support that behaviour.

Taken together, these categories reveal how practitioners constructed meaning around fawning despite the lack of formal guidance. Category 1 provides the conceptual foundation by repositioning fawning as an adaptive survival response rather than a pathology. Category 2 demonstrates the therapeutic impact of this reframing (how it helps transform survivor shame into empowerment through contextualised meaning-making). Category 3 identifies the structural and cultural barriers that have kept fawning hidden and stigmatised, highlighting why such reframing is often absent from mainstream practice. In combination, the categories illustrate practitioners' creative, critical meaning-making processes that enable them to validate clients' experiences of fawning while working within (and pushing against) the constraints of their professional contexts.

Novel Theoretical Contributions

This study makes several distinct contributions to trauma theory, extending beyond existing scholarship. First, it provides what appears to be the first empirical exploration of how practitioners themselves interpret and respond to fawning in the absence of formal frameworks. Prior research has established the neurobiological basis for appeasement responses (polyvagal theory in Porges, 2009a) and has critiqued the omission of these responses in trauma theory (Thompson, 2021), but no studies have examined the interpretive processes that clinicians use in real time to make sense of fawning in practice. Our findings begin to fill that gap.

Second, the ecological framework that emerged from our data demonstrates how practitioners integrate insights from disparate theoretical traditions (neurobiological, feminist, and social constructionist) to develop a coherent approach to fawning. This grassroots integration process, documented in participants' accounts, reveals specific mechanisms through which theoretical innovation occurs at the practice level. The framework expands on existing ecological models of trauma (Bronfenbrenner, 1986) by explicitly incorporating power dynamics and epistemic justice considerations as central, rather than treating socio-political factors as a peripheral context.

Third, the study identifies a previously under-recognised phenomenon, which is the rapid transformation of shame through contextual meaning-making about survival responses. While Herman's (1992) classic model of trauma recovery emphasises the importance of meaning-making, and assumptive world theory (Janoff-Bulman & McPherson Frantz, 1997) explains how trauma challenges core beliefs, our findings show how explicitly reframing a "disempowered" response like fawning into a survival strategy can catalyse an almost immediate shift in a survivor's self-concept from one of pathology to one of resilience. This suggests that meaning-making interventions may be even more powerful than previously understood when they directly address structural dimensions of trauma (such as gendered power imbalances and victim-blaming ideologies) rather than focusing only on individual cognitive reappraisal.

Advancing Clinical Practice Understanding

Our findings challenge dominant assumptions about trauma treatment, particularly the limitations of individualistic approaches for survivors who exhibit fawning responses. Current evidence-based treatments largely focus on symptom reduction and individual skill-building. For example, many mainstream interventions (as popularised by works like van der Kolk's The Body Keeps the Score, 2014) emphasise techniques to regulate the nervous system or challenge personal cognitions. Participants in this study consistently reported that such approaches, when applied without context, often increased shame in clients who fawn. If a therapy protocol implies that the solution is to train the individual to respond "better" (fight, flee, assert boundaries), a fawning survivor may only feel more defective for not being able to do so. Our research provides initial empirical evidence that contextual, power-aware approaches, which validate the fawning response and situate it within external circumstances, may be more effective for this subgroup of trauma survivors.

The study also advances understanding of specific therapeutic mechanisms. Participants identified a process through which intense shame can transform into self-compassion almost instantaneously (the "aha moment" when a survivor fully grasps that their fawning was an adaptive way to stay safe). This phenomenon is distinct from the slower processes of gradual exposure therapy or cognitive restructuring typically discussed in trauma treatment. It suggests there is a potentially unique pathway to healing for certain trauma presentations, one that hinges on insight and reframe rather than prolonged exposure or skills training. In practice, facilitating these insight-based re-interpretations of survival behaviour could become a targeted therapeutic strategy.

Furthermore, our study highlights how gendered socialisation creates differential therapeutic needs and considerations. The finding that men may experience additional shame around fawning due to norms of masculinity (making it more difficult for them to acknowledge or work through), whereas women may face criticism when they don't fawn (being labelled "difficult" or "aggressive"), indicates that trauma therapy must be gender-responsive. It is not enough to generically teach about fawning; clinicians should be mindful that clients of different genders might carry different narratives and societal pressures around the behaviour. This insight extends the existing gender-informed trauma literature by identifying specific mechanisms (masculine shame, feminine social expectations) through which socialisation influences both the manifestation of trauma responses and the process of therapy.

Implications for Professional Education and Training

Our study reveals critical gaps in professional training that, to date, have not been systematically documented. It is widely acknowledged that trauma content in curricula has been insufficient (Courtois & Gold, 2009); our research provides

concrete evidence of how these gaps manifest in practice and the consequences for client care. Specifically, all participants had to develop alternative understandings of fawning through on-the-ground experience or independent learning, indicating that current training programs are not just incomplete but potentially counterproductive if they implicitly dismiss or pathologise what is actually an adaptive response. When training fails to mention appeasement, practitioners may either overlook it or misinterpret it, thereby unintentionally perpetuating the very stigma and misunderstanding that this study's participants worked to overcome.

To address these shortcomings, we identify several specific content areas that should be integrated into mental health training programs:

1. Curricula should include coverage of neurobiological literacy such as polyvagal theory and "tend-and-befriend" research (Taylor et al., 2000) to provide students with a biological foundation for understanding a range of trauma responses. The current emphasis on fight-or-flight is simply too narrow for real-world clinical practice;
2. Practitioners need explicit training in recognising and analysing power relations (gendered, racial, socioeconomic) that shape trauma responses and recovery processes. This represents a significant shift from individualistic training models toward a more sociological or systemic lens;
3. Epistemic justice awareness training should address how professional knowledge systems themselves may exclude or pathologise certain populations' experiences. For example, students could learn how trauma theory has historically marginalised women's accounts, and how similar patterns might affect other groups. This helps future practitioners recognise and correct knowledge gaps (like the absence of fawning in theory) as issues of injustice, not just oversight;
4. Trainees should be taught to assess contextual frameworks in their relational, cultural, and political settings rather than automatically treating them as symptoms of individual disorder. This might involve integrating ecological and intersectional case formulations into diagnostic and treatment planning exercises.

Implementing these changes in education could better prepare clinicians to validate and work with responses like fawning. Moreover, teaching about appeasement as a normal trauma response can itself have a destigmatising effect and new practitioners entering the field would carry an expectation that such behaviours are part of the adaptive repertoire, not signs of "weak character" or pathological attachment.

Broader Social Justice Implications

Our findings underscore that professional mental health practice can either perpetuate or challenge larger systems of oppression. In line with arguments by postmodern feminist scholars that trauma treatment is inherently political (Thompson, 2021), this study shows how even the language and concepts used in therapy connect to structural power dynamics. For instance, whether a clinician views a survivor's appeasement as "maladaptive dependency" or as "intelligent self-preservation" is not neutral as it can either reinforce or resist societal victim-blaming narratives.

This research also illuminates specific mechanisms of epistemic injustice within mental health. The systematic exclusion of fawning from textbooks and training is an example of what Fricker (2007) calls structural epistemic injustice, when certain knowledge (often that of marginalised groups) is omitted or discredited because it challenges dominant paradigms. We document how this exclusion has tangible effects as practitioners felt underprepared, survivors felt misunderstood, and harmful misconceptions went unchallenged. In a sense, the lack of formal recognition for fawning constituted a secondary harm to survivors, an invalidation that occurred in the therapy room or institution when their experiences did not fit the "approved" model.

On a more hopeful note, our findings suggest possibilities for resistance and transformation within these professional structures. The participants in our study demonstrated how frontline practitioners can act as agents of change by creatively integrating marginalised knowledge. In their everyday practice, they effectively bridged postmodern feminist insights, neurobiology, and client narratives to fill the gaps left by formal theory. This kind of grassroots innovation implies that social change in mental health might emerge not only from top-down policy shifts, but also from bottom-up practice-based movements. In other words, when enough clinicians start validating appeasement, teaching peers about it, and perhaps publishing case studies or curricula, the field can evolve to include it formally.

Study Limitations and Methodological Considerations

Several limitations of this study must be acknowledged. First, the sample consisted exclusively of practitioners who identified as women, all based in similar sociocultural contexts within urban Australia. Their perspectives, while richly detailed, may not capture how practitioners with other gender identities or those from different cultural backgrounds make sense of fawning. Therefore, the transferability of our findings to all mental health practitioners is limited as we describe how these practitioners construct meaning, which may or may not align with others' experiences.

Second, by focusing on practitioner perspectives, we only access one side of the therapeutic equation. We did not interview clients/survivors in this study. While practitioners provided some observations about client experiences, our results do not directly represent survivor voices. This means we cannot fully know from this data alone how survivors feel about these meaning-making processes or whether they agree with practitioners' interpretations.

Third, as a qualitative GT project, our aim was exploratory and theory-generating, not to determine prevalence or efficacy. We cannot claim that most practitioners think a certain way, nor can we prove that the approaches described actually improve client outcomes. Those questions would require different methodologies (surveys for prevalence, controlled trials for efficacy).

It is also important to note that our own theoretical lens (a postmodern feminist perspective) undoubtedly influenced the research. While we have been transparent about this stance and believe it helped us notice power dynamics in the data, it may have also inclined us to emphasise certain properties (like gender and oppression) over others. Researchers with a different orientation might have asked different questions or interpreted some data points differently.

Despite these limitations, the study has several strengths that enhance credibility. We conducted repeat interviews with each participant, allowing for deeper exploration of concepts and member checking (participants could validate or clarify our interpretations in follow-ups). We used the constant comparative method and memo-writing to ensure a systematic and reflexive analytic process, rather than relying on hunches or first impressions. We also employed theoretical sampling to test

and refine emerging ideas until we felt saturation was reached. Together, these strategies support the trustworthiness of our findings, even if they are contextually bounded.

Future Research Directions

This study points to several important avenues for future research. Foremost is the need for outcome-focused studies as we need to investigate whether the contextual, power-aware approaches to fawning that participants described actually lead to better survivor outcomes compared to more standard treatments. For example, a useful next step could be a comparative study where one group of clinicians is trained to explicitly validate and reframe fawning in therapy (perhaps as part of a meaning-making intervention), while another group provides a typical evidence-based trauma treatment that does not address fawning. Outcome measures could include client self-compassion, trauma symptoms, and therapy engagement. A randomised controlled trial or mixed-method design could shed light on whether directly addressing fawning (and the shame around it) accelerates recovery or improves wellbeing.

Another priority is research from the survivor's perspective. Our study was practitioner-focused; the complementary piece would be to talk with trauma survivors directly about their experiences of fawning and its treatment. Qualitative studies – via in-depth interviews or participatory research – with survivors who identify with the fawn response could enrich our understanding. They could reveal nuances that practitioners might miss, such as what language resonates or alienates them when discussing appeasement, or what their own meaning-making process looks like outside therapy. Survivor voices are crucial for designing interventions that truly meet their needs.

Mixed-methods research could also explore relationships between survivor characteristics and the use or impact of fawning. For example, quantitative measures could examine if certain factors (such as type or chronicity of trauma, age, cultural background, gender) correlate with stronger tendencies to fawn or with differing therapeutic preferences. Qualitative data alongside could explain why those patterns exist. An intersectional approach is important here, questioning how might race, class, disability, or sexuality intersect with gender in shaping fawning responses and their interpretation? Community-informed participatory research, involving survivors as co-researchers, would ensure these investigations remain grounded in the expertise of lived experience.

On the professional side, research should examine how to effectively integrate fawning content into training curricula. For instance, studies could develop and pilot educational modules on trauma responses beyond fight/flight (including appeasement and freeze) to see if they improve student knowledge and sensitivity. It would also be worth evaluating different teaching approaches (does learning through case studies, simulated clients, or reflective discussion) to determine how well new practitioners grasp the contextual nature of fawning. Longitudinal research could track whether adding this content in training leads to changes in practitioners' clinical skills or client outcomes down the line.

Finally, further theoretical work can continue to refine the emerging model of fawning as an ecological, power-informed phenomenon. Cross-disciplinary dialogue (bringing in perspectives from sociology, gender studies, neurobiology) will help build a more robust theory. Our findings suggest that transforming trauma practice requires simultaneous attention to multiple levels such as theoretical frameworks, professional education, and political awareness. Future scholarship might explicitly explore strategies for synchronising these levels of change.

Synthesis: Toward Transformed Trauma Practice

Overall, this study demonstrates that mental health practitioners can develop sophisticated approaches to marginalised trauma responses even within constraining professional structures. The ecological framework that emerged – integrating neurobiological, relational, and political dimensions – provides a comprehensive model for understanding fawning that moves decisively beyond viewing it as an individual pathology. Instead, fawning is conceptualised as a contextual adaptation with meaningful survival value.

Our research suggests that true transformation of trauma practice may require parallel shifts in theory, education, and politics. Theoretical innovation alone is insufficient if practitioners on the ground lack training in new frameworks. Educational reform is limited if it occurs in isolation from a broader recognition of how professional knowledge can exclude certain voices. And raising political awareness (encouraging therapists to recognise oppression) will not translate into better therapy unless practitioners have practical frameworks and tools to apply that awareness with their clients.

Perhaps most significantly, our study illustrates how epistemic justice in trauma care can be advanced through practice-based meaning-making that validates survivor knowledge while challenging dominant assumptions. The rapid "shame-to-relief" transformations that participants described indicate that approaches which honour the survivor's adaptive responses (instead of judging them by normative standards) may unlock therapeutic power that traditional methods miss. In effect, by reframing fawning, practitioners were not only healing trauma but also subverting the narrative that those who appease are "weak" or "broken".

The implications extend beyond the specific issue of fawning. They raise broader questions about whose knowledge counts in mental health and how clinical practice can become more inclusive of diverse survival strategies. By documenting how practitioners successfully integrated a marginalised response into a coherent therapeutic approach, this study contributes to ongoing efforts to decolonise trauma practice, that is, to challenge the colonial and patriarchal biases in what is considered valid knowledge or "best practice". It offers practical guidance for clinicians working within current constraints: even if one's training omitted something, it is possible (and necessary) to keep learning from clients and from outside voices.

In sum, our findings highlight a path toward trauma-informed care that truly serves all survivors. When practitioners validate the full range of human responses to adversity (including those historically overlooked or stigmatised) they help create a mental health system that no longer privileges a narrow set of reactions aligned with dominant cultural values. Instead, such a system would honour each survivor's adaptive ingenuity, thereby fostering healing that is grounded in understanding rather than judgment.

Conclusion

Mental health practitioners face a fundamental challenge in serving clients whose trauma responses fall outside dominant theoretical frameworks. This study reveals that, in the absence of formal guidance, practitioners can develop effective approaches to fawning by creatively integrating insights from multiple paradigms within explicitly power-aware, postmodern feminist frameworks. The ecological understanding that emerged from participants' accounts challenges core assumptions of individualistic trauma treatment, while offering practical guidance for contextualised,

socially informed practice. The finding that making meaning of survival responses can rapidly transform a survivor's self-concept from "pathology" to "resilience" points to new possibilities for trauma intervention, ones that centre on validating adaptive responses rather than solely aiming to eliminate symptoms.

However, our analysis also shows that structural barriers (including gendered professional socialisation, training gaps, and epistemic exclusion) continue to marginalise fawning within mainstream trauma theory and education. Addressing these barriers will require systemic changes by integrating neurobiological literacy, power-analysis skills, epistemic justice awareness, and contextual assessment approaches into how we train and supervise practitioners. Reframing the meaning of fawning (from individual pathology to contextual adaptation) represents a broader opportunity to decolonise trauma practice by valuing knowledge previously pushed to the margins. Our study provides both empirical grounding for this reframing and practical evidence that such change is possible, even now, through the innovation of thoughtful practitioners.

Ultimately, advancing trauma practice may depend on precisely this kind of practitioner-led innovation that bridges theoretical traditions while maintaining a clear commitment to validating diverse survival strategies. Such innovation offers a pathway towards more inclusive and effective trauma treatment, one that honours the full range of human responses to threat, rather than privileging only those responses historically deemed acceptable. The implications reach beyond clinical technique to touch on fundamental questions of knowledge, power, and healing in the mental health professions. By showing how practitioners can successfully integrate marginalised responses into coherent care, this research contributes to the ongoing effort to build mental health systems that truly serve and restore dignity to all survivors of trauma.

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The Efficacy of Interactive Drawing Therapy for Emotional Regulation in Children: A Literature Review and Critical Appraisal of Research Gaps

Shalini Shaji and Zoe Caldwell

Introduction

Emotional regulation (ER) is a foundational developmental task in childhood, with direct implications for mental health, interpersonal functioning, and academic achievement (Adynski et al., 2024). ER involves monitoring, modulating, and appropriately expressing emotions (Fancourt et al., 2019). According to Drake (2023), this process demands not only the identification of strategies, but also the capacity to implement them appropriately in context. This underscores its complexity as a developmental task.

ER is closely tied to interoception, language development, motor coordination, and reflective thinking (Fancourt et al., 2019). For children with developmental delays, trauma histories, or neurodivergent presentations, talk-based therapies may not be developmentally appropriate. As an accessible and non-verbal method, drawing offers a psychologically safe avenue for emotional processing (Yilmaz Bursa, 2024). It externalises affect using colour, shape, and metaphor (Withers, 2006), serving as a therapeutic tool for both distraction and reflection (Boulton et al., 2023). Research findings suggest that irrespective of whether the therapeutic benefits relate to distraction or reflection, positive shifts in sad affect can persist for multiple days post-intervention (Drake et al., 2016).

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Interactive Drawing Therapy (IDT) addresses the more nuanced aspects of ER, as it features an eclectic combination of free drawing, narrative, and therapist-guided inquiry to support those navigating states of distress (Withers, 2006). It enables symbolic processing, emotional containment, and self-reflection, often in the absence of robust verbal skills (Withers, 2009).

This literature review critically examines the theoretical and empirical evidence supporting IDT's efficacy when applied to dysregulated children. To reflect the paucity of research on this modality for younger demographics, search terms have been expanded to include terms such as "drawing", especially when the therapist's technical application mirrors IDT's approach. This includes when words/narrative elements are included, when clients draw in response to specific prompts, or when new images/words are added retrospectively to capture novel/emerging insights. Gaps and areas requiring further research are also highlighted.

Development of Emotional Regulation in Children and Intersections with Drawing Interventions

The development of ER is biologically grounded in the limbic system, particularly the amygdala and hippocampus (Zharova et al., 2025). These structures facilitate emotional response and memory formation (Zharova et al., 2025). Secure attachments and co-regulatory relationships with caregivers promote neural development, enabling children to differentiate real from perceived threats and eventually self-soothing with greater effectiveness (Fitter et al., 2022). Trauma (Pollack & Smith, 2020), inconsistent/hostile parenting styles (Goagoses et al., 2022), and developmental delays (Marquis et al., 2017) can interfere with limbic system development and functionality, thereby complicating the ER process for vulnerable young people.

Drawing serves as a compensatory pathway, by allowing children to externalise/symbolise what would otherwise be abstract internal experiences (Olaoye & Abdallah-Tani, 2024). Drake (2023) notes that drawing can also be used as a form of distraction for dysregulated children. Skinner and Zimmer-Gembeck's (2007) earlier research notes that while younger children seem to prefer the behavioural distraction that drawing affords, children utilise cognitive distractions more readily as they transition into adolescence. Drawing accommodates both strategies; younger children can behaviorally distract themselves whilst continuing to engage with evocative symbolic material,

whilst adolescents can cognitively distract themselves by responding to drawing prompts that divert attention away from the evocative imagery and towards something more hopeful.

Theoretical Underpinnings of Drawing Interventions

The Expressive Therapies Continuum (ETC), developed by Kagin and Lusebrink (as cited in Bergs Lusebrink et al., 2013), provides a tripartite model through which drawing facilitates ER and processing (Kinaesthetic/Sensory [K/S], Perceptual/Affective [P/A], and Cognitive/Symbolic [C/SY]). The K/S level involves physical engagement, the P/A level enables emotional expression, and the C/SY level supports abstract reflection (Bergs Lusebrink et al., 2013). IDT aligns closely with this model, potentially enabling children to progress fluidly across these domains.

Furthermore, Gross' (1998) Process Model of Emotions (PME) describes the emergence of emotion as occurring in four stages: Situation, Attention, Appraisal and Response. This model can be applied to IDT, with evocative scenarios being drawn (Situation), attended to by the therapist and client (Attention), collaboratively interpreted according to the client's meaning (Appraisal) and engaged with therapeutically (Response). When applying this model, it could be reasonably assumed that IDT's collaborative search for meaning allows the clinician to become more adept at helping the child client appraise emotionally evocative stimuli with greater accuracy, potentially resulting in more appropriate responses. Fancourt et al. (2019) reiterates that the appropriateness of emotional expression is a core sub-task within the broader task of ER, thereby enhancing the relevance of Gross' PME (1998).

Theoretical Framework of IDT

IDT, created by Withers in the early 1990s, is grounded in psychodynamic, client-centred, and attachment-based theories (Withers, 2006). Using simple materials, clients alternate between drawing and narration on the same page, producing a visual record of emotional growth (Withers, 2009). The process attempts to track changes associated with inner psychological states, revealing new unconscious material symbolically and progressively (Everts & Withers, 2006).

IDT departs from classical Freudian projections by inviting clients to imbue drawings with personalised meaning (Everts & Withers, 2006). The therapist supports exploration without imposing interpretation (Pearson & Wilson, 2024), consistent with Winnicott's (1965) "holding environment". Drawings can become ritualised, either by being folded, preserved or destroyed (Malchiodi, 1998). This provides the individual with unique opportunities to express themselves beyond the act of drawing itself.

Attachment theory informs IDT's relational stance. Early emotional imprints shape how children navigate ER, and symbolic representations in IDT can bring implicit relational patterns to the surface (Olaoye & Abdallah-Tani, 2024). This highlights IDT's capacity to capture symbolic information about relationship dynamics and the young person's self-concept, potentially allowing for more accurate conceptualisations about attachment.

Evidence from Literature: Individual Case Studies

An existing body of literature supports drawing interventions for children struggling with ER. Brownlow (2022) provides an anecdotal example, describing a client who used a spider to symbolise strength and developed increased emotional literacy through iterative modification of the drawing. Similarly, Stenner (2022) illustrates how drawing containers helped a client symbolically set aside distress and cultivate intentions for self-care. While these examples have not been empirically tested, they represent a growing number of therapists who have personally observed shifts in ER, through monitoring subtle shifts in body language, emotional arousal and/or the child client's attitude towards their personal stories of hardship.

Ho and Chiu's (2020) case study working expressively with an Autistic child and his mother provides a more robust analysis into the application of art-based modalities and the potential to address dysregulated affect and attachment-related issues. Joint painting, drawing and other expressive techniques were applied across 23 sessions and the mother learnt to recognise that her own responsiveness had a subsequent impact on her son, thereby affirming the relational and regulatory benefits of artmaking (Ho & Chiu, 2020; Yan et al., 2021). Similar findings that speak to the broader efficacy of drawing for Autistic children have been replicated on a larger scale in subsequent studies (An, 2025).

Evidence from Literature: Peer-Reviewed Literature

Everts and Withers (2006) provided 235 IDT clinicians with an anonymous survey, prompting reflections about its efficacy. Whilst some had only completed a foundational IDT course and reported success in a limited portion of their work, responses highlighted its usefulness with both child and adolescent populations (Everts & Withers, 2006). While individual differences in therapists' interactional style will vary, similarities between Australian and New Zealand cohorts, especially in relation to cultural attitudes about artmaking (Gattenhof et al., 2022) could see Everts and Withers' (2006) findings generalised cross-culturally.

Torabi Goodarzi et al. (2024) looked further into parent-child interactive drawing and found that it had the potential to reduce separation anxiety and fortify damaged attachment bonds. The cohort included 16 parents of 6–8-year-old children with separation anxiety and randomly assigned them to either the experiential or control group (Torabi Goodarzi et al., 2024). Those in the experiential group completed 13 sessions of interactive drawing and this had a significant effect on the presenting separation anxiety ($p=<0.05$). This finding substantiates the importance of moving beyond the client-counsellor relationship and inviting parental involvement for enhanced results.

More recently, Podobnik et al. (2024) asked 226 pedagogy students to interpret a six-year-old child's drawings and captured their analyses in a questionnaire. Results indicated that it was impossible for students to accurately interpret the content of the drawings without engaging in a dialogue with the client (Podobnik et al., 2024). With Gross (1998) outlining the importance of Appraisal, these findings implicitly suggest that client-led interpretations can amplify interpretative analysis. This sentiment aligns closely with IDT's reflective ethos (Withers, 2006)

Quantitative studies offer insight into drawings and their potential mechanisms of action. Drake (2019) found that children

assigned to distraction-based drawing prompts had better mood outcomes than those engaging in expressive drawing, thereby acknowledging instances where distraction can be reframed as protective rather than maladaptive. Brechet et al. (2022) reached similar conclusions; drawing that expressed either happiness or neutral affect enhanced ER comparative to children who were prompted to draw emotionally evocative material as a means of venting.

Critical Analysis of the Literature and Future Directions

Therapist responses to questions posed about the efficacy of IDT placed importance on the speed in which emotional relief is achieved (Everts & Withers, 2006). Whilst broadly relevant to ER, the importance of subtler shifts over longer treatment periods remains largely unexplored, at least from the therapist's perspective. After considering Gross' PME (1998) and Kagin and Lusebrink's ETC (as cited in Bergs Lusebrink et al., 2013), it becomes apparent that ER features a more nuanced series of sub-tasks, emphasising not just the immediacy of ER strategies, but also the importance of parental collaboration (Ho & Chiu, 2020) and accurate therapeutic input (Podobnik et al., 2024). More longitudinal research could be conducted, to honour self-reports from parents and children about longer-term shifts in ER capacity. Measuring a child's capacity for ER pre-, during and at various points post-intervention, could bolster the credibility of the existing research on adult clients (Drake et al., 2016).

Greater exploration of IDT's bihemispheric and attachment-informed processes could enrich our understanding of how symbolic expression contributes to regulatory processes within the parent/child dyad. Studies by Torabi Goodarzi et al. (2024) and Podobnik et al. (2024) underscore the importance of child-led interpretations and engaging primary caregivers when the distress relates to separation anxiety. Additional research could investigate whether the parent's involvement has a modulating or mediating effect on the child client. This could be achieved by changing independent variables (absent versus present parent groups), or by thematically analysing how the quality of the parent's attunement impacts pre and post-testing results.

Additionally, neuropsychological studies demonstrate that drawing stimulates bilateral brain activity in healthy individuals (Raimo et al., 2021). IDT engages the right hemisphere's implicit emotional processes, then integrates this information via verbal reflection, activating the left hemisphere (Withers, 2006). At present, no study has explicitly explored how an IDT therapist's efforts to activate the left hemisphere may need to involve non-conversational approaches, especially when working with younger children with speech language deficits. This interhemispheric bridging could be explored in greater detail, with additional scope to differentiate how bilateral brain activation can be achieved differently, depending on whether the deficit is because of neurodivergence, traumatic dissociation or something else.

Conclusion

Research on the efficacy of IDT for younger demographics remains sparse and the existing literature focuses on short-term outcomes post-intervention, with less emphasis on longer-term follow-ups. In this context, drawing is predominantly positioned as a distraction-based tool for children and adolescents. Future research could look beyond the behavioural and cognitive distraction that drawing affords, perhaps by differentiating observable shifts in mood in-the-moment from longitudinal outcomes. Honoring the child's lived experience, whilst continuing to collect data from the adult caregiver and assigned therapist, may result in a more refined understanding of IDT's efficacy, rather than prioritising a sole opinion. Irrespective of what future research reveals, the results of this literature review remain clear. Drawing can facilitate enhanced emotional regulation, with improvements in both a child's self-concept as well as enhanced connectivity between parent and child, both noted as additional positive outcomes.

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A Therapist's Reflective Analysis on Cultural Perspectives of Time, Harmony & The Rise in Anxiety

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Keywords: *Indigenous Culture, Tempo, Social & Emotional Health, Anxiety, Stress*

Abstract

This paper showcases the author's work as a counsellor in Australian Aboriginal communities using a model of rhythmic music, drums and percussion linked to reflective discussions. It reflects on his learning, received through the "Two-Way" or "Two-Eyed" learning principle used widely in cross-cultural settings, referring to a respectful partnership where knowledge passes in both directions, and its influence on the author's practice. Among the many different views between the author's western cultural orientation and the Australian Aboriginal world-view, the perception of time is of particular interest, and how it significantly shapes the lives of both groups in very different ways. This paper explores the ramifications of an increasing focus on speed in modern life, and the pressures, stressors and anxieties it produces, compared to the more relaxed associations of time shared by Indigenous peoples. This accelerating pace – "the need for speed" – is reflected in musical interactions, particularly when working with individuals who struggle with emotional regulation. However, these paradigms provide opportunities for both therapists and educators to introduce exercises that challenge this tendency and raise awareness of different strategies for managing such emotional arousal and anxiety more generally.

Introduction

For over twenty years I have been working in therapeutic practice with Aboriginal people in communities across Australia, and more recently with Indigenous peoples in New Zealand, Canada and the USA. As a newly trained counsellor I spent my formative years working in the alcohol and drug sector in Western Australia and was posted to remote regions to support prevention initiatives on a regular basis. I quickly learned that my training, in traditional "talk-based" cognitive therapies, was inadequate for engaging people for whom English was often a third language and whose cultural norms meant that discussing sensitive personal issues was highly "shameful".

With the advice and support of local Aboriginal Noongar elders I started to introduce music, predominantly hand drumming, into my practice. Initially my intention was to use music to attract people to my sessions, though it wasn't long before the therapeutic potential of the music itself became apparent. Rhythm-based music, using hand drums and percussion, has provided me with convenient tools for engaging a broad range of participants, and I have combined this participatory practice with reflective conversations, utilising analogies, to connect the musical experience to relevant life issues. Not coincidentally, it is hand-drumming that has dominated indigenous healing practices in societies around the world across many thousands of years. As trauma researcher Bruce Perry notes:

"Amid the current pressure for 'evidence-based practice' parameters, we should remind ourselves that the most powerful evidence is that which comes from hundreds of separate cultures, across thousands of generations, individually converging on rhythm, touch, storytelling and reconnection to community as the core ingredients to coping and healing from trauma." (Perry, 2015).

Research into rhythm-based music has shown a link between the auditory and motor systems of the brain, enabling rhythmic musical input to impact a range of somatic and neurological functions including those that influence our response to stress (Thaut, 2014). When we look at how people manage stressful situations generally, there is often a rhythmic element within their efforts to regain control. We see this demonstrated for people with autism and other sensory perception conditions, through repetitive stimming behaviours, but it is equally apparent in the way many people control their breathing in times of emotional stress or seek regular routines to combat the unpredictability of traumatic experiences. Rhythmic music is a powerful tool for this same purpose.

Way Learning, 'Two-Eyed Seeing' & Cultural safety

A key focus of my work across Indigenous communities has been ensuring cultural safety, and in particular focusing on Two-Way Learning in Australia (Turner et al, 2025) and Two-Eyed-Seeing in Canada (Wienman & Malhotra, 2023), an approach that strengthens participants' sense of cultural identity and belonging, and serves to foster inter-cultural understanding and respect. Every theme that we cover in our work asks the question: what can we learn about this issue from the perspective of the Indigenous culture? The terms "Two-Way" or "Two-Eyed" represent a need for communication and knowledge to pass in two directions. Additionally, this helps to clarify language differences and meanings and provide explanatory bridges of

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understanding and awareness for both groups. This reciprocal relationship comes with responsibilities to each other, informed by Aboriginal & First Nations' ways of being, whereby "you give to me and I give back to you." This involves such things as attempting to understand each other's worldview, exerting efforts to trust each other, and making relations stable through transparent obligations and expectations.

Although drumming is not generally recognised as a traditional form of musical expression in Australian Aboriginal communities, it does have a significant history for many groups including the Koori nation across Victoria and within the tribes of the Cape region of northern Queensland. Some of the earliest recorded Aboriginal paintings, as well as first contact descriptions of corroboree gatherings, from elder William Barak, show women drumming with sticks on tightly rolled up possum skins as their "menfolk" danced (Owen, 2003).

In Indigenous communities across Canada and the USA where there is a strong ongoing tradition of drumming, it has been imperative to seek guidance on the appropriate use of the drum and permission for bringing any contemporary form of therapeutic drumming practice into these communities. My own work avoids teaching rhythms and focuses instead on improvised play. In these North American communities there are often strict protocols around drumming; who can drum, where, and how the drum is treated. However, my own experience, working first-hand with the coastal Salish, and Nuu-chah-nulth peoples in British Columbia has been that when consulted, and the intent of the program clarified, even the strictest adherents to cultural drumming protocols will make an exception for this type of therapeutic program, if there is an established level of trust.

Cultural Perspectives on Time

One of the most challenging and eye-opening differences I have had to adapt to as an Anglo-Celtic Australian working within Indigenous communities in Australia, New Zealand, the USA and Canada is the different way time is viewed and measured. Despite all the pressures of conforming to the western clock, in most Aboriginal communities I have visited few people wear a watch and the priorities of cultural and family life are still the dominant factors on how time is utilised. Delivering therapeutic sessions or training local education and health workers requires a level of flexibility and patience at odds with western scheduling. These differences have led to ongoing conflict and hardship in the quest for cultural integration, particularly in relation to education and employment (Burbank, 2006; Steel & Heritage, 2020).

There can be no greater symbol of cultural dominance and oppression than forcing one model of time on another culture whose perception is radically different.Yet this is exactly what has happened to peoples around the world since the ticking clock began to dominate society at the start of the Industrial Revolution, and people's time became money (Griffiths, 2004). In Aboriginal Australia, time is subjective and contextual. Time is evident in the daily (circadian), monthly, or yearly cycles of nature. Aboriginal peoples view time as circular with the past, ever present and an ongoing relationship between past and future. In contrast, a linear understanding of time cuts off history with the past seen as dead and gone.

From the earliest days of colonisation, Aboriginal peoples have rejected the western view of time, that can be counted, saved and spent and the way it dictates so much of life.

"With the arrival of the missionaries, they taught us to work for money. We had to work for money for needs we never had before. Clocks marked the time for work, making people the slaves of time." (Griffiths, 2004).

The resistance of many Indigenous peoples to conform to the western time system has often been viewed negatively by their varying colonisers, giving rise to racist stereotypes defining such peoples as idle or unwilling to work (Korff, 2025). Yet the alternative – being our modern obsession with speed, punctuality, and efficiency – is linked to stress, high blood pressure, ulcers, and a failing immune system (Rudd, 2019). Society rewards productivity and associates it with honour and competence, while slowing down is often connected to feelings of inadequacy and shame. It is easy to fall into behavioural patterns and thoughts where our sense of purpose and value is measured by how much we get done. At the same time, constant busyness can also be a way of evading difficult feelings and memories, with this type of avoidance often leading to physical, emotional and mental burnout (Sword et al., 2014).

Modern perceptions of time and the ideology of speed, embedded in global commerce, undermine relationships and threaten the future of humanity itself as we rush forward with little time to consider the ramifications of our actions. When we are moving fast, we are more likely to be reactive and our reactions and responses are less thoughtful and more misaligned; how often have we wished we could recall a text or email we sent without due consideration? Travelling slowly has many advantages: time to reconsider, make adjustments, gain greater perspective and insight. Negotiating compromise in relationships benefits from time, whether on a personal, family, community, or international level, where all viewpoints and outcomes are considered.

Working cross-culturally, within a respectful "2-Way Learning" approach; one that accepts and values the knowledge of each culture, offers much to be learned from an appreciation of Indigenous perspectives of time (Adams, 2019). In my experience working across different indigenous communities, there is rarely a sense of urgency to adhere to a schedule, and no one is ever late – time is subjective and contextual. The focus is almost always on the present, as all time; past present and future are perceived as current as opposed to the western linear orientation towards the future and the notion that change is progress. For Indigenous peoples progress is often tied to stability, ceremony and the importance of family relations (Adams, 2019).

The oppression enforced on Indigenous peoples through adherence to the western clock and the "progress" it entails is being increasingly recognised in light of the impacts on population health and the environment globally. In questioning and sometimes rejecting this dominant "progress" ethos; the philosophies, values and practices of Indigenous peoples, and their perspectives on time, are commonly offered as more sustainable and healthier alternatives (Gratani et al., 2016).

Modern-day society's relationship with time

There is no doubt that speed is exciting and exhilarating, often super-charged by the release of dopamine. We feel the power and exhilaration of it in the music room just as we do in other aspects of modern life – fast cars, fast service, fast internet speed, fast drugs. However, the need for speed often comes at a cost – car accidents, poor service, loss of focus, withdrawal and comedown. And this is clearly evident in the music circles I facilitate as the faster the rhythm becomes, the louder people play, and the more connection and harmony dissipates. Similarly, in my own therapeutic practice, the problematic impacts of a high-paced environment are becoming more common, with presentations of stress, anxiety, poor sleep and burnout on the rise.

The pull towards speed in everyday life and its consequences are increasingly replicated in the music I observe in my practice. As we travel faster our autonomy disappears, making it harder and harder to shift our rhythm. We become locked into this forward momentum and spontaneity reduces. We no longer have the time to adjust or incorporate change – we plough forward unrelentingly. Similarly, it becomes more difficult to play slowly and softly. More and more of my clients are caught

in life's increasingly demanding tempo, particularly those who are juggling the – often incompatible – demands of work and family, and are struggling to keep up.

In modern society slowness is commonly denigrated, associated in economic dogma with a lack of productivity, and inefficiency. Phrases like "you snooze, you lose" and FOMO (fear of missing out) are common drivers in both business and in the social lives for many in today's competitive society. People are increasingly impatient when they have to wait; wait for an outcome, attention, an answer. This impatience is another driver of stress, increasing frustration and reinforcing negative emotions that are increasingly impacting people's mental health (Al-Aria, 2023). As Shakespeare, said:

> *How sour sweet music is*
> *When time is broke, and no proportion kept!*
> *So, it is in the music of men's lives.*
> *I wasted time, and now doth time waste me;*
> *For now, has time made me his numbering clock*
> *My thoughts are minutes*
> *Richard II, Act 5*

Music as a Tool for Social and Emotional Health

Music is increasingly used as a conduit to engage people of all ages in social and emotional learning (SEL) and to directly address clinical issues impacting individual mental health. The flexibility and creative opportunities of arts-based curriculum make them one of the few subject areas compatible for many young Indigenous people who struggle with the static nature of mainstream academic learning. Many students, no matter their culture, no longer find school a safe and welcoming place due to factors like violence, bullying or simply the stifling routine of desk-based learning. As a result, more are avoiding school, acting out or staying home. In Australian Aboriginal communities, school attendance rates are significantly below mainstream average with some remote communities struggling to reach 50 per cent attendance (AIHW, 2023). At the same time, in mainstream Australia, rates of home schooling & school refusal have increased by over 100 per cent since the COVID pandemic, with similar trends found across other western countries (Jamison et al., 2023; Slater et al, 2020)

The experiential nature of various music based, therapeutic interventions, reflects the traditional learning practices of many indigenous cultures, giving them a real-world relevance and authenticity. These approaches have been shown to increase student engagement, improve learning effectiveness and enhance the development of life skills (Burch et al, 2019). The social aspects of participatory music, playing or singing in harmony with others, makes it ideal territory for assisting people struggling for social belonging and inclusion and helping develop and practice the social skills that support this connection. For individuals with neurological differences, or other differing abilities, these issues of connection and inclusion are often the central challenges of their variance. For the educator and therapist, numerous analogies exist for linking musical experiences to life and its many challenges that can help support individuals facing issues that are impacting their social and emotional health.

Music as a Panacea in the 'The Age of Anxiety'

Among the most pressing health issues being experienced by people today are the rapidly increasing levels of anxiety and other associated mental health conditions. Even before the COVID-19 pandemic, anxiety levels were on the rise, and since then, they have more than doubled, with over 20 per cent of school age children in western countries managing anxiety conditions (Australian Bureau of Statistics, 2020-2022; Benton et al., 2021). Similarly, adult rates of anxiety and depression have also grown significantly since the pandemic (World Health Organisation, 2022). In music-based SEL programs and clinical interventions, one key focus in addressing anxiety is drawn from the connection between music and time. These initiatives explore the coercive way modern perceptions of time, punctuality, speed and competition dominate our lives, and the "hurry sickness" that results.

In my own practice, I have developed a range of analogies and accompanying exercises that link our experiences in the drumming music-circle to these types of issues in people's lives, and allow for reflection. For example, we can:

- Look at the value of slowing down a musical rhythm – and how that impacts our awareness generally and in particular that of our relationships, both within the music circle and in real life. *When we slow down, we are able to give more time and focus to our relationships with others.*
- Look at how slower tempos require less energy and allow us to relax a little more, while at the same time giving us additional room to learn and master more challenging musical rhythms. *When we slow down, we reduce the energy we expend physically, we recharge, and have more aptitude to master complex tasks or problems in our lives that cannot be solved when time is scarce.*
- Look at how leaving more space/time between the notes leaves more space for others to be heard and for relationships to be made. *When we leave space musically, we open up opportunities for dialogue and connection, just as listening closely to others helps cement healthy relationships in our lives.*
- Look at how leaving more space/time leaves more opportunity for adaptation and adjustment when things are changing around us. *Slowing down allows us to adapt to change; we can adjust our rhythm, and make better choices.*
- Look at how leaving more space/time allows room to bring in new elements, understandings, perspectives etc. *When the tempo increases, we are focused on forward momentum and keeping up. When we slow down, we have time to look back and learn from the past.*
- Practice playing more slowly and sparsely while resisting the temptation to rush in and fill the space. *As a cue to emotional regulation, we can represent emotional overload with fast and erratic play and practice cutting through the chaos and returning to a stable base.*
- Explore how we can accommodate those who struggle to keep time – "who are out of time". *We can learn to be tolerant and understanding of those who struggle to fit into societal expectations.*

This last point is a particularly sensitive one for many music educators and therapists, yet vitally important in the context of social and emotional education and health. On many music education forums members consistently pose the question: How can I help my students connect in time? While there are many strategies that can assist – auditory cues, visual cues, kinaesthetic or tactile support – few explore the importance of learning to accommodate people who struggle with timing; with the focus being on changing them. When we think about how often in life, we do not quite get our timing right and do not quite fit in; the importance of being tolerant and understanding becomes all too clear. For people who are neurodivergent and other members of our communities with differing abilities, this

concept of tolerance and understanding is vital to helping them find their place in the world. Music, through analogies such as these, offers a gateway to this awareness.

Music and Mindfulness

In addressing anxiety, one of the most common strategies is helping individuals shift their focus from the past or future to the present moment; another lesson clearly apparent in Indigenous perspectives on time. Meditation, mindfulness, journaling, grounding techniques, art therapies and music making are all recognised ways of assisting this cause (Keng et al., 2011; Kiken et al., 2017). In the driving rhythms of a percussive music circle, the relentless forward motion of chronological time can fade, replaced by an immediate awareness of the present and a state of flow. When we play music together joy often erupts from the shared exuberance of the creative experience, especially where there is freedom of expression, as in improvised music. Playing music requires a surrender to being in the moment.

In modern life we often focus on the future, unaware of experiencing and celebrating where we are in the present. Opportunities to step out of the racing current of time are critical yet increasingly rare. Time away from the linear march of "progress and accomplishment" is continually shrinking as working hours increase, holidays and festivals decline and spending time engaged in spontaneous and imaginative play becomes less common. Yet these are the critical times where community is built. Across more than twenty research studies on the impact of therapeutic drum-circles, themes of connection and belonging are ever present (Faulkner, 2021). This sense of bonding during musical play is further enhanced by the release of neurotransmitters, endorphin and oxytocin, which are also critical in mitigating the stress response (Myint et al., 2017).

In rhythmic musical play it is rare to hear the groove disappear altogether; volume may decrease, tempo slow but still the pulse continues – and before long we are in full flight again. Stepping off the rhythm train, away from the pulse, takes courage, yet it often leads to some of the most rewarding experiences in group music making. This technique is particularly useful in reflective, therapeutic group work where analogy can speak to the challenges and benefits of taking similar steps in real life. Here it is, that flexibility, fluidity and responsiveness can flourish. Percussion circles with a diverse range of instruments, especially those that resonate such as chime bars, are particularly valuable in this context, fostering the strengthening of relationship and dialogue through the deeper listening entailed.

Deeper listening is another skill being sacrificed at the altar of speed. When it comes to therapeutic practice, deep or active listening is often touted as the core skill for cementing the therapeutic relationship, building rapport, understanding the client's perspective, validating experiences and facilitating emotional processing (Bradshaw, Siddiqui, Greenfield, & Sharma, 2022). Yet the pace, distractions and scheduling restraints of modern life make this form of focused attention an extremely challenging skill to implement. Above all, the western linear notion of time posits a response as the natural reaction to another's comment, and this expectation often displaces deeper listening and contemplation. In her book Traumas Trails (2002), Professor Judith Atkinson describes deep listening as the Aboriginal gift to the nation – the Indigenous practice of inner, deep listening and quiet still awareness, that is the key to recovery from trauma.

One example from my own work for practicing deeper listening and examining these issues, as they impact our lives and relationships more generally, is to alternate between fast drumming, (symbolising the busyness of modern life), and the sequential resonance of three chime bars of different notes interspaced around the music circle. The lingering sound of each chime evokes a stillness and focused awareness missing from the drumming. This exercise I call sit with the silence is conducted in different rounds, with the time spent listening to the chimes gradually increasing each time in proportion to the time spent drumming. Discussions focus on the importance of balance between the external, busy pace of life and time for introspection, quiet, and rest. For young people who struggle with focus and attention or who are caught in hypervigilant states and anxious, this exercise is used to expose them, in graduated steps, to the uncomfortable feelings associated with stillness and improve their ability to manage these feelings.

Summary

I lower the volume with a signal from my descending hand and as the music quietens, I ask the group once more to focus on their collective tempo, hold their rhythm steady, and resist the urge to speed up.

This is not an uncommon scenario for many music educators or therapists using music in their practice, and certainly not for me in my regular work with young people and adults impacted by trauma and struggling with emotional regulation. In this instance, however, I was working with a group of professional therapists; counsellors, psychologists and social workers, who similarly were struggling to maintain a steady tempo and found themselves, time and again, playing faster, pulled along by an unconscious drive to race forward.

What is of interest to me is the connection between this increased tendency of spiralling tempo in the music we share, and the speed that increasingly dominates people's daily lives, along with the social and emotional health implications of this shift. Many people struggle with holding time steady when playing music and small inconsistencies are a natural part of human timing. Momentum itself can escalate tempo and propel even a faint increase into a gathering speed. However, it seems increasingly likely that there is also a deeper connection between the way our lives are increasingly dominated by the linear movement of time, rushing forward to the ticking of the clock, and this tendency I am increasingly witnessing in the music I facilitate.

Our relationship with time, in the name of progress, and efficiency, has left us caught on a treadmill to an unsustainable future on both an individual and global scale. Indigenous peoples across the world have rejected this push and offer insight into an alternative paradigm. Music too, offers us – and those we teach and support – an opportunity to step away from this narrow perception of time, restore some balance and gain awareness of what is being sacrificed and what may be recovered. Research has demonstrated that music with a slow steady rhythm may provide stress reduction by altering inherent body rhythms, such as heart rate and blood pressure (Sword et al, 2014). Similarly, we recognise that reducing the pace of our busy lives, and restoring balance with other aspects of time; time for self, friends, family, and with nature, may provide the antidote to the stress and anxiety so many of us live with.

Therapists and educators have at their disposal a valuable tool for supporting individuals through the challenges impacting their social and emotional health. Rhythmic music, in particular, with its long history as a healing modality, offers a useful and accessible entry point for clinicians and their clients. A focus on the differing impacts of tempo – fast versus slow – and on the quality of the music made as tempo changes, and its direct relationship to social and individual harmony generally, are just some of the many ways music can be utilised to support people through the current challenges of a busy and often anxious life.

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