Common Client Issues in Counselling: An Australian Perspective

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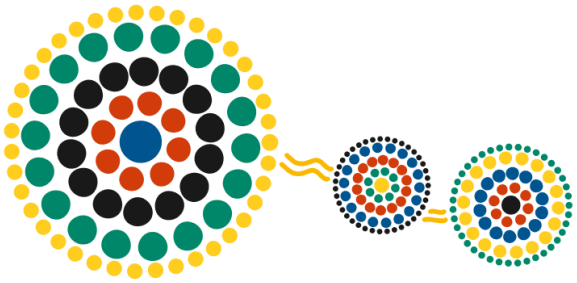
We celebrate the continuous living cultures of First Nations Australians and acknowledge the important contributions Aboriginal and Torres Strait Islander people have and continue to make in Australian society.

The University respects and acknowledges our Aboriginal and Torres Strait Islander students, staff, Elders and visitors who come from many nations.



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Introduction

NATHAN BEEL; CHRISTINE CHINCHEN; TANYA MACHIN; AND CAROL DU PLESSIS

INTRODUCTION: THE STORY OF THIS OPEN TEXTBOOK

One responsibility of counselling educators is to provide appropriate textbooks in their courses to help prepare students to be tomorrow's counsellors. However, choices for textbooks are often limited to texts written by authors in the United States and United Kingdom, or are written to prepare students for other professions, such as psychology and social work. With the profession of counselling being relatively young in Australia, there is a limited range of counselling texts written by authors who live and practice in Australia.

When I, Nathan, began teaching in 2008, I taught a subject that would introduce students to key issues that counsellors needed to know how to work with. The subject had no textbooks assigned, and each issue was supported by selected readings from a range of sources. I contacted the publishers for them to recommend a textbook on counselling issues. They could not identify any, and the closest recommendations they made were abnormal psychology texts. These texts prioritised diagnosable mental disorders within a medical model framework. The emphasis and intended audiences for these texts were not counsellors. We needed something more customised for Australian counselling students.

In 2019, I suggested to my colleagues, Carol du Plessis and Tanya Machin, that perhaps we could initiate the writing of a counselling issues textbook rather than continue waiting for one to arrive. They excitedly agreed. Around this time, we discussed the idea with Adrian Stagg, the University of Southern Queensland's Manager for Open Educational Practice. He discussed the benefits of publishing open texts in contrast to using commercial for-profit publishers. The editing team had been concerned about the rising costs of textbooks and understood that these costs added considerable financial strain to some students. We decided to create an open textbook so that no costs would be passed on to the teachers or students of counselling.

The editing team recruited Australian authors who have expertise in their chapter areas, and when some chapters were still not allocated, we later sent requests to counselling educator groups to recommend potential authors. In seeking out authors, we prioritised people with "real-world" as well as academic experience as we wanted to ensure that the textbook contained a balance of both views. To our knowledge, all authors have real practice experience, so are not solely relying on theoretical knowledge.

The authors, who come from academia and/or practice, volunteered their time and expertise to contribute to this book. Every chapter has been peer reviewed by at least two reviewers, to ensure the quality of those chapters is to the highest standard. Where possible, we have aimed to include counsellors and/or counsellor educators as both authors and reviewers to ensure the content is appropriate to Australian counsellor training.

In the final stage of the process, we engaged Christine Chinchen as part of the editing team. Christine's inclusion supported the team to complete this important project in time for the 2023 academic year. This meant we had another Australian practitioner and academic on board who believed in the project's aims.

THE OPEN TEXTBOOK FORMAT

The open textbook model means that this textbook and associated chapters can be provided free of charge,

in multiple formats. The material can be consumed in hardcopy, online, or downloaded in popular ebook digital file formats for computers, tablets, ebook readers, and smartphones. The Creative Common licence enables academics and students to share and repurpose material to suit their learning objectives. We believe that making the text freely accessible and adaptable will reduce educational barriers and maximise learning opportunities.

THE CONTENT

Counsellor education prepares students in subject areas such as counselling skills, therapeutic modalities, formats of practice, ethics, working with various groups, and working with clients with a diverse range of issues. It is the latter this textbook focuses on. The issues are not limited to mental health issues, but address a wider range and continuum of difficulties that clients face. The textbook includes chapters on depression, anxiety, crisis, grief, trauma, relationship distress, and more. It aims to introduce the types of issues that counsellors are likely to address in their real-life practice. Additionally, the chapters also include case studies for students to work through and to critically engage in a potential client case.

Terminology

This book primarily uses the title of counsellor and its associated terminology. In Australia, counsellors and psychotherapists share the same peak bodies (i.e., Psychotherapy and Counselling Federation of Australia (PACFA) and the Australian Counselling Association (ACA)), however, PACFA delineates psychotherapists from counsellors. While both share the same core training standards, psychotherapists have additional criteria. There are other, more inclusive terms that are also used periodically in this book, such as therapists and practitioners. For simplicity and in recognition that all share common counselling training standards, this book predominantly makes use of the terms counsellor and counselling.

COUNSELLING IN AUSTRALIA

The chapters address the issues in ways that we think will be most helpful to counsellors of all persuasions. In Australia, counsellors are trained in, and use, a wide range of approaches, including humanistic, experiential, cognitive behavioural, psychodynamic, relationship, and integrative approaches (ACA, 2020; Bloch-Atefi et al., 2021; PACFA, 2018). Accordingly, we invited authors to address a diversity of major approaches and theories of relevance to the selected issues. The chapters provide key approaches used for each issue, as well as major principles and approaches for addressing them. As an introductory text, it is not designed to comprehensively inform students in each of the areas but enables students to gain a broad overview of the topic and integrative approaches. We hope this exposure will provide a tantalising taste for counselling students, to motivate them to seek further information on each issue, and to learn how to effectively work with clients who present with these issues.

MODELS OF HEALTH, ISSUES, AND HELPING

Before examining the individual issues presented in each chapter, it is important to note there is not one way of understanding client wellbeing, difficulties, or helping. Some useful questions to reflect upon include: How do we make sense of human distress and behaviour? How should people in the helping professions best serve their clients? Our answers to these questions may influence what strategies we might choose. Likewise, understanding philosophical differences between helping paradigms can help students identify how to locate the authors' suggestions, but also recognise there are multiple ways to address the same issue.

THE MEDICAL MODEL

A dominant international model (and the primary mental health model used in Australia) for understanding psychological concerns that can significantly interfere with client wellbeing and functioning is known as the medical model (or biomedical, allopathic, or disease model). This model, borrowed from medicine, applies to understanding what might be termed abnormal psychology. There is an assumption that certain impairing psychological problems are evidence of psychological disorders that can be identified, categorised, explained, and diagnosed. Two major categorisation systems based in this understanding are the Diagnostic and Statistical Manual of Mental Disorders, fifth, text revised edition (DSM-5-TR) (American Psychiatric Association, 2022), and the International Classification of Diseases, eleventh edition (ICD-11) (World Health Organization, 2022). Labels such as Major Depressive Disorder, Bipolar Disorder, and Post Traumatic Stress Disorder are examples of terms given for issues deemed to be psychological disorders (or mental illness).

Mental health professionals using this model may administer interviews and psychological testing to determine which, if any, disorder or disorders a patient (otherwise known as a client) has. Once the disorders are identified, the practitioner will select the treatments that have been demonstrated (primarily through clinical trials) to be effective. These are referred to as evidence-based treatments (EBTs). The treatments must be expertly applied, and often require that the patient understand and accept the diagnosis and the treatment offered, and participate with the procedures and tasks of the treatment. The application of the EBT brings an expectation that the symptoms of the disorder/s will decline in severity, duration, and impact.

Psychiatrists, clinical psychologists, and medical practitioners most commonly view problems that match psychiatric criteria as evidencing a psychological disorder. They translate the client's stories about their concerns and lived experience into a diagnosis that will then require specific types of treatment. Authors presenting information that aligns with a medical model perspective may use terminology such as disorder, condition, diagnosis, patient, treatment, aetiology, evidence-based treatment (or evidence-based practice).

Counsellors may feel ambivalent about what they may feel is pathologising clients, locating dysfunction within the client, and ascribing them diagnostic labels. While this discomfort suggests that caution and balance may need to be applied, dismissing the medical model in its entirety is also unbalanced and potentially unhelpful. The medical model framework enables upsetting patterns of human experience to be studied, defined, described, and measured (Huda, 2019). It enables individuals and families to access funding for support, professionals to meaningfully communicate about these patterns with other professionals and the public, and provides a means of determining treatment decisions. It can lead some clients to feel relief that there is a known human problem they are experiencing, and not an individualised inadequacy or flaw.

Many of the chapters of this book will reference relevant psychological disorders and their descriptions. When students conduct research on issues that have been officially recognised and included in diagnostic manuals, they are likely to find that most information on the topic will link to information associated with the medical model framework. Language used may include diagnosis, symptoms, and treatment.

Counsellors assess, not diagnose

Counsellors are trained in assessment (PACFA, 2018). Assessment involves gathering information from which to inform a meaningful understanding that will inform the counsellor's decision-making. In assessing a client, the counsellor will gather information across a range of areas of relevance to the presenting issue and the client. This includes the nature, impact, and history of the concerns, and also the client's history, relationships, current life context (e.g., employment), strengths, risks, and vulnerabilities, and therapy goals and preferences. Counsellors are aware of psychological disorders, which may inform their decision-making and conceptualisation. However, counsellors in Australia have not had the training to make diagnoses of mental disorders or medical conditions and therefore refrain from doing so. If such a diagnosis is warranted, counsellors should refer the client to a psychologist or medical practitioner.

THE CONTEXTUAL MODEL

The medical model—while popular—is not the only model available. An alternative model is called the contextual model (Wampold & Imel, 2015). The contextual model is based on a common factors understanding of therapeutic effectiveness. The contextual model argues that, rather than the selection and application of specific treatment models according to the 'correct' assessment of the 'real' problem accounting for most of the improvement, it is the healing context that explains why counselling is effective. It highlights that all approaches designed to be therapeutic work are roughly equivalent in relation to outcomes. In addition, ingredients common to all approaches account for most counselling effectiveness and differences between therapies account for very little client change. It emphasises contributors to change such as client factors (e.g., hope), therapist factors, the therapeutic relationship, the client's agreement of the issue description and approaches offered to the client by the socially sanctioned healer (e.g., counsellor), and extra-therapeutic factors (i.e., other factors that may help or harm their progress, outside of the therapeutic context, such as finances and social support) as being significantly more important than the choice of modality. For the contextual model, the medical model is one approach among many other potentially helpful healing paradigms. All healing paradigms, including the medical model, are potentially culturally appropriate and acceptable to clients, and the medical model, although socially dominant in Western cultures, may have cultural dominance but generally does not enhance effectiveness over and above other alternatives.

Besides these two meta-theories, there are other paradigms that counsellors may draw on. These will be described next.

BIOPSYCHOSOCIAL APPROACH

The biopsychosocial approach (Engel, 1977) of health includes understanding both physical and psychological health. This model challenged the biological and physical reductionism of the medical model (Borrell-Carrió et al., 2004) and called for a more holistic understanding of health and problems. These factors would need to include understanding the person in context as well as the social, the psychological, the behavioural, and the biological when conceptualising problems and developing interventions. Many allied health professions, including psychologists and social workers, are trained in the biopsychosocial model.

RECOVERY-ORIENTED MODEL

Both professional counselling peak bodies have aligned themselves with a recovery-oriented model of mental health care (ACA, 2020; PACFA, 2018). The recovery-oriented model emphasises several assumptions and practices that are complementary to and enhance the existing treatments available to clients. It emphasises that clients and their families are active co-contributing agents in their own recovery, bringing with them rich knowledge and experience, and unique hopes and circumstances that need to be factored into the helping experience (Commonwealth of Australia, 2013). It is important not to solely focus on treating the identified issues but to work towards strengthening the client's overall wellbeing in life. This may mean working together with consumer peers, mental health professionals, and community supports, while also encouraging the clients to be active within their own recovery experience (Gyamfi et al., 2022). This approach aligns well with counselling ideas of empowerment, client autonomy and self-determination, maintaining egalitarian collaborative relationships with providers, and recognising clients' individual and social resources that they can bring to support their own recoveries.

PERSON-CENTRED CARE

Both the ACA and PACFA highlight that counsellors take a person-centred care approach. The underpinning values of person-centred care can be traced back to Carl Rogers in the 1940s (Rogers, 1942). Rogers began privileging the client's subjective experience, emphasising the importance of the quality of the relationship

between the counsellor, and what he started terming the client (contrasted with patient terminology that has more hierarchical connotations). While there is a specific modality called person-centred counselling, person-centred care is a more generic application of the principles. As a broader approach to mental health, the counselling profession sees counsellors as ensuring the client's experience is prioritised, the client's needs are viewed holistically, and their family and other intervention providers are included as needed, with the ultimate aim of client empowerment (ACA, 2020; PACFA, 2018). In short, the person-centred approach prioritises and emphasises the importance of the client's own needs, preferences, and experience, and while practitioners will bring their expert knowledge associated with their mental health expertise, they are careful to ensure this expertise is not imposed on the clients at the expense of the client's own preferences, values, and wishes. While this is not always possible, such as when the client's level of impairment, insight, and/or safety is compromised, nonetheless privileging the client's voice is a foundational principle for counsellors.

STEPPED CARE

The stepped care model is another framework emphasised in both counselling peak bodies' scope of practice documents (ACA, 2020; PACFA, 2018). These show a directional shift for counselling to seek greater recognition and participation within government mental health networks, services, and strategies. The stepped care model takes a more preventative approach by recommending low intensity interventions when people are developing mild-to-moderate issues, and increasing the intensity of interventions, pathways, or options in response to need. Within this framework, counsellors may work with various levels of intensity of intervention, with case managers, and in a network of other helping professionals to ensure clients receive appropriate help to meet their needs.

This section showed a range of frameworks that are part of the larger mental health discourses in Australian society. The medical model emphasises the incorporation and application of expert knowledge to treat socially and professionally legitimised understandings and definitions of human impairment and distress. With this comes the privileging of the expert voice and their power; it nonetheless offers access to rigorously studied patterns of human experience and treatment options. Given its social dominance and acceptance from many clients themselves, the community, employers and government, counsellors would be unwise to be ignorant or antagonistic towards it. Yet counsellors also recognise the limitations of the tendency towards diagnostic and treatment reductionism in contrast to the richness of individual lived experience and the wide range of counselling options available. This said, without meaningful conceptual knowledge that can help make sense of the client's concerns, counsellors may equally lose direction and be unable to help in a meaningful way. The counselling peak bodies' scopes of practices provide frameworks that enable counsellors to work within medical model informed frameworks and systems, whilst still enabling client centred practice. For students studying counselling, the aim is to work collaboratively with clients, while being able to draw on expert knowledge in ways that empower rather than disempower clients. It is a challenge we face each session, to negotiate the client's rich expertise on their own experience, with our expertise and knowledge as practitioners.

In your reading of the chapters in this textbook, the authors are presenting expert knowledge. We do so trusting that the knowledge will be used to support our client's voice and empowerment. Where they do not fit the client's lived experience, we need to consider whether the ideas are applicable at that point in time with that client; and perhaps whether alternative ideas and practices are more appropriate. Building a rich knowledge of key issues that clients bring for counselling, and being willing to hold them lightly, allows counsellors to foreground or background our knowledge depending on the needs and preferences of the clients themselves.

SCOPE OF PRACTICE

Nathan, the primary author of this chapter, recounts an incident that occurred early in his teaching of counselling where he was approached by a colleague from another profession who expressed a view that

counsellors only worked with 'worried well' clients, that is, generally well-functioning clients with simple, relatively minor problems. She went on, saying that when clients were deemed to have more serious problems, they should be referred to psychologists. While this view did not align with his own professional experience of the clients he saw counsellors work with, it raised the question of which clients and/or issues are inappropriate for counsellors. After all, counsellors' own ethics codes require that counsellors work within their level of competence (ACA, 2022; PACFA, 2017). While these ethics codes do not specify which clients or issues counsellors are competent (or not competent) to work with, both bodies have Scope of Practice documents (ACA, 2020; PACFA, 2018) that aim to enhance clarity for counsellors and external stakeholders alike (ACA, 2020).

Who can join PACFA and the ACA?

The Psychotherapy and Counselling Federation of Australia (PACFA), and the Australian Counselling Association (ACA), are recognised as the two peak bodies for counselling and psychotherapy in Australia. Each has their own membership criteria, training standards, scope of practice, and ethics codes. In order to join either body, individuals must complete training with an accredited training provider. Once they are members, practitioners need to adhere to certain standards of practice and meet continuing education requirements to maintain their membership. The names of practicing members of both PACFA and the ACA are placed on the Australian Register of Counsellors and Psychotherapists (ARCAP). Members of the public can search ARCAP online to determine the registration status of their therapist

Both the ACA and PACFA agree that counsellors must practice within their competency. However, guidance as to what specifically falls in and outside of scope is somewhat vague. This vagueness is likely intentional given the wide range of contexts, clients, issues, and stakeholders that counsellors work with.

COUNSELLING EXPERIENCE

The counselling experience of the counsellor is valued by both professional bodies. The experience is measured by the self-reported, supervisor endorsed, client contact hours that counsellors log as part of annual membership requirements. However, a lack of experience alone should not be seen as automatically disqualifying a qualified counsellor from working with clients with specific issues. Qualified counsellors will have gained knowledge in their original training, or failing this, in specialised areas they can seek out further learning opportunities. Post-qualification learning is gained in professional development, in counselling supervision, in relevant literature, by generalising from other relevant knowledges, and from the client's own knowledge they share.

COUNSELLING SUPERVISION

Counselling supervision is undertaken by all registered counsellors (and counselling interns). This is a process whereby counsellors can discuss issues, difficulties, and strategies in their practice, and receive support, guidance, and education from a (usually) more experienced counselling practitioner. This process can determine what skills and knowledge are needed to work with a client or whether a referral may be required. Students can be assured that they have access to more frequent supervisory support and guidance in their placement.

MONITOR OUTCOMES

Counsellors can also make use of formal feedback measures to help determine whether client outcomes are progressing, stagnating, or declining. Formal outcome feedback systems such as the Outcome Questionnaire

(OQ-45; Lambert & Finch, 1999), or Outcome Rating Scale (ORS; Miller & Duncan, 2000), provide validated measures that give reliable feedback about client progress. These measures can assist with decision-making, especially when a client is not progressing or even deteriorating.

WHEN TO REFER

The requirement to work within one's competence is partly guided by the ethical principle of doing no harm. During the beginning stages of their careers, counsellors will regularly see clients presenting with issues that they have no prior counselling experience working with and, on most occasions, with the support of the clinical supervisor, private research, and professional development, they will gain experience on the job. However, we would argue there are some issues and circumstances we would recommend counsellors should refer as a matter of course. These are situations where the client will need more specialised support than a counsellor can provide, situations where there is a significant risk of harm to the client or third party by not referring, and/or where there are legislative or social expectations that such a referral should occur.

Examples of ethical, moral, or legislative imperatives are where there may be a foreseeable risk of harm or disclosures of historical harm. This might be when the counsellor has formed a reasonable opinion that the client may be planning on taking their own life, at risk of bringing harm to another person, or may have harmed a member of a specific vulnerable group (e.g., children). Clients who may need medical or psychiatric attention, such as clients in a psychotic state, would also be beyond the scope of the counsellor, and hence referred.

Counsellors should also consider referral when they do not have the capacity to service the client's level of need. In the intake assessment interview, or initial session, the counsellor may recognise that the client's levels of need may require intensive support. For example, a client with frequently high levels of crisis may not be a good fit for a counsellor who is available for counselling one day per week. Or perhaps if the counsellor is a private practitioner but the client's level of need may be better suited to a community agency that has a multidisciplinary team available, a referral may ensure a more complete service.

Another reason for a referral is when clients fail to progress or worse, demonstrate a trend of deterioration. This is more reliably identified using formal feedback measures, as mentioned before. Not every counsellor can help every client and if it becomes evident that clients are not progressing as expected with their issues, the counsellor should discuss referral as a possibility with their clinical supervisor and, as appropriate, with their client. Some clients may need more time before progress is evident, however for some clients, a change of approach or service provider may be required (Maeschalck & Barkfnecht, 2017).

Referral does not necessarily mean that one stops working with the client. For instance, counsellors will often recommend their clients have a medical examination to clarify if there are health conditions that may be contributing to the client's issues. They may also refer clients to psychologists for psychological testing. While there are times the client may move to a different service provider, at other times, they will continue working with the counsellor. Counsellors should request written permission from the client to exchange information with the new service provider or to share information when acting as part of a multidisciplinary team.

Counsellors and medication

Counsellors will invariably have clients who are on medications to help them manage the issues with which they are presenting. Counsellors themselves will have personal opinions about the place of medication for addressing psychological problems, but should always remember that these are their personal opinions and do not have a place in their professional practice. It needs to be remembered that the treatment or advice relating to medication is outside of scope for counsellors. Counsellors are not trained in pharmacology and are therefore not qualified to provide any advice or guidance or opinion in relation to medication. Counsellors should refer their clients back to their prescribing medical professional or pharmacist to discuss their questions or concerns about medication.

It is also not the place of a counsellor to suggest to clients that they should ask their doctor for medication, as it infers the counsellor has the expertise to recommend this option. Rather, if the counsellor believes medication

might assist, they might recommend the client see their doctor for an evaluation and to inquire with their doctor about treatment options. If a client indicates they have reduced or stopped taking their medication without telling their prescribing physician, the counsellor should recommend they discuss their decision with a trusted medical professional. A counsellor should never suggest to a client that they should stop taking or change their medication. There can be significant risks associated with withdrawing from some medication without medical guidance.

HOW TO USE THIS BOOK

This book has been developed for counselling students and educators within Australia. We hope that the choice of common issues, based on our own experience of practice and teaching, is helpful to counselling students and their educators. You will note both the title and much of the language in the chapters is non-pathologising and non-medical in nature. Instead of diagnosis or symptoms, we use indicators. Problems is replaced with issues. Treatments is replaced by intervention. This aligns with the counselling profession and training of counsellors in Australia. We encourage you to read the relevant chapters that are of interest to you. For educators, we encourage you to use chapters or the whole book as a resource for counselling issues.

THE STRUCTURE OF THIS BOOK

While each chapter is unique in its focus on a particular common issue that presents itself in counselling, the format of each chapter is generally similar and includes:

- an abstract that provides an overview of the chapter and its focus areas
- content usually offered with an historical perspective to provide perspective and then specific content related to the issue being discussed
- a case study where the same case study is followed throughout the chapter to show the application of the theory to an example
- counsellor reflections where the author/s offer their insights into the issues being discussed
- recommended resources that offer a range of books, journal articles, websites, and so forth for your review
- learning activities – sometimes throughout the chapter and sometimes at the end of the chapter
- glossary of terms which cover key terms related to the issue being discussed.

Each chapter presents an integrative approach to the issues being discussed. As mentioned, many of the chapters offer a case study to show how the theory is applied. There are also counsellor reflections that provide rich insights into the author/s' experiences in their professional practice. The chapters are offered in alphabetical order of the issue being discussed.

ADDICTIONS

John Falcon brings his wealth of experience in assisting people with addictions, both chemical and behavioural, to this chapter. John considers the motivations for help-seeking and how counsellors can respond. The interventions discussed sit within the lens of the attuned counsellor. The important areas of stigma and shame, along with their impact on those with addictions, are explored. Risk factors for developing addictions are offered and include physiological, psychological, neurobiological, and sociological aspects of addictions. John uses the 5Ps approach to conduct an assessment process. Interventions discussed include attachment theory, motivational interviewing (MI), acceptance commitment therapy (ACT), neuropsychotherapy, cognitive

behavioural therapy (CBT), and couples and family interventions. As with many issues counsellors face, the risk for burnout is present, so John offers some self-care strategies.

ANXIETY

Christine Chinchen offers insights into the various forms of anxiety, the most common mental health issue both in Australia and globally. Christine distinguishes between forms of anxiety that are protective in nature and those which may debilitate. As with many mental health issues, clients with anxiety may or may not fit diagnostic criteria. To this end, the World Health Organization's idea of exploring a diverse set of individual, family, community, and structural circumstances is applied in this chapter. The importance of a comprehensive history and in-depth assessment are stressed as central to effective interventions. The myriad of interventions is explored through a meta-analysis.

CHILD MALTREATMENT

Govind Krishnamoorthy, Kay Ayre, Bronwyn Rees, and Samantha Brown have developed their expertise in child maltreatment through their professional areas of work. They bring these different backgrounds and common ground to this chapter. As they point out, we know that child maltreatment may have lifelong impacts on an individual's physical and mental health. Key theoretical models, alongside principles of practice and interventions when working with at-risk families, are explored. As in other chapters, the importance of self-awareness, self-reflection, and self-care are discussed in relation to working with such vulnerable populations.

CRISIS

Claire Malengret and Claire Dall'Osto make valuable distinctions between crisis and other forms of counselling. The assessment and interventions vary due to the nature of crisis. Through a case study, the authors apply the theory to the practice of counselling. Of importance is a further distinction between crisis stressors resulting in exposure to a traumatic event and ongoing traumatic stress responses requiring long-term counselling, psychiatric services, and/or specialised mental health intervention. The high prevalence of burnout and work-related stress in this field requires attention to self-care, including regular clinical supervision, and the continuing maintenance of the counsellor's general health and wellbeing.

DEPRESSION

James Brown and Nathan Beel identify depression as the second largest cause of disability globally. A variety of ways of conceptualising depression are offered. Grief and suicidality associated with depression are explored. Responses to depression, including medical, psychological, and lifestyle interventions, and rationales are important to be aware of in counselling. The chapter also offers generic recommendations for counsellors to consider when working with clients showing signs of depression.

DOMESTIC VIOLENCE

Nathan Beel explores domestic violence, its prevalence, impacts, and risk factors. Importantly, the use of language in this counselling issue is highlighted. Differentiations between two major paradigms that inform the research and practice of domestic violence responses are made. A resulting delineation between systematic and situational violence is offered. Descriptions of key interventions, generic principles, and models of counselling that are effective in working with victims-survivors and perpetrators are both described and applied to the case study.

GRIEF AND LOSS

Judith Murray emphasises that the experience of loss and its consequent grief are integral and unavoidable aspects of life. Equally, loss is also implicit in nearly all adverse life experiences. This universal nature of the suffering of grief means that loss can provide a key integrating concept of care for adverse life events. As counsellors, it is, therefore, essential to understand loss and grief. The chapter offers a rich overview of loss and grief theory and research. Of importance is the process of grieving and when grieving becomes problematic. An integrative approach to care is discussed.

RELATIONSHIP DIFFICULTIES

Trish Purnell-Webb and John Flanagan begin this chapter by identifying the adverse effects on adults, children, and communities from relationship difficulties. These include increased mental health concerns, increased use of opioids, impoverishment, poorer outcomes for future relationships, decreases in education, and increased employment difficulties. Couple therapy may be fraught with many factors that reduce the likelihood of success. Yet the authors guide us through evidenced-based approaches to couple therapy, such as Gottman method couples therapy (GMCT) and emotion focused couples therapy for couples (EFT-C), that counter these difficulties. These and other approaches provide frameworks, interventions, strategies, and skills to assist in the management of complex presentations.

TRAUMA IN ADULTS

Amy B. Mullens, Govind Krishnamoorthy, John Gilmore, and India Bryce, bring their extensive experience in working with trauma to this chapter. Counsellors may encounter clients who have a history of trauma that impacts on the presenting issues. Different trauma responses are identified, alongside ways to intervene to assist clients. A useful comparison of diagnostic criteria for PTSD and C-PTSD is offered. Four main interventions are discussed as are risk and protective factors. Notions of post-trauma growth and resiliency are offered. The chapter concludes with the importance of counsellor self-care when working with clients who have experienced trauma.

TRAUMA IN CHILDHOOD AND ADOLESCENCE

Govind Krishnamoorthy and Amy B. Mullins offer valuable insights into the impact of traumatic events on children and adolescence. A variety of potentially traumatic events are presented in this chapter. An important point is to consider the potential link between exposure to a potentially traumatic situation and presenting behavioural and/or emotional dysregulation. Indicators of trauma include changes in emotions and affect, behaviour, thinking and beliefs, as well as attachment and relationships. It is stressed that early intervention is important to reduce the impact on traumatic events in childhood and adolescence. This reduces the risk of the ongoing impacts of trauma into adulthood.

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Addictions

JOHN FALCON

ABSTRACT

This chapter will discuss the complexity of chemical and behavioural addictions. It will provide counsellors with in-depth knowledge of the field of addictions including both chemical and behaviour addictions. It will focus on what motivates clients seeking assistance and what counsellors need in terms of skills and knowledge in the interventions for addictions. Applying an attuned therapist approach will be offered. Counsellors will develop sensitivity to the stigma and shame surrounding addictions, and the social exclusion experienced by individuals and their families who have a vulnerability to addictions. Highlighted in the chapter is the prevalence of addictions both globally and in Australian society, including the overarching framework for services and interventions. The chapter will examine physiological, psychological, neurobiological, and sociological aspects of addictions, understanding current categories that are present. The aetiology of addictive behaviours will be outlined in terms of epigenetics and neuroscience, the effects of the mechanism both in the brain and a practical application in psychotherapy. Assessment protocols and case conceptualisation will be offered as a road map for client interventions.

Counsellors will learn and apply the major evidence base and practice-based models and interventions that fit clients' needs, considering mental health issues and trauma. Attachment theory, motivational interviewing (MI), acceptance commitment therapy (ACT), neuropsychotherapy, cognitive behavioural therapy (CBT), and couples and family interventions, will be reviewed. Ongoing intervention planning including relapse prevention and support will be outlined. Importantly, self-care strategies will be offered to counsellors for best practice in combating burnout. Resources are provided throughout the chapter in order to support your further research into these areas.

Learning objectives

- Use the terminology and understanding of the concepts of addictions, both chemical and behavioural.
- Apply a case vignette in the assessment, intervention, and relapse/craving plan development.
- Apprehend the global and Australian statistics on the issue of addictions.
- Identify the challenges that counsellors face with current issues in policy and trends explaining the risk factors and variety of-risk populations' conditions, including the family roles in the family system.
- Articulate the current approaches in addictions and identify a variety of options, including the use of various pharmacology.
- Evaluate a variety of theories and develop assessment, case conceptualisation, and referral skills appropriate to clients with addictions.
- Critically analyse the attachment theory and how it applies to the aetiology of addictions and effects on

the brain.

- Discuss how shame and stigma interfere with intervention and how to motivate clients to intervention for addictions.
- Develop an integrative approach in addictions intervention, including biopsychosocial, mental health issues, and the effects of trauma mental health and the effects of trauma, and apply advanced theoretical knowledge for relapse prevention strategies and ongoing continuing care plan.
- Develop self-care strategies and protective strategies and identify the benefits of being an attuned practitioner in fostering a therapeutic alliance.

INTRODUCTION

Research into addictions has focused on two main areas: what causes addictions and how do we treat addictions. What causes addictions? Initially, two basic models emerged—the biological or the disease model and the behavioural model. The disease model describes an addiction as a disease with biological, neurological, genetic, and environmental sources of origin. The behavioural model of addiction sees addiction as involving a compulsion to engage in a rewarding non-substance-related behaviour—sometimes called a natural reward—despite any negative consequences to the person's physical, mental, social, or financial well-being. Rather than adopting a specific model, this chapter draws on the interplay between four main areas: physiological, psychological, neurobiological, and sociological aspects of addictive behaviours.

The overlapping feature common to all behavioural addictions is the failure to resist an impulse or urge, leading to persistent engagement in the behaviour (e.g., online gambling, sex addiction, disordered eating, avoidance addictions including compulsive use of the internet, mobile phone, video gaming, and shopping addiction, despite returning harms (Grant et al., 2010). A unified approach to intervention that is research enhanced is offered in this chapter as a method of assessing intervention and its effectiveness.

Counsellors need to have a framework to identify the aetiology and work clinically collaboratively with individuals who come to therapy exploring individual and relational scripts, an important part of attachment-sensitive counselling (Schore, 2003). Shore talks about a "two person" psychology where right brain-to-right brain, embodied, affective, autonomic change between therapist and client becomes central to the therapeutic process (Schore, 2003). This is the basis of being an attuned counsellor. Attachment theory is central to working with clients with addictions and has become very useful in recovery. As Oliver Morgan argued, in his ground-breaking work Wired to Addiction, addiction is an attachment disorder (Morgan, 2019). Attachment therapy can be used to shift someone's emotional distress, external mood modifiers chemical and behavioural forms. Therefore, counsellors need to critically evaluate themselves with current approaches to emotional regulation and addiction through attachment theory. The rapid, implicit emotional processing of deeper brain structures requires the therapist to engage in psychotherapy that goes well beyond the traditional cognitive–behavioural understanding. Studies have shown that attachment styles from client's interaction with their primary caregivers determine the child's brain structure. The moulding of approach and avoidance patterns drive strong neural connections. Therefore, creative interventions and understanding are important ways of changing attachment patterns (Siegel, 1999).

Counsellors also need to consider mental health issues and trauma as important pathways to addictions intervention. Supporting clients more comprehensively is the focus of this chapter utilising both neuroscience and traditional models. Counsellors need to have a competent understanding of the positive effects of a unified approach in order to work with clients with substance/s use and addiction. It is important for counsellors to know that trauma and addictions go hand-in-hand. Intolerable emotions and psychological pain coupled with self-medication with alcohol, drugs, food, sex, gambling, and so on (Dayton, 2000, p. 18) become a survival mechanism for clients with trauma and mental health issues. We need to look at the root of emotional

problems and trauma and most often the root causes are found in the family system where addictions and trauma have eroded the infrastructure (Dayton, 2000, p. 307). Attachment theory helps to make those links necessary for counsellors to understand.

Importantly, counsellors need to establish an understanding of their limitations when working with clients with addictions. Equally important are the challenges faced in practice with clients with addictions and the need to develop protective strategies through self-care and clinical supervision. In the meta-framework of neuropsychotherapy, clinical practice is informed by insight that has been gleaned from contemporary neuroscience and related disciplines. These insights lead to a key challenge to traditional approaches from Grawe, a key researcher in neuropsychotherapy. He argues that "we ought to conduct a very different form of psychotherapy than what is currently practiced" (2007, p. 417). This includes engaging in deliberate practice to enhance therapeutic effectiveness and self-care as central foci.

Underpinning the contemporary work of counsellors three important principles are emphasised. First, we need to understand and apply research in our work, i.e., be research informed. Second, we need to tailor our approaches to addictions to the individual needs of our clients. Third, we need to work as attuned counsellors and see the complexity of addictions and associated mental health issues. Rather than applying a specific model, the primary concern of working with clients with addictions must be the individual needs of the client and always working within a supportive therapeutic relationship (Swisher, 2010).

Case study: The story

George is a 40-year-old who presented in counselling due to his wife's insistence after a visit to the GP. George's GP was concerned with the depression symptoms that George has had for the last 6 months. He has been isolated at home and at work and has sleep problems, irritability, not getting projects done at work, unable to concentrate, withdrawing from family, and relying on alcohol to reduce feelings of being overwhelmed and unhappy. George has been married for 5 years and they both want a child, but George says he is not ready until work improves. He has been in his job now for 2 years as a manager in an electrical engineering aerospace company.

George's wife reports that George has become unhappy, isolated from her, and hard to talk to. He has increased his drinking and she is worried when he could not go to work due to his drinking. She has given him an ultimatum that he seeks counselling, or she will leave the marriage. George states his drinking is normal. He drinks with his friends 4–5 times a week after work drinking 6-7 beers and, on the weekends, while watching sport where he drinks about 6-10 beers. He and his mates do online bets and his wife says that is also a problem with their budget. He blames his increase in drinking due to pressures at work and from his wife about having a child.

George's mother has had a diagnosis of depression for most of his life and he is ashamed of her condition and, therefore, does not believe he is depressed like her. His rationale is that it is just stress at work. His mother has been on depression medication for most of his life and that scares him. She was distant when he was growing up and George tried to assist her when she had depressive episodes. She had times of suicide ideation, but George denies any suicide ideation or attempt.

George's father is a heavy drinker and so is his grandfather and George believes it is part of the family culture. His father is very demanding of him to succeed in his small business and was always distant when George was growing up because he was busy.

George was diagnosed at primary school by the psychologist with the learning disability dyslexia and identified as on the autism spectrum. He was put in a special school, which his father was against, but his mother insisted and supported him. He felt some shame and a stigma about being in that special school yet did well in maths and technology. He has always had poor social interaction and was a lonely child with few friends at school. At work he fears being rejected by his team members, so his managerial style is to be laisse faire. He states he feels out of place in most social situations and drinks to avoid discomfort and rejection.

George is ambivalent about his drinking problem and blames his wife for pressuring him. He does not like being diagnosed as depressed due to his mother's history but has low motivation for intervention.

An intervention plan will address his lack of motivation with drinking and monitor his depression symptoms. The

treatment plan will depend on his assessment results considering his high level of drinking and depression symptoms. Other compulsive behaviours will be considered in the overall plan. Couples therapy will be offered to address stressors and improve communication in the marriage.

TOWARD TREATMENT IN THE 21ST CENTURY

We will now look at developing greater understanding of the field of addictions. This involves identifying the prevalence of addictions, both globally and locally. Policy frameworks will be presented along with risk factors that have negative impacts on addictions. Current psychopharmacological interventions for craving, withdrawal, and tolerance will be examined as well as new neurobiological approaches.

We begin by looking at definitions of substance use disorders and addictions which have changed substantially over the years. The literature has moved from addiction to dependency and now substance use/addiction. The term substance use disorder was introduced by the American Psychiatric Association (APA) in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, 2013) and refers to the recurrent use of alcohol or other drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home (American Psychiatric Association, 2013). For this chapter, we define a drug as any non-food substance illicit (illegal) or prescribed. We define a drug user or substance user as anyone who takes drugs which are illicit or prescribed in order to alter their function or state of consciousness. Addiction is the fact or condition of being addicted to a particular substance or behaviour where there is a presence of dependency, craving, compulsion, tolerance, and withdrawal. Thus, addiction is a neuropsychological and physical inability to stop consuming a chemical or being involved in a behaviour causing harm to self and others.

PREVALENCE OF ADDICTIONS

The prevalence of substances in society is explored with both global and Australian figures.

Globally, the Institute for Health Metrics and Evaluation (IHME) identified the following:

- substance use was responsible for 11.8 million deaths in 2017
- tobacco risk factor for early death in 11.4 million instances
- over 350,000 deaths from alcohol and illicit drugs use disorders (overdoses) each year
- alcohol and illicit drugs addiction accounted for 1.5 % of global disease burden, with some countries identified as over 5%
- over 2% of the world population has an alcohol or illicit drug addiction
- the USA and several Eastern European, more than 1-in-20 (5%) were dependent
- alcohol was more common in Russia and Eastern Europe (IHME, Global Burden of Disease, 2017).

The figures for Australian use are from the 2016 National Drug Strategy Household Survey: Substance abuse in Australia (AIHW, 2017).

Illicit drug use:

- more than 3 million Australians use an illicit drug
- about 1 million Australian misuse a pharmaceutical drug every year
- more than 40% of Australians over 14 years old have used an illicit drug in their lifetime
- more than a quarter of people in their 20s have used an illicit drug each year

- about 1 in 8 Australians had misused at least 1 illegal substance in the last 12 months and 1 in 20 had misused pharmaceutical drugs
- in 2016, the most commonly used illegal drugs used at least once in the past 12 months were cannabis (10.4%), cocaine (2.5%), ecstasy (2.2%), and meth/amphetamines (which includes "ice") dropped to 1.4% from 2.1% in 2013.

Alcohol use:

- 8 in 10 Australians had consumed at least 1 glass of alcohol in the last 12 months
- among recent drinkers:
    - o about 1 in 4 (24%) had been a victim of an alcohol-related incident in 2016
    - o about 1 in 6 (17%) put themselves or others at risk of harm while under the influence of alcohol in the last 12 months
    - o about 1 in 10 ((%) had injured themselves or someone else because of their drinking in their lifetime.

Polydrug use:

- 39% of Australians either smoked daily, drank alcohol in ways that put them at risk of harm or used an illicit drug in the previous 12 months
- 2.8% of Australians engaged in all 3 of these behaviours
- 49% of daily smokers had consumed alcohol at risky quantities, either more than 2 standard drinks a day on average or more than 4 on a single occasion at least once a month
- 36% of daily smokers had used an illicit drug in the previous 12 months
- 58% of recent illicit drug users also drank alcohol in risky quantities (either for a lifetime or single occasion harm) and 28% smoked daily.

The statistics so far do not include other addictive behaviours and their effects. However, we do have AIHW (2021) statistics for gambling:

- Australians lost approximately $25 billion on legal forms of gambling in 2018-2019
- social costs of gambling include adverse financial impacts, emotional and psychological costs, relationship and family impacts, and productivity loss and work impacts-estimated around $7 billion in Victoria alone
- the national Household, Income and Labour Dynamics in Australia (HILDA) Survey estimated that in 2018, 35% of Australian adults aged 18 and over, spent money on one or more gambling activities in a typical month, a 4% decrease from 39% in 2015
- HILDA 2015 and 2018 identified gambling activities as Lotto or lottery games (30% and 27%), instant scratch tickets (8.5% and 6.3%), poker machines/pokies (8.1% and 7.4%), betting on horse or dog races (5.6% and 6.2%), and betting on sports (3.3% and 6.2%)
- HILDA found that between 2015 and 2018, regular gambling on Lotto/lottery games, instant scratch tickets, and poker machines/pokies decreased while betting on horse or dog races, betting on sports, keno, casino table games, private betting, and poker increased (AIHW, 2021).

RISK FACTORS IN ADDICTIONS

Research has identified a number of risk factors that contribute to the development of addictions. The

focus of research has included genetic predisposition, neural/brain characteristics vulnerability, psychological factors, environmental factors, early age onset of use, and specific populations. An important discussion in the research has been focused on the link between nature (genetics) and nurture (environment). The genetic predisposition argument proposes that a client's genetic information related to their familiar profile is an important consideration in addictions. Over recent decades research involving intergenerational studies, twin studies, adoption studies, biological research, and the search for genetic markers of addictions have been utilised to further explain addictions vulnerability. While psychological and environmental factors appear to be more influential in determining whether an individual starts to use substances or engages in compulsive behaviour, genetic factors appear to have more of an influence in determining who progresses in the addictions process (CASA Columbia, 2012). Based on these studies, addiction is 50 percent due to genetic predisposition and 50 percent due to poor coping skills. This has been confirmed by numerous studies. One study looked at 861 identical twin pairs and 653 fraternal (non-identical) twin pairs. When one identical twin was addicted to alcohol, the other twin had a high probability of being addicted. The study showed 50-60% of addiction is due to genetic factors (Melemis, 2019). Therefore, psychoeducation on genetics is an important intervention strategy when motivating clients to make an informed decisions about intervention.

THE BRAIN

Neurobiological advances in the *brain* and addictions have been studied for decades. In more recent times, neuroimaging technologies and associated research have shown that certain pleasurable activities, such as gambling, shopping, and sex, can also co-opt the brain. The pleasure principle in the brain has a distinct signature: the release of the neurotransmitter dopamine in the nucleus accumbens, a cluster of nerve cells lying underneath the cerebral cortex. Dopamine releases in the nucleus accumbens are so consistently tied with pleasure that neuroscientists refer to the region as the brain's pleasure centre. Dopamine not only contributes to the experience of pleasure, but also plays a role in learning and memory—two key elements in the transition from liking something to becoming addicted to it. Further, in the brain's process, we find drug reinforcement circuits (reward and stress) that include the extended amygdala (the central nucleus of the amygdala, the bed nucleus of the stria terminalis, and the transition zone in the shell of the nucleus accumbens). A drug- and cue-induced reinstatement (craving) neurocircuit is composed of the prefrontal (anterior cingulate, prelimbic, orbitofrontal) cortex and basolateral amygdala, with a primary role hypothesised for the basolateral amygdala in cue-induced craving (Galanter & Kaskutas, 2008). A drug-seeking (compulsive) circuit is composed of the nucleus accumbens (NAcc), ventral pallidum, thalamus, and orbitofrontal cortex (OFC), and is important to the craving mechanism. Neuroscience continues to conclude that the brain has demonstrated opportunities for intervention and prevention based on the rewards systems. See Figure 1: The 3 phases of addiction in the brain.

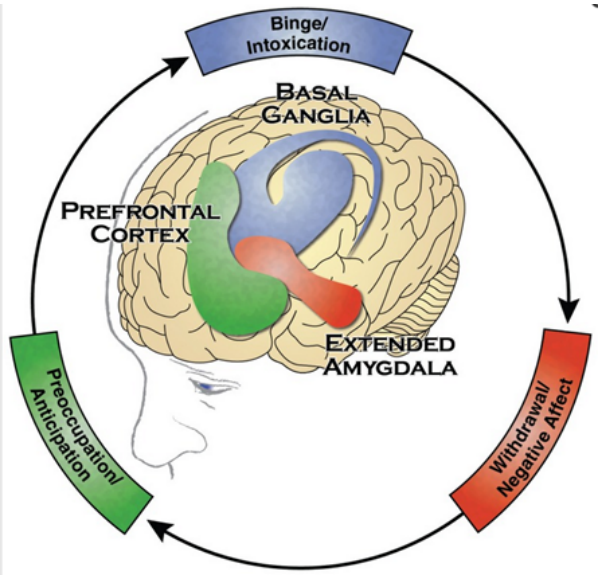

Figure 1: The three stages of the addiction cycle and the brain regions associated with them by National Center for Biotechnology Information, 2016, is in the Public Domain, CC0

PSYCHOLOGICAL FACTORS

A cross section of psychological factors (e.g., stress, personality traits such as high impulsivity or sensation seeking, depression, anxiety, eating disorders, and other psychiatric disorders) have been researched. The presence of these factors increases the risk that people will develop addictions (Schore, 2003). Individuals actively avoid experiencing adverse states and addictive behaviours continue to alleviate these states despite harmful effects (Jacobs, 1996). In other words, people use chemicals and compulsive behaviours to avoid painful feelings and regulate their distress.

ENVIRONMENTAL FACTORS

Environmental factors include exposure to physical, sexual, or emotional abuse and or trauma, substance use or addiction in the family or among peers, access to an addictive substance, and exposure to popular culture references that encourage substance use. We are seeing more young people engaging in technology to avoid loneliness and to connect which are basic human needs. Adverse childhood experiences or childhood trauma have been linked to an increased risk of developing a variety of addictive disorders including addictions to alcohol, gambling, video games, shopping, and sex (Thege et al., 2017).

AT RISK POPULATIONS

Children living in families with addictions are another risk group. Children raised in chemically dependent families have different life experiences than children raised in non-chemically dependent families. Children raised in other types of dysfunctional families may have similar developmental losses and stressors, as do children raised in chemically dependent families. There is strong, scientific evidence that alcoholism/addictions tend to run in families. Children of alcoholics are, therefore, more at risk for alcoholism and other drug abuse than children of non-alcoholics. Based on clinical observations and research, a relationship between parental alcoholism and child abuse is indicated in a large proportion of child abuse cases. Children of alcoholics experience poorer physical and psychological health (and therefore higher hospital admission rates), poor

educational achievement, eating disorders and addictions problems, many of which persist into adulthood (NACOA, 2020).

FAMILIES AT RISK

Intervention issues with families and addictions commenced alongside the foundation of Alcoholics Anonymous in 1935. From the late 1960s and early 1970s, researchers began to consider the influence that the family systems of individuals with addictions problems had on alcohol and substance use. Specifically, family studies began to investigate and identify the 'functions' that alcohol and other substances serve in different types of families (McCrady et al., 2012). Family systems have the potential to enable addictions and compulsive behaviour. This is because family members tend to react to substance use and compulsive behaviour according to their particular patterns. These patterns have a tendency of perpetuating the use of other drugs and behaviours (Crnkovic & Del Campo, 1998). Parents may have addictions themselves; siblings may have addictions problems; family values and attitudes as well as practices may influence problems, family dynamics and relational problems; and genetic and biological factors impact the individuals (Waldron & Slesnick, 1998). The contemporary view of addictions and families takes into consideration cultural differences and how these impact family roles, dynamics, communication, priorities, support structures and so on (McCrady et al., 2012).

WOMEN AT RISK

Researchers have identified risk factors for women that differ from men. The National Institute of Health and the National Institute on Alcohol Abuse and Alcoholism (U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), 2008), for example, have compiled a summary of research in the area of women and have developed specific interventions that address women's needs such as stress, childhood abuse, victim of sexual violence, trauma, and pregnancy. Women who are in partnership with addicts also need interventions that focus on the area of co-dependency.

ADOLESCENTS AT RISK

Adolescents are another risk group to consider when working in the field of addictions. They are influenced by socialisation and cultural environment factors. As part of their developmental process adolescents can be influenced toward chemical and behavioural addictions. New technology and lifestyle, peer group practices (peer pressure), wanting to be accepted and approved, experimentation, and risk-taking behaviours, are all part of the picture counsellors will be faced with when working with this population. The AIHW (2022) found the smoking and drinking patterns of Australia's teenagers have shown some positive signs in recent years; many young people are deciding not to smoke or drink in the first place, while others are older when they first try. Illicit drug use has also fallen among Australian teenagers—those aged 14–19 were less likely to use illicit drugs in 2019 (31%) than in 2001 (37%). Cannabis use changed over the same period (21% in 2001 to 8.2% in 2019), use of ecstasy and cocaine increased from 8% and 5.1% in 2011 to 10.8% and 10.8% in 2019, while use of meth/amphetamines decreased from 13.2% in 2001 to 2.3% in 2019. However, there remain developmental risks for this group.

OLDER ADULTS AT RISK

Older adults are vulnerable to addictions. Research identified that issues of getting older, retirement, loss of a partner, and medical conditions, all affect older adults. The use of chemicals and addictive behaviours help to relieve emotional distress (Satre, 2010).

LGBTQI+ AT RISK

The abbreviation LGBTQI+, often used to refer to people of diverse sex, gender, and sexual orientation, stands for lesbian, gay, bisexual, transgender, intersex, plus. However, the limitations of this term when trying to describe the full extent of people's gender diversity, relationships, sexualities and lived experiences should be acknowledged. This group is vulnerable to addictions and counsellors need to be able to work with this highly vulnerable group. As the 2016 National Drug Strategy Household Survey found, adults who identified as homosexual or bisexual or not sure/other sexual orientation, reported higher levels of psychological distress than heterosexual adults. Evidence from small-scale LGBTQI+ targeted studies, and some larger population-based surveys, indicate that LGBTQI+ people face disparities in terms of their mental health, sexual health, and rates of substance use (ABS, 2008). It has been suggested that many LGBTQI+ people use these substances to cope with the discrimination and difficulties that LGBTQI+ people regularly experience, that there may be a normalisation of substance use in some LGBTQI+ social settings, and that people who identify as being homosexual or bisexual are generally more accepting of regular adult use of drugs than people who are heterosexual (Leonard et al., 2015). This has major implications for intervention strategies with this population and needs to be considered in the at-risk group profile.

SOCIAL INEQUALITY IN AT RISK GROUPS

Social inequality is a strong predictor of addictions, especially related to lower social class (Room, 2005). This includes race/ethnicity factors in the literature. Culture impacts alcohol and substance use and misuse in many ways: what are considered 'norms' relating to alcohol and substance use; what substances are considered normal and abnormal, legal and illicit, acceptable and not acceptable; and represents an important factor in intervention and intervention planning. Culture also plays a central role in forming the expectations of individuals about warnings and problems faced with drug use. For example, Indigenous Australians constitute 2.6% of Australia's population. However, they experience health and social problems resulting from alcohol use at a rate disproportionate to non-Indigenous Australians. Indigenous Australians suffer from dispossession, the stolen generation, intergenerational trauma, poor health status, high levels of incarceration, and diversion of income which create social inequalities. Primary interventions have had challenges for this population to recover over the decades. There were also no significant changes in drug use among Indigenous Australians between 2013 and 2016 but changes are difficult to detect among Indigenous people in the NDSHS due to the small Indigenous sample (AIHW, 2017).

PHARMACOLOGY AND PSYCHOACTIVE SUBSTANCES

An understanding of the various substances in society and their categories is important for counsellors. There are two areas to consider with the action of psychoactive substances: depressants and stimulants, and the effects on the central nervous system (CNS). Depressant drugs begin their action in the cerebral cortex and work their way down to the midbrain. This action is an inhibitor and sends a cascade of effects to the body and brain. These include disinhibition, impaired judgment, emotional liability, loss of motor control skills, and in extreme cases poisoning. The classification of these psychoactive drugs includes alcohol/ethanol, barbiturates, benzodiazepines, GHB, (Club Drug), and opiates. (See*Commonly abused drugs charts* for names, physical, psychological, possible effects, overdose effects, and withdrawal syndrome.) Additionally, pharmacotherapy for alcohol dependence, including anti-craving medications for relapse prevention, is important for counsellors to understand. (See *Pharmacotherapy for alcohol dependence: Anticraving medications for relapse prevention* for further details.)

MAJOR THEORIES OF ADDICTIONS

The four factors of physiological, psychological, sociological, and neurobiological, support the theoretical understanding of addictions. Emerging trends for treatments that match these 4 factors will be offered alongside intervention application for all four.

PHYSIOLOGY

Physiology involves the effects of chemicals and compulsive behaviours on the body and mind. Drugs are chemicals that affect both body and brain. Changes in the brain mechanisms have been researched and are complex because we must consider short term use, long term use, a variety of drugs, consumption, and age of onset. All these conditions need to be considered when assessing a client with an addictions issue. Research by Licata and Renshaw (2010) demonstrated that drug abuse affects neuronal health, energy, metabolism, maintenance, inflammatory processes, cell membrane turnover, and neurotransmission. What is important to remember is that the brain has been the recipient of psychoactive substances and the compulsive behaviours in addictions allow individuals to cope with internal and external stressors. However, substances have been used for a variety of other reasons including pain relief, pleasure, mystic insight and spirituality, escape, to relax, and stimulation.

Substance use issues have been segregated from the rest of health care and, as a result, are treated very differently from other chronic conditions such as anxiety or depression. However, we know that substances cross the blood-brain barrier and cause changes in the brain. Biological markers of disease states, therefore, need to be considered. In the disease/condition model, there is an organ, the midbrain; the defect is the cause of addictions (e.g., genetics, trauma, mental health issues, stress); and then there are the indicators such as loss of control, "bad behavior", criminality, and so forth (McCauley, 2015). From a physiological perspective, addiction to alcohol and other drugs (and associated compulsive/pathological behaviour) is considered a brain disease whereby drug actions on brain circuitry result in changes in the control of behaviour (Tomberg, 2010).

Intervention approaches in physiology are detoxification, harm reduction, mindfulness-based stress reduction, mindfulness without meditation. These models reduce the effects of the chemicals in the body and reduce emotional dysregulation in the brain. Detoxification from alcohol/drugs is the removal of substances clients have become dependent on and withdrawal symptoms are medically monitored within a medical setting. Harm-reduction model is used for clients who are moderate in their use and wish to cut down on their use to avoid becoming dependent on substances. Mindfulness-based cognitive therapy is a combination of cognitive behavioural techniques and mindfulness strategies (such as meditation, breathing exercises, and stretches) that are designed to help individuals better regulate their emotions and conflicting thinking. As a result, clients learn how to manage and relieve feelings of distress without reliance on substances.

PSYCHOLOGY

As we explore the psychology of addictions, we need to consider several aspects. One characteristic is mental health disorders which are generated by drug use and addictions. The other characteristic is that people use drugs to emotionally regulate themselves. This term for this dynamic used to be labelled *dual-diagnosis* and now called it is known as *comorbidity*. Chronic use of some drugs can lead to both short- and long-term changes in the brain which can lead to mental health issues including paranoia, depression, anxiety, aggression, hallucinations, and other problems. Many people who are addicted to drugs are also diagnosed with other mental disorders and vice versa. Alcohol and drug abuse can also increase the underlying risk for mental disorders. Mental disorders are caused by a complex interplay of genetics, the environment, and other outside factors. If you are at risk for a mental disorder, drug or alcohol abuse may transform the underlying risk for a mental health issue. Multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder (Ross & Peselow, 2012). Data show high rates of comorbid substance use disorders and anxiety disorders—which

include generalized anxiety disorder, panic disorder, and post-traumatic stress disorder (Magidson et al., 2012). Substance use may also sharply increase symptoms of mental illness or trigger new symptoms. Alcohol and drug abuse also interact with medications such as antidepressants, anti-anxiety pills, and mood stabilizers, making them less effective.

Trauma and addictions are other considerations for counsellors. Trauma can lead people to use chemicals or compulsive behaviours to seek pleasure or self-medicate with alcohol or other drugs, food, sex spending, gambling, and the internet. People who have had subjective experiences of trauma, not feeling safe, adversity, and fear in their childhood and in their family may also have parents with addictions and mental illness disorders. This complex combination is unpredictable and uncontrollable and can cause psychological damage. These symptoms are encoded in their memory and genes are expressed to avoid pain and seek pleasure. A person who is abused or traumatised may develop dysfunctional defences strategies or schemas designed to ward off emotional and psychological pain (Dayton, 2000).

Intervention approaches in psychological issues can include many models. Current examples that are evidence-based are motivational interviewing (MI), mindfulness and addiction therapy, acceptance and commitment therapy (ACT), dialectical behaviour therapy (DBT). ACT addresses clients' goals and values to guide the process of behaviour change and increase psychological flexibility (Hayes et al., 2012). CBT is a treatment approach for a range of mental and emotional health issues including anxiety, depression, and substance misuse. CBT aims to help a person identify and challenge unhelpful thoughts and to learn practical self-help strategies. These strategies are designed to bring about positive and immediate changes in the person's quality of life.

SOCIOLOGICAL THEORY

Social theory explores how the social harm of addictions reaches across several areas within the social context. In social learning theory, people who experience fragile social bonds tend to deal with those situations by using drugs and engaging in compulsive behaviour to deal with their discomfort and isolation. Role modelling is an associated factor to consider in the social frame of family structures. Children who live in a family with addictions have role models and witness strategies to reduce stress by using drugs (NACOA, 2020). This action, called social reinforcement, plus genetics, have an influence on how children make choices when feeling socially isolated or distressed. As a result, stress and coping become learned neural pathways that are habitual. Most of these children and then adults have poor coping skills and an inability to deal with stressors and are at high risk of addiction and compulsive behaviours and activities (Miller & Carroll, 2006). The social theory model also considers where addictions are highest, such as in clusters in a city or town, alongside poverty, where there is a decline in labour and skilled jobs, increased lack of housing, and living costs rise, and where there is child abuse or neglect.

Social models for intervention focus on the counsellor's need to consider support groups and group psychotherapy to help clients learn how to reconnect with themselves and others. These models help clients to learn how to reconnect and establish healthy relationships as well as tools to maintain their recovery. Three support groups are the 12 step programs (AA, NA, and so on), SMART recovery, and group psychotherapy.

12 Step program is a community support group where recovering clients can find hope. It works by connecting people and providing support. It is worldwide and has some good results for outcomes in abstinence and recovery. It can be a lifetime process. Sack asserts in his article, *Mapping AA: The Neuroscience of Addiction* (2014), that not only does chronic substance abuse rewire the neural pathways, but that 12-step recovery can be of great help by providing prosocial connection and repairing faulty wiring that chronic substance abuse has caused.

Research for positive outcomes can be found with *Project MATCH* (Matching Alcoholism Treatment to Client Heterogeneity): rationale and methods for a multisite clinical trial matching patients to alcoholism intervention found 12 Step groups, Motivational Interviewing, and then Cognitive Behavioural Therapy, to be the most effective intervention outcomes for alcohol/addiction (NIAAA, 2020).

Group psychotherapy, most often found with in-patient treatment, residential programs, and outpatient

programs, allows clients to feel that are not alone with many of the issues that they are experiencing. DrugAbuse.com (2020) identifies five types of groups for psychotherapy:

1. psychoeducational groups which offer general education and information on a range of issues related to addictions
2. skill development groups which offer specific strategies for handling triggers, communication and parenting, anger responses, and managing finances
3. cognitive behavioural therapy groups for changing thinking and behavioural patterns, as well as relapse prevention
4. support groups offer care and support between the group leader and group members as well as between group members
5. interpersonal process groups focus on emotional development and childhood concerns which impact on decision-making, impulsivity, and coping skills.

These groups combine to provide education and strategies on the recovery process, support, problem-solving, feedback from others, and healthy skills in developing relationships (DrugAbuse.com, 2020).

NEUROSCIENCE

The neuroscience theory has been a paradigm shift in psychotherapy over the past two decades. The breakthroughs in neuroscience have given us neural underpinnings for behaviour, validating affectively focused practice (Dahlitz, 2015). Grawe grounded neuropsychotherapy in a model of mental functioning he termed the consistency-theoretical model (Grawe, 2007). This model identifies the psychological needs being served by schemas. In addictions, clients form a schema of their needs, neural networks are then encoded in childhood in their genome or epigenetic expressions of genes and learning (memory formation). These memories are implicit or unconscious and they lie at the base of approach/avoidance motivational schemas. This constitutes a primary target for therapeutic change. It is therefore pertinent to understand something of how memory is formed on a neural level and what conditions counsellors might be necessary for change (Dahlitz, 2015). In working with clients with addictions, counsellors need to beware that a client is operating from these memories and has no awareness of them. These memories also inform how clients anticipate their future. The motivation for addictions then is a driving force to avoid pain and seek pleasure. Knowing what drives or motivates people to distract themselves helps to increase their awareness and decrease shame as they develop new learning through neuroplasticity. Substance-related and compulsive behaviour is therefore a disorder of regulation.

Motivational interviewing (MI) is another intervention approach that works with neuroscience. Motivational interviewing has been researched for over 30 years for its effectiveness in addictions intervention (Miller & Rose, 2009). The work of Prochaska and DiClemente (1983) lay the foundations for MI with the change model. MI explores motivation and change from a relational perspective rather than from a rational decision-making process. MI allows for a recognition of normal ambivalence with clients who have a strongly developed defence mechanism, low levels of trust, and a low motivation to change due to implicit learning (hijacked brain).

Acceptance and commitment therapy (ACT), developed by Steven C. Hayes and colleagues, is an overarching approach which incorporates a range of therapeutic approaches, including DBT, CBT, and MBCT. The aim of ACT is to accept private events, such as unwanted thoughts, feelings, memories, images, or bodily sensations, rather than change them. In this way, there is an increase in commitment to the change the client chooses. Additionally, ACT addresses clients' goals and values to guide the process of behaviour change and increase psychological flexibility (Hayes et al., 2012).

Dialectical behavioural therapy (DBT) is another model that works with neuroscience. DBT incorporates concepts that work with addictions and modalities are designed to promote abstinence and to reduce the

length of adverse impact on relapse. Several randomized clinical trials have found that DBT decreased substance abuse in clients with borderline personality disorder. The intervention may also be helpful for clients who have other severe disorders co-occurring with addictions or who have not responded to other evidence-based addictions therapies (Dimeff & Linehan, 2008). For substance-dependent individuals, substance use is the highest order DBT targets within the category of behaviours that interfere with the quality of life**.**

Cognitive behavioural therapy (CBT) is another model that can fit with neuroscience**.** CBT is a classification of mental health counselling founded in the 1960s by Dr. Aaron T. Beck. Cognitive behavioural therapy is used widely today in addictions intervention. CBT teaches recovering addicts to find connections between their thoughts, feelings, and actions and increases awareness of how these things impact recovery. CBT identifies negative "automatic" thoughts. These thoughts are implicit, in memory, and not conscious. These thoughts are impulsive and come from an encoded misconception of reality formatted in childhood in the face of un-nurturing caregivers. They come with loaded emotions and reactions with defences that are in the brain pathways.

Mindfulness-based cognitive therapy (MBCT) is another model that can be applied to neuroscience. MBCT is a combination of cognitive behavioural techniques and mindfulness strategies (such as meditation, breathing exercises, and stretches) that is designed to help individuals better understand their emotions and thoughts (www.themindfulword.org). As a result, clients learn how to manage and relieve feelings of distress and lowers cortisol in the brain to reduce stress, which allows for neuroplasticity (Dahlitz, 2015).

Component model of addiction argues that addictions can be both substances and behavioural and have different expressions, yet there is a common underlying disorder and mechanisms which need to be addressed in intervention. So, the component model (also known as the transdiagnostic treatment model) of addictions targets underlying similarities between behavioural and substance use addictions (Hyoun & Hodgins, 2018). All addictive disorders have common vulnerabilities that all have psychological, cognitive, and neurobiological characteristics. This more current approach explores behaviours such as gambling, including internet gambling, which are compulsive behaviours and found in the DSM 5-TR (2022). Common to all substance use and addictions are the underlying disorders of compulsivity. Interventions aim to address those vulnerabilities such as negative urgency, deficits in self-control, expectancies and motives, deficits in social support, and compulsivity, and maladaptive preservation behaviour. Interventions with this model involve a number of approaches which have empirical support for their efficacy (Sauer-Zavala et al., 2017).

Interventions within the component model include CBT models which are transdiagnostic as they address the present conditions while targeting underlying vulnerabilities. They also include mindfulness-based interventions and ACT which are all based on a transdiagnostic model. ACT research is at the forefront of process research, with initial data supporting the ACT model (for a meta-analysis, see Levin et al., 2012).

ATTACHMENT THEORY AND ADDICTION

Attachment theory recognises that human beings are interactional and constantly impacted by our relationships and the environment. When the fundamental ability to connect with others is damaged, as in families with addictions or trauma, it is not surprising that some clients seek emotional support and regulation through substances and compulsive behaviour. As the use of substances increase, the individual is further impaired, and the cycle of addictions is set in motion (Fletcher et al., 2015). Attachment theory highlights the connection between the social, psychological, and biological. Emotions, thoughts, and a sense of self emerge from neural structures and processes that occur within the social environment and impact the psychological and biological aspects of the client (Schore, 2014).

Interventions with attachment theory involves what Oliver Morgan calls "Counselling for Connection" (2019). This model, as mentioned in the introduction of this chapter, focuses on affect regulation and emotional integration through appropriate attachment between the client and counsellor. Attachment-sensitive counselling encourages a welcoming empathic relationship therapy healing and repair. Connection with another self becomes healing and "growth-facilitating" (Schore & Schore, 2008. p. 13). As stated earlier, this is a person-to-person healing process. The goal of this model is to heal wounded attachments that have

created current difficulties. The counsellor needs to be attuned to the client's needs through compassion, empathy, and non-judgmental relating. It is a co-creating process as the more secure interaction allows for the application of corrective (reparative) relational experiences in a new safe environment (Morgan, 2019). Attachment-sensitive therapy develops a therapeutic alliance/relationship and the capacity for compassion and acceptance.

All of these models mentioned work with neuroscience and can also overlay to other models as described in this section. Models can be very flexible in working with substance use, addictions, and compulsive behaviours. This all depends on where the client is at and what their goals are. In the next section counselling with an issue of addictions, we will explain further how this all works by applying screening techniques, assessment, referrals process and self-care linking to the models.

COUNSELLING WITH ADDICTIONS

Counsellors need to be emotionally attuned caregivers providing a growth-enhanced environment and exploring clients' motivation and their resources (Gassmann & Grawe, 2006). Counsellors need to create a positive environment for change because people are naturally inclined toward positive growth and have a great capacity for self-understanding and modifying their behaviour and attitudes, given the right environment, climate, and support (Gassmann & Grawe, 2006). Research has shown that positive social interactions promote both safety and new neural patterns. This can result in enhanced attachment and control, and stress reduction (Alison & Rossouw, 2013).

Assessment can be seen as the exploration of the nature and potential causes of a client's issues (Lewis et al., 2011). The assessment considers a holistic approach. Counsellors need a curiosity-oriented approach. While not a therapy in itself, it is a state of being that shifts the mind, alters the flow of energy and information within the brain, and changes biology all the way down to gene expression and protein synthesis to produce the biochemical milieu. These changes create the best conditions for therapeutic progress toward beneficial change (Hill, 2020). There is an energy flow between both therapist and client. These "mirror neurons" show how we are wired with each other (Siegel, 2001). Neuroscientists tell us that the therapeutic co-regulation occurs, says Schore and Schore, through a "relational unconscious" in which "one unconscious mind communicates with another unconscious mind" (2008).

Assessment of this unique population must consider neurobiological, psychological, and learning defences. Here are a few considerations to ponder.

- Neurobiological approach: People who engage in substance and behavioural addictions need an integrative approach to assessment. Many of the behaviours that users display can be impulsive, compulsive, and sometimes aberrant, some argue that substance use is not tied to neurobiology but is a behaviour of choice (McCauley, 2015). This argument negates what happens in the brain's reward system and scientific evidence.
- Why do they come? Many clients come to therapy because they are forced and are, therefore, involuntary. Some enter interventions due to health problems, others because they are referred or mandated by the legal system, employers, or a family member (Milgram & Rubin, 1992). Initially, counsellors need to determine the client's readiness for change (Australian Government Department of Health, 2020). Without this important information nothing you offer the client will work and they will not take ownership of their recovery process. Motivational Interviewing captures all the positive ideals of being with the client in a cooperative manner, allowing for a psychological connection and dialogue to develop between the therapist and client.
- Barriers: Learned defences need to be considered first in order to achieve a positive outcome in the assessment process. Assessment can for any client be overwhelming, so careful consideration of that factor alone is needed here. The traditional way was to confront the client's "denial" to get results and we found that did not work. We need to hold the diagnosis and first connect with the client. We

know from neuroscience, that the relationship/connection is the key element for the best possible outcome in psychotherapy (Dahlitz, 2015).

- Stigma/shame: Stigma has the potential to negatively affect a person's self-esteem, damage relationships with loved ones, and prevent those suffering from addictions from accessing interventions (Room, 2005). Social stigma is a perception that these individuals and their families are deviant, a moral approach. As shame is a major barrier to engagement, Flanagan developed an account of addictions which includes shame as part of the addictions phenomenon (Flanagan, 2013). Counsellors must also assess their own stigmatisation attitudes toward people with addictions (Myers & Salt, 2007).

The next step in the assessment process is to consider what level a substance user is at—mild, moderate, or severe—all these issues need to be considered in a comprehensive assessment. The proposed interventions also need to be integrative in their approach. Behavioural addictions were not found in the DSM so the component model discussed earlier will be utilised in this chapter to address behaviour assessment.

Mild users (previously called experimental user) use the drug with no significant ill effects and with no marked withdrawal or tolerance. This person can use alcohol and drugs and return to their normal life. The practice can be precarious, however, because even early, voluntary use can interact with environmental and genetic factors and result in addictions in some people, yet not in others. The concept of behavioural addictions is still controversial. While some people exhibit manageable behavioural self-regulation—even in so-called behavioural addictions like over-eating, pathological gambling, and video gaming—others with these disorders often manifest compulsive behaviours with impaired self-regulation (Volkow et al., 2016). Addictions used to be considered a continuum of use, or stages of use, but the theory no longer has much value because not everyone who uses experimentally becomes an addict.

Moderate users may not consider what is happening in their brains, so psychoeducation needs to be utilised to increase their awareness. When use is increased and the reward system is activated, users may pursue that reward with some negative effects. There may be some ambivalence in their thinking that they can use like others and that there is no problem; stigma and shame may also be present. This is a fine edge for clients and for intervention providers in helping clients to participate in interventions. Harm reduction approaches can be very effective for them.

Severe users are characterised by an increase in a psychological need to use. Tolerance develops in that they need more of the drug to get the same high or reward. In a person with addictions, the reward and motivational systems become reoriented through conditioning to focus on the more potent release of dopamine produced by the drug and its cues. As a result, with severe use, the person no longer experiences that same degree of euphoria (tolerance). In addition to resetting the brain's reward system, repeated exposure to the dopamine-enhancing effects of most drugs leads to adaptations in the circuitry of the extended amygdala in the basal forebrain; these adaptations result in increases in a person's reactivity to stress and lead to the emergence of negative emotions (Davis et al., 2010; Jennings et al., 2013).

SCREENING

Again, it is important to note that the best indicator of which level your client is at (and it is not linear) is your connection with the client. Instruments are best used after you have established rapport with your client, otherwise as said earlier, they will become defensive and shut down. Remember that diagnosis limits vision and it diminishes the ability to relate to your client (Yalom, 2002). Connection and rapport are key in the first phase of the interview; with that said we also can learn much from psychometric instruments and so can the client. There are at least 100 instruments that can be used that have shown good reliability in the research. They are also designed to fit different chemicals of addictions and that can be a challenge if your client presents with multiple chemicals and behaviours. Screening is useful to determine the intervention needs of the client.

REFERRALS

Given that many clients in drug and alcohol counselling are involuntary, referral to an advocate (legal or otherwise) may be required at times to independently safeguard their interests. This is a recommendation of the AASW Code of Ethics (2010). As substance-using clients present with many co-occurring conditions and life difficulties, other services are highly likely to be needed. Therefore, gaining written client consent for making referrals, writing referral letters and reports, is essential. It is also essential when referring clients to services to explain the reason for making the referral and the benefits for them, and the role that the service will play in their lives (Rubin, 2012).

SELF-CARE

Burnout is an occupational hazard in our work as counsellors. Working with clients who present with addictions can be most challenging due to their defences that involve neural networks, shame, and stigma. Burnout can be disabling but if recognised early can be rectified quickly. Counsellors are impacted by emotional trauma, and they are often witnesses to horrific stories of distress and pain. Counsellors need to develop personal boundaries and be mindful of transference (the phenomenon whereby we unconsciously transfer feelings and attitudes from a person or situation in the past to a person or situation in the present) and countertransference (the response that is elicited in the counsellor by the client's unconscious transference communications. Countertransference response includes both feelings and associated thoughts). The first step is to be aware of the indicators. Because counsellors are in a therapeutic relationship with many clients who have poor social skills and histories of difficult relationships, these clients may project feelings about someone else, particularly someone encountered in childhood, onto the counsellor. Counsellors may have a reaction to these issues and take such experiences personally, especially when the counsellor has diffuse boundaries. As a result, there will be a rupture in the relationship.

Counsellors can protect themselves by getting out of the isolated bubble and seek support through supervision or co-counselling with other counsellors. Personal counselling on issues that may surface while working with clients is suggested. Recharging is also important such as taking time to exercise, eating healthy food, developing hobbies, and utilising meditation and relaxation techniques which can assist. All strategies you offer your clients when they are distressed can be useful for you as a counsellor. Combating burnout can include not having high expectations of yourself and your client and knowing it is natural to experience burnout and require support.

KEY INTERVENTION WITH COMPONENT MODEL OF ADDICTION/TRANSDIAGNOSTIC MODEL OF BEHAVIOURAL AND SUBSTANCE ADDICTIONS

A key intervention with the component/transdiagnostic models addresses the underlying mechanisms that are common to both substances and behaviours (Hyoun & Hodgins, 2018). Intervention with this model encompasses a number of approaches which have empirical support for their efficacy (Sauer-Zavala et al., 2017). In considering which model to apply the counsellor needs to consider common underlying conditions: negative urgency, deficits in self-control, expectancies and motives, deficits in social support and compulsivity, maladaptive preservation behaviour. For example, addressing expectancies and motives by applying CBT elements. Cognitive expectancies for the effects of addictive behaviours have been found to be an aetiology and maintaining factor of addictive disorders (Mudry et al., 2014). There are two types of thoughts that maintain dysfunctional beliefs: permissive beliefs and anticipatory beliefs. Interventions might include disputing beliefs that justify substance use or compulsive behaviour and what addictive behaviours do for them. These beliefs may maintain and/or exacerbate engagement in the addictions. In relation to addictions, three motivations have been identified: 1. enhancement motivations (i.e., engaging in addictive behaviours to enhance excitement and positive affect); 2. social motives (i.e., engaging in addictive behaviours for social benefit) or basic human need to connect; and 3. coping motives (i.e., engaging in addictive behaviours

to alleviate negative affect). These three motives are linked to neurobiology and can be addressed in neuropsychotherapy by utilising motivational interviewing to develop awareness and coping skills. Relapse prevention as an intervention for ongoing recovery also needs to be considered. This is an important issue and requires counsellors to address relapse with their clients in the early stages of intervention. There is evidence that approximately two-thirds of clients who complete intervention for addictions relapse within the first 90 days. The frequency of return to drinking is estimated to be between 70 and 74% within the first year. More current studies show that the relapse rate for substance use disorders is estimated to be between 40% and 60% (American Statistics/Drug & Substance Abuse Statistics, 2019).

Remember post-acute withdrawal (PAW) symptoms are not easy to observe as they are sub-clinical, long term (about 12-18 months), and cause dysfunction in recovery. Clients have difficulties with thinking clearly, managing their emotions, remembering things, sleeping restfully, physical coordination, and managing stress. All of these symptoms of PAW can be addressed in treatment with counsellors in outpatient or individual therapy. In therapy, high risk situations need to be addressed. These are any experiences that can activate the urge to use alcohol or other drugs or compulsive behaviour in spite of the commitment not to. Counsellors can assist clients to manage high-risk situations by identifying the high-risk situations and developing strategies for managing them. CBT can be utilised to log experiences of high-risk situations by identifying the specific situations that can happen, and giving the situations a title, name, or a phrase to help the client remember their commitment (Gorski, 2007).

Case study George: Assessment

George was interviewed and assessed using the 5 P's for case conceptualisation (Macneil et al., 2012).

1. Presenting problem: Drinks 5 times a week and 6-10 beers on weekends, over the alcohol limit for males, marriage breaking up due to drinking, and work problems due to alcohol leading to missed days and poor performance at work.
2. Predisposing factors: Family history of alcoholism and parental neglect due to mother's depression. He felt shame and stigma because of her depression. Father was distant and emotionally demanding. In his adulthood, he has had intimacy problems with his wife and has a conflictual relationship with her.
3. Precipitating factors: Isolation at school and poor performance due to learning disability. Drinking to avoid painful emotions interfering with marriage. Isolation due to symptoms of depression.
4. Perpetuating factors: Ambivalence to change due to fears. Shame about his sex addiction. Fear of being depressed like his mother and an alcoholic like his father. Isolation loss of contact with family and friends. Restless and bored.
5. Protective factors: George is motivated to change. Realises that an alcohol lifestyle goes against his values. Has attempted to stop before and he loves his wife.

The psychosocial assessment with George showed that: he was having problems in his marriage due to alcohol use; had symptoms of depression from his depression, anxiety, stress scales (DASS) score; and the Attachment Scale Test results showed a preponderance to dismissive-avoidant attachment style because he tends to keep an emotional distance between his wife and has poor connections with others at work. He has a history in his family of alcoholism and his parents were not emotionally available to him. Addiction adaption to early adversity. He has had physiological problems due to his drinking, and an enlarged liver. He feels disconnected from the world and his drinking helps to protect himself from pain.

George was given several screening tests. The Alcohol Use Disorders Identification Test (AUDIT) and his total score was 25 points (i.e., addiction likely). He took the Cut-Annoyed-Guilty-Eye (CAGE) screening test and answered 2 questions positive for alcohol problems. He undertook the Gambling Addiction test and scored high for gambling addiction. He also disclosed the compulsive use of pornography and was given the Sexual Addiction Screening Test (SAST) and scored high on the test.

On the basis of this assessment, counsellors can develop appropriate strategies to assist George.

Case study George: Intervention plan

The conclusions for George are severe on the DSM 5-TR screening for alcohol use, high score on the AUDIT (17) and gambling and sex addiction tests. George has multiple addictions and interventions will focus on these issues. Because of George's ambivalence and fear, and his high level of dangerous drinking, he will be detoxed first in an in-patient hospital setting and transition to the in-patient program to work with his addictions in a safe environment. He will be given medication for craving management and for his depression symptoms.

Intervention strategies are medical management, withdrawal management, and post-withdrawal management. George will first work with his therapist utilising motivational interviewing to access his motivation for treatment. He will attend group psychotherapy daily to work on his family-of-origin issues. One-to-one weekly therapy will focus on developing an ongoing intervention plan and monitoring medication and intervention targets. In his therapy sessions, he will work with his common vulnerabilities and develop strategies to overcome the vulnerabilities utilising CBT and ACT strategies. He will develop skills in recovery utilising the DBT workbook in the group process. Family/couple therapy will be part of his intervention plan. He will complete in-patient treatment and then be transitioned to outpatient to continue his craving management and attend 12 Step support groups for ongoing continuing care. His goals are to become alcohol-free in 3 months' time, manage his cravings, and work on his marriage. He will develop exercise plans to enhance his recovery and develop a healthy diet. Attending AA 12 Step Support groups aim to get an understanding of his addiction and how to remain abstinent from his addictions. This integrative approach will address all his addictions in the intervention settings.

CONCLUSION

This chapter has provided an overview of approaches to addictions intervention. Addictions intervention is very complex, and in constant flux. Counsellors have to keep up to date with the policy changes in each country as well as the new research in pharmacology, models, current statistics, and new developments in intervention. This chapter reviewed some of the traditional approaches as well as the new 21st century approaches to addictions. The intention was to offer a more user-friendly approach in terms of assessment and diagnosis, utilising an integrative approach. The inclusion of more modern concerns, such as internet addiction, mobile phone addiction, video-gamming, and internet gambling, have been discussed along with common vulnerabilities in addictions. The field of addictions is facing a challenge for counsellors because more people are searching for entertainment and distraction due to our stressful world. Some people are more vulnerable to becoming addicted whilst others may have a problem rather than addiction and still need support. Shame and stigma have been key issues to be dealt with when dealing with our clients.

We, as counsellors, need to be more attuned to ourselves and our clients. Clients with addictions have a natural defence networked in their brains and meeting them face-to-face, human-to-human, right-brain-to-right-brain, leads to better outcomes. When we can accept that moderate to severe use is more than a behavioural disorder or choice and see it from a scientific perspective as a condition of the brain, then the stigma and shame can be reduced. Interventions need to be integrative. This means considering the genetics and family influences for prevention strategies, the damage to the cortex, and the imbalance of the midbrain's neurochemistry. Addictions is more than a behavioural disorder. It involves behavioural changes and complications, cognitive and emotional changes. Therefore, a comprehensive approach needs to be applied to address relapse and cravings. Utilising the integrative and alternative therapies discussed in this chapter can heal the brain. The good news is recovery is possible!

LEARNING ACTIVITIES

Learning activity 1: Multidimensional family therapy

Please watch the following YouTube clip presented by Howard Liddle as an introduction to MFT: *Multidimensional Family Therapy, An Introduction (1 of 2)* (10:15).

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=28#oembed-1

- Reflect on the MFT model.
- Reflect on how effective this approach might be for families with addictions.
- What are the limitations of this theory?
- Would you incorporate this approach into your own practice?

Learning activity 2: Family rules

Please watch the following YouTube clip by Judy Saalinger, *3 rules that govern the family system in addiction – LastingRecovery.com,* (5:00).

- While watching the video consider what were three common 'rules' found in families impacted by the misuse of drugs and alcohol.
- While watching the video consider one of the rules and discuss what is the long-term impact on adult relationships resulting from this rule.
- Observe this particular rule and its impact overall on the family.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=28#oembed-2

Learning activity 3: : The disease theory of addiction

Please watch the following video on addiction (2:24).

One or more interactive elements has been excluded from this version of the text. You can view them online here:
https://usq.pressbooks.pub/counselling/?p=28#oembed-3

- Reflect on some of your thoughts about this model.

Learning activity 4: Australian culture in drinking

Watch the following YouTube clip by *DrinkWise Australia – Attitudes to alcohol*: *Creating cultural change in Australia* (3:54).

One or more interactive elements has been excluded from this version of the text. You can view them online here:
https://usq.pressbooks.pub/counselling/?p=28#oembed-4

This video shares thoughts and concerns about the drinking culture in Australia.

- Reflect on how you could apply this understanding in the psychoeducation of your clients.

Learning activity 5: Dr. Kevin McCauley on the periodic table of intoxicants

Please watch this video of Dr. McCauley (3:43).
This video shows a complete list of addictions.

- Reflect on what you learned from this presentation that would be useful in your practice.

Learning activity 6: Using AUDIT

AUDIT screening is the most common form of assessing alcohol use. Please review the AUDIT tool.

- Complete the AUDIT from your own experience.

Learning activity 7: ACT Exercise

Here is a simple acceptance exercise. Use at your own risk. If in doubt seek professional advice. Please take some time and practice this method

- **Observe** – scan the body for any feelings of tension, pain, etc. Try not to listen to your head telling you what the feelings mean, and just observe the actual physical sensation. What colour, temperature, etc is the feeling?
- **Breathe** – imagine breathing into and around any uncomfortable feelings. It is normal for the feeling to shift, becoming bigger or smaller; just hang in there. Remember this is not a relaxation exercise, even if some people do end up feeling more relaxed afterwards.
- **Allow** – come back to the present moment, without pushing the awareness away. Don't struggle with any thoughts or feelings that come up, but also become aware of the world around you.

Reflect on your experience.

Learning activity 8: Attunement

Please watch this video on *Attunement* (9:26).

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=28#oembed-5

This video addresses attunement for clinicians, as mentioned in this chapter. It provides a wider perspective of the concept.

- Reflect on how you might apply this concept to your practice.
- What part of attunement do you need to practice further in order to feel confident?

RECOMMENDED RESOURCES

Some selected websites for further information on substance use and addictions

These websites are for counsellors who want to learn more about this field and expand their practice. There are a number of government websites, models, information about substances, and additional factors that impact clients with addictions. These are just a small sample, and it is incumbent on each counsellor to develop their own practice.

- American Psychiatric Association (2022). Alcohol-related disorders. In *Diagnostic and statistical manual of mental disorders: Text revised version* (5th ed.).
- American Psychiatric Association (2022). Cannabis-related disorders. In Diagnostic and statistical manual of mental disorders: Text revised edition
- Addictions

- Partnership to end addiction
- Neurobiology of addictions. An integrative review.
- Substance Abuse and Mental Health Services Administration.
- The Institute for Addiction Study.
- Drug and alcohol information on statistics and treatment-recovery research at the Recovery Research Institute
- The American Journal on Addictions.
- Project MATCH Research Group (1997). Matching alcoholism treatment to client heterogeneity: Project MATCH posttreatment drinking outcomes.

Additional resources on addictions in Australia, including health policy and at-risk populations

- Australian Institute of Health and Welfare (AIHW).
- Commonwealth of Australia (2017). National Drug Strategy 2017-2026. Department of Health and Ageing.
- National Institute on Drug Abuse (NIDA) (March 2017) Mental health effects.
- Ministerial Drug and Alcohol Forum (MDAF).
- National Aboriginal Torres Strait Islander Peoples Drug Strategy 2014-2019 [PDF].
- National Alcohol and other Drug Workforce Development Strategy 2015-2018 [PDF].
- Australian Indigenous Health*InfoNet*; Alcohol and other drugs knowledge centre.
- Aboriginal Health & Medical Research Council of NSW.
- State of Victoria, Department of Health and Human Services (April 2018). Alcohol and other drugs program guidelines – part 2.
- Young people and addictions.
- The MERIT Program.

Additional resources on screening and treatment options

- Substance Abuse and Mental Health Services Administration (SAMHSA).
- The National Institute on Drug Abuse (NIDA).
- Motivational interviewing (MI).
- ACT and mindfulness activities worksheets [PDF].
- Mindfulness resources from the Mindsight Institute.
- Dialectical behaviour therapy (DBT) workbook and a complete description of DBT.
- Cognitive behavioural therapy model.
- Mindfulness-based stress reduction.
- Popular mindfulness-based stress reduction exercises.
- The component model.
- Numerous assessment and screening tools.
- Screening with alcohol – Drinkers Checkup and Alcohol Screening.

- Information on overcoming codependency.
- Information on neuroscience and the science of psychotherapy.
- Depression and other resources from the Black Dog Institute.
- Ellen Langer on the science of being mindlessness and mindfulness.
- Claudia Black on family issues.

Information on substances and support groups

- Illicit use of drugs.
- Cannabis use and psychosis: what is the link and who is at risk?
- Smartphone use and smartphone addiction among young people in Switzerland.
- World-first medication trial for ice addiction.
- 12 Step support groups on how they work.
- SMART recovery.
- Ayahuasca information.
- Mindfulness.

GLOSSARY OF TERMS

abstinent—not using substances of abuse at any time

acute care—short-term care provided in intensive care units, brief hospital stays, and emergency rooms for those who are severely intoxicated or dangerously ill

addiction—a psychological and physical inability to stop consuming a chemical or being involved in a behaviour causing harm to self and others

CAGE questionnaire—a brief alcoholism screening tool asking subjects about attempts to Cut down on drinking, Annoyance over others' criticism of the subject's drinking, Guilt related to drinking, and use of an alcoholic drink as an Eye opener

coerced—legally forced or compelled

combined psychopharmacological intervention—treatment episodes in which a client receives medications both to reduce cravings for substances and to medicate a mental disorder

co-occurring disorders (COD)—refers to co-occurring substance use (abuse or dependence) and mental disorders. Clients said to have COD have one or more mental disorders as well as one or more disorders relating to the use of alcohol and/or other drugs.

deficit—in the context of substance abuse treatment, disability, or inability to function fully

detoxification—a clearing of toxins from the body

downers—slang term for drugs that exert a depressant effect on the central nervous system

ecstasy—slang term for methylenedioxymethamphetamine (MDMA), a member of the amphetamine family (for example, speed)

epigenetic—is the study of heritable changes in gene expression (active versus inactive genes) that do not involve changes to the underlying DNA sequence—a change in phenotype without a change in genotype—which in turn affects how cells read the genes

hallucinogens—a broad group of drugs that cause distortions of sensory perception

impaired—hampered or held back from being able to do some mental or physical task

intervention—encompasses the specific treatment strategies, therapies, or techniques that are used to treat one or more disorders

marijuana—the Indian hemp plant *cannabis sativa*; also called "pot" and "weed"

motivational interviewing (MI)—a client-centered, directive method for enhancing intrinsic motivation to change by exploring and resolving ambivalence

neuroplasticity—also known as brain plasticity, neuroplasticity, or neural plasticity, is the ability of the brain to change continuously throughout an individual's life, new learning.

opioid—a type of depressant drug that diminishes pain and central nervous system activity

pathological gambling—persistent and recurrent maladaptive gambling behaviour that disrupts personal, family, or vocational pursuits

psychopharmacological—pertaining to medications used to treat mental illnesses

psychosocial—involving a person's psychological well-being, as well as housing, employment, family, and other social aspects of life circumstances

referral—a process for facilitating client/consumer access to specialized treatments and services through linkage with, or directing clients/consumers to, agencies that can meet their needs

relapse—an unfolding process in which the resumption of substance abuse is the last event in a series of maladaptive responses to internal or external stressors or stimuli

relapse prevention therapy (RPT)—a variety of interventions designed to teach individuals who are trying to maintain health behavior changes how to anticipate and cope with the problem of relapse

screening—a formal process of testing to determine whether a client warrants further attention at the current time for a particular disorder and, in this context, the possibility of a co-occurring substance or mental disorder

stigma—a negative association attached to some activity or condition leading to shame or embarrassment

substance abuse—a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances

substance abuse treatment program—an organised array of services and interventions with a primary focus on treating substance use disorders, providing both acute stabilisation and ongoing treatment

substance dependence—a maladaptive pattern of substance use characterised by a need for increasing amounts of the substance to achieve intoxication

trauma—violent mental or physical harm to a person, damage to an organ, etc.

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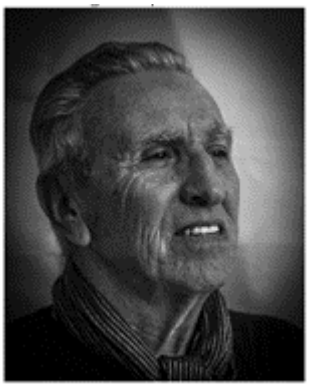

John Falcon is a registered psychologist, clinical supervisor, and educator who is committed to providing clients, supervisees and learners with the requisite knowledge, skills, and support to not only enhance their own lives and career aspirations but to also consciously apply that learning in practice. Throughout his career of over 35 years, John has specialised as a counselling psychologist in addictions therapy which has led to a variety of short and long-term positions in Australian and American therapeutic clinics. John has also maintained his career as an educator and student support officer over the past 20 years. John has also contributed to the currency and scholarship of the subjects he teaches and actively participates in course and assessment review and development processes. He is an experienced and informed facilitator of learning, acutely aware of an individual's strengths and limitations, and is highly experienced in providing the necessary support and/or advocacy so that the individual can achieve their personal, professional and/or academic objectives.

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Anxiety

CHRISTINE CHINCHEN

ABSTRACT

Anxiety is a leading mental health issue both in Australia and globally. It is important to distinguish between anxiety which serves a protective function and anxiety that may become an unproductive and sometimes debilitating issue. While our clients may not always fit diagnostic or other criteria for anxiety disorders, their health and wellbeing may be compromised by their various forms of anxiety. As counsellors, we need to be aware of the various factors, biological, psychological, social, developmental, and contextual, that may impact anxiety in our clients. Finally, when considering interventions, counsellors need to be aware of the different approaches and modalities available and how they may best fit with the client's circumstances.

Learning Objectives

- Define anxiety and identify its various forms.
- Explore the different theoretical understandings of anxiety.
- Evaluate the efficacy of different interventions for anxiety.
- Develop an approach for assessing and responding to anxiety in a counselling setting.

INTRODUCTION

What is anxiety? What are its nature, types, degree, causes, effects, and responses? Anxiety may be seen as a natural response to stressful situations and be accompanied by feelings of worry, nervousness, and/or apprehension (Australian Psychological Society, 2022). When these feelings do not resolve after the stressful situation has passed, become excessive, or compromise the health and wellbeing of a client, there may be an anxiety issue needing intervention. These feelings of excessive worry may lead to avoidance of situations felt to be associated with the anxiety (Beck & Hindman, 2021). The risk is that this avoidance of internal and external stimuli decreases the healthy interaction a person has with their world and the people within it (Australian Bureau of Statistics, 2022a). In this way, the 'safety behaviours' actually increase rather than decrease anxiety (Centre for Clinical Interventions, 2021). Ultimately, clients experience anxiety within many situations they face. What is important for counsellors to identify are the potential factors that can lead to an increase in anxiety and interventions that have been found to decrease the impact of anxiety. Both are discussed later in this chapter. The interventions are explored through Reavley et al.'s (2019) analysis of evidence-based approaches.

It is important to distinguish between productive and unproductive anxiety. Not all anxiety is "irrational, abnormal and neurotic … the capacity to be anxious is a biological function necessary for survival" (Rycroft, 1988, p. xii). Our evolutionary history required the quick assessment of potential threats. Anxiety formed the

basis of 'life or death' decisions (Arden & Linford, 2009). When walking into traffic we unconsciously respond using our evolved 'predatory defense' (LeDoux & Pine, 2016), treating the traffic as if a predator threatening our survival. We instantly stop our forward motion and return to safety. In contrast to the obvious external threat of traffic, we may also experience anxiety when internal signals indicate conditions such as low energy supplies, fluid imbalance, or hypothermia (LeDoux & Pine, 2016). Crocq (2015) argued, not only is anxiety "a normal emotion" but it is "adaptive since it promotes survival by inciting persons to steer clear of perilous places" (p. 319). It is also described as an inborn and adaptive emotion (Glick & Roose, 2010; Mulhare et al., 2010; Ray et al., 2017).

Clients usually only seek assistance for their anxiety when it moves beyond a short-term response to events they face. This persistence impacts the client in a variety of ways, including reducing their engagement in their world (Craske & Stein, 2016) and may "eclipse critical priorities" (Westra, 2012, p. 3) including education, career, relationships, leisure activities, and feelings of contentment. Whilst anxiety might be seen as common, the distress, impairment, and reduced quality of life require attention and interventions to reduce its impact (Westra, 2012).

Fear appears to be at the centre of all anxiety issues (Arden & Linford, 2009; Craske et al., 2009; Duits et al., 2015; Dunsmoor & Paz, 2015; Milad et al., 2014; Stein et al., 2007). So the words 'fear' and 'anxiety' are often used interchangeably. Further, in the literature no distinction is made between the subjective states of fear and anxiety, or the different systems involved in each (LeDoux & Pine, 2016). It is perhaps more accurate, according to LeDoux and Pine (2016), to consider both fear and anxiety as both mental states and subjective feelings. These states and feelings are underpinned by different behavioural and physiological responses. This distinction highlights the differences between feelings of fear, which arise when a threat "is either immediate or imminent" to the client and specific in nature, and anxiety, which arises when the threat "is uncertain or is distal in space or time" or further away from the client (LeDoux & Pine, 2016, p. 1084). Additionally, anxiety is not circumstance or context-specific, rather it is non-specific in nature (Craske & Stein, 2016; LeDoux & Pine, 2016). A further distinction is between anxietus or trait anxiety (i.e., being prone to anxiety due to a tendency to respond to various situations with concerns and worry, e.g., generalised anxiety) and angor or state anxiety (i.e., current anxiety that tends to be transitory after the situation passes, e.g., dental anxiety) (Crocq, 2015; Saviola et al., 2020).

Anxiety is also used as a clinical term to suggest a particular type of mental disorder category, as described in the ICD-11 (World Health Organization, 2022a), or DSM-5-TR (American Psychiatric Association, 2022). Different forms of anxiety are categorised according to their intensity, usually expressed as mild, moderate, or severe. Distinctions are also made based on the characteristics of each presentation of anxiety. Depending on the presentation, anxiety may be categorised into:

- generalised—a free-floating form that something is just not right
- phobic—associated with situations such as giving a speech, sensations such as fear of falling, or fear of animals or insects such as cats or spiders
- as part of post-traumatic stress disorder (PTSD)—episodic, acute, associated with flashbacks, and can be triggered to the level of the panic attack by stimulus like a car backfiring
- complex PTSD (C-PTSD)—the consequence of repeated or chronic traumatisation and repeated losses leading to the person organising their life around survival (Schwartz, 2021)
- obsessive compulsive disorder (OCD)—fear that a catastrophe is waiting to happen and can be forestalled by the use of rituals such as putting things in a particular order or scrubbing the hands alongside or part of a medical issue (Arden & Linford, 2009).

The general diagnostic criteria for anxiety include:

- feeling very worried or anxious most of the time
- finding it difficult to calm down

- feeling overwhelmed or frightened by sudden feelings of intense panic/anxiety
- experiencing recurring thoughts that cause anxiety, but may seem silly to others
- avoiding situations or things which cause anxiety (e.g., social events or crowded places)
- experiencing ongoing difficulties (e.g., nightmares/flashbacks) after a traumatic event (Reavley et al., 2019, p. 6).

The Australian Psychological Society (2022) adds characteristics of difficulty concentrating, restlessness, rapid heartbeat, trembling or shaking, feeling lightheaded or faint, numbness or nausea, and/or sweating. Clients may also experience nausea, stomach pains, tension in neck and shoulders, sleep issues, and irritability as anxiety builds (Australian Government, Department of Health and Aged Care, 2019).

Rather than focusing on specific anxiety disorders as per DSM-5-TR (APA, 2022) and ICD11 (WHO, 2022), this chapter takes a broader approach to include aspects of anxiety which involve biological, psychological, social, developmental, and contextual elements as well as their interplay. This aligns with Eifert and Forsyth's (2005) suggestion that looking at common processes involved in the establishment and maintenance of anxiety-related issues can lead to more effective and impactful interventions.

Learning activity 1

Please watch *What is anxiety?* [1:31] to gain further understanding of the variety of presentations of anxiety and their impact. Please pay particular attention to the movement between natural anxiety and diagnosable conditions of anxiety.

One or more interactive elements has been excluded from this version of the text. You can view them online here:
https://usq.pressbooks.pub/counselling/?p=65#oembed-1

PREVALENCE

Anxiety is considered a common mental health issue both in Australia and globally. In its 2022 World mental health report, the World Health Organization (WHO, 2022b) noted both the commonality of anxiety and its increase by 25% during the first year of the pandemic. The Australian Bureau of Statistics (ABS) reported 16.8% or 3.3 million people in Australia reported anxiety in the 12 months of 2020–2021 (2022a). The ABS figures were further broken down into panic disorder (3.7%), agoraphobia (4.6%), social phobia (7.0%), generalised anxiety disorder (3.8%), obsessive compulsive disorder (3.1%), and post traumatic stress disorder (5.7%). These figures represent people who have been diagnosed; however, they do not represent people who may have diagnosable anxiety yet remain undiagnosed or those whose anxiety is not at the level required for diagnosis.

RISK FACTORS

The World Health Organization (WHO, 2022b) identified a diverse set of individual, family, community, and structural circumstances that all contribute to mental health. Additionally, the combination of life experiences

and genetic predisposition may increase anxiety into a more intense form of anxiety (Hofer, 2010). These diverse factors are included when assessing anxiety from a biopsychosocial perspective (Engel, 1977). Anxiety, from this perspective, is seen as a combination of the biological factors of the person, the psychological factors of the person, and their reciprocal interactions with the social aspects of the person (Engel, 1977). This can be complemented by developmental theories from Bronfenbrenner (ecological model) and Samorof (transactional model). These models emphasise the importance of seeing the biopsychosocial factors within the broader context and culture of a person's life. These factors interact and develop over the lifetime of the person and are unique to the historical time of that person (Lehman et al., 2017).

While any person can develop anxiety, there are some additional risks based on specific characteristics. It is beyond the scope of this chapter to discuss all the potential risk groups and factors. However, some are discussed next.

GENDER

The ABS (2022) reported that gender comparisons show females are more likely than males to develop anxiety (21% compared to 12.4%). Drilling further down into the statistics, females were more likely than males to have social anxiety (9.8% compared with 5.7%) and post-traumatic stress disorder (7.6% and 3.6%) (ABS, 2022). This is a consistent finding in the research on anxiety (Cabral & Patel, 2020). These differences may be due to biological differences in brain structure which are impacted by genes, hormones, and environment. Gender-role expectations, power dynamics, vulnerability to impacts of domestic violence and sexual assault, and other risk factors may also impact. These factors may be combined with misogyny, discrimination, being seen as inferior to males, and lower rates of pay that affect females (Rodgers et al., 2020). Gender is a complex and not yet clearly understood dynamic of anxiety.

AGE

In the 16–24 year old age group in Australia, almost a third (31.5%) were identified as having anxiety, including 41.3% of females (ABS, 2022). Anxiety may be compounded by sleep issues. This is particularly relevant to this age group due to the brain development at this time. Issues with sleep can be exacerbated by social media and other technologies, and potentially associated cyberbullying (Cabral & Patel, 2020). Bandelow and Michaelis (2015) reported that anxiety issues start in childhood and adolescence or early adulthood, peak in middle age, then tend to decrease with older age. This pattern was identified in epidemiological studies and supported by Craske and Stein (2016), who further argued that it is important to identify people at risk and commence interventions as early as possible. Longitudinal studies, according to Pine and Fox (2015), typically suggest that adults who exhibit chronic anxiety had experienced it from childhood. It is, therefore, not surprising to find the age group of 16–24 year old has a high rate for anxiety. It is also important to consider that anxiety may arise in later periods due to exposure to accidents, illness, and other issues. So anxiety, whilst most prevalent in earlier stages of life, can continue or arise in later stages.

Additional areas of concern for youth include separation anxiety, selective mutism, social anxiety, and generalized anxiety (Palitz & Kendall, 2020). Excessive and developmentally inappropriate anxiety from actual or imagined separation from caregivers in youth over six years old is seen as separation anxiety. As Palitz and Kendall (2020) noted, similar separation anxiety before six years old is considered developmentally appropriate. Social anxiety may arise in youth as avoidance of social situations, avoiding asking questions in class, difficulties with starting or joining conversations, and is present both with adults and peers. Selective mutism is a failure to speak in certain situations despite being able to speak in others. It is important to note that when youth have one form of anxiety, they have a roughly 80% chance of a co-existing anxiety issue of another form (Palitz & Kendall, 2020).

Of additional concern in the youth age group is the increased risk of self-harm and suicide. While the median age of suicide is 44.8 years, there is a higher rate of suicide in youth (Suicide Prevention Australia, 2022). This

is something to be mindful of at any age but is particularly important as the brains of youth develop, impulse control and risk analysis may be low, and feelings of anxiety and isolation can be overwhelming.

IDENTIFICATION

The ABS (2022) reported that 44.7% of people who identify as gay, lesbian, bisexual, asexual, pansexual, or queer reported anxiety. People in these groups may encounter stigma, prejudice, and discrimination leading to a social environment that can be both stressful and hostile (Hill et al., 2020). These phenomena may present in medical treatment that is culturally insensitive or misinformed, violence and harassment, lack of family support, and workplace mistreatment (Rodgers et al., 2020).

SOCIAL CIRCUMSTANCES

There are a range of social circumstances that potentially affect the prevalence of anxiety. People living in one parent family households with dependent children (28.7%) reported anxiety (ABS, 2022). Low socioeconomic status contributes to higher rates of anxiety (Moreno-Peral et al., 2014). Existential concerns can trigger anxiety. These concerns may include not leading a meaningful life or the eventuality of death (LeDoux & Pine, 2016). Stressful events which are ongoing and/or uncertain may also trigger anxiety, for example, being a new parent, work changes, relationship issues, and the death of loved ones (Reavley et al., 2019).

FAMILY FACTORS

Based on epidemiological studies, heritability of anxiety issues is estimated to be between 30–50% (Shimada-Sugimoto et al., 2015). Factors increasing anxiety risk for children include parental anxiety issues (Beesdo-Baum & Knappe, 2012; Strawn et al., 2020) and certain parental personality disorders (cluster A and cluster C) (Kaplowitz & Markowitz, 2010; Strawn et al., 2020). Children are also at an increased risk of a variety of mental health issues, including anxiety, through: childhood maltreatment and neglect (Chu et al., 2013; Vachon et al., 2015); physical punishment in childhood (Clauss & Blackford, 2012);. and over-protective or overly harsh parenting style (Beesdo-Baum & Knappe, 2012). Attachment research has highlighted the increased risk of anxiety issues in children with an anxious attachment style (Bowlby, 1973). This includes all forms of insecure attachment as these styles raise anxiety sensitivity and contribute to viewing others as undependable, result in chronic anxiety, increase difficulty in emotional regulation, and cause cognitive errors about threats (Mulhare et al., 2010). Similarly, separation anxiety (from major attachment figures) has been studied by researchers as a form of persistent, developmentally inappropriate anxiety (Bögels et al., 2013; Comer & Olfson, 2010). The authors report that one third of childhood separation anxiety persists into adulthood (Comer & Olfson, 2010) while Silove et al. (2015) reported over 43% of lifetime separation anxiety had an onset after 18 years of age. Separation anxiety can also reform into other forms of anxiety and depression.

ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Reavley et al. (2019) reported high levels of psychological distress, including feelings of anxiety, in Aboriginal and Torres Strait Islander peoples. The identified causes of anxiety in this group of peoples needs to be understood through the existence of intergenerational trauma, and social, historical, cultural, and spiritual factors. These causes include racism and discrimination, loss of cultural identity, being away from country, and not being able to have ceremony. Further information on this issue can be found in the Intergenerational Trauma Animation below [4:02].

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https://usq.pressbooks.pub/counselling/?p=65#oembed-2

CULTURALLY AND LINGUISTICALLY DIVERSE (CALD)

People from culturally and linguistically diverse (CALD) backgrounds represent a significant group within Australia. The ABS (2021) reported just over 7 million (27.6%) of the population (almost 26 million) were born overseas (ABS, 2022). A range of issues may arise from being in the CALD group and may contribute to anxiety or other mental health issues. These include increased stigma in their native cultures around mental health issues as well as concerns about trust and confidentiality when interacting with providers of health services (Baker et al., 2016). This lack of trust is particularly understandable for those who have experienced human rights violations and persecution leading to their relocation (Phillips, 2015). Trauma, and its associated anxiety, may arise from a variety of causes in their homelands—such as poverty, political unrest, gang violence, and natural disasters (Amnesty International, 2022). Appreciating such potential for trauma may be contributing to presenting anxiety is an important aspect of working with people from CALD.

INDIVIDUAL ATTRIBUTES

Many individual attributes contribute to anxiety risk. For example, Clauss and Blackford's (2012) meta-analysis found behavioural inhibition, such as clinging to familiar others in the presence of strangers, was specifically predictive of social anxiety. Tendencies towards perfectionism, being easily flustered, timid, inhibited, having low self-esteem, and/or wanting to control everything can contribute to anxiety in childhood, adolescence, and adulthood (Beyond Blue, 2022). So too can certain thinking styles including anticipating the worst, and persistent negative self-talk. These can occur alongside difficulty accepting uncertainty, low self-esteem, sensitivity to internal physical responses, such as increased heart rate, and misinterpreting these physical symptoms as indicating something catastrophic (APA, 2022).

A tendency to misinterpret ambiguous situations contributes to a range of emotional issues including anxiety in both social and generalised forms. This tendency for misinterpretation also contributes to specific issues such as body dysmorphia (Dietel et al., 2021). Body dysmorphia is related to physical appearance interpretation bias (reduced positive and increased negative). This interpretation bias promotes social anxiety which also has a higher fear of negative evaluation (Fang & Hoffman, 2010).

COPING MECHANISMS

Some coping mechanisms work well to reduce the development and impact of anxiety. These are often referred to as adaptive coping mechanisms. They sit alongside protective factors to reduce the risk of developing ongoing anxiety. However, clients will often be drawn to coping mechanisms that may negatively impact their anxiety.

Some coping mechanisms that place a client at greater risk of anxiety include the use of substances such as alcohol, cannabis, amphetamines, sedatives, emotional eating, gambling, and so forth. These can reduce effects of anxiety initially but increase the anxiety when the effects of the coping mechanism begin wearing off (Reavley et al., 2019). A common coping mechanism is avoidance. Avoidance is mentioned by researchers such as Dietel et al. (2021) and features in the diagnostic criteria for anxiety disorders (APA, 2022; WHO, 2022a). The

tendency to avoid situations that trigger anxiety, rather than facing such situations, can result in an increase of anxious indicators (APS, 2022a; Westra, 2012).

LIFE EVENTS

While many life events may involve or contribute to anxiety, this chapter focuses here on four examples of life events where anxiety can arise. The first two relate to common developmental issues—having a baby, and ageing. These show that specific life events that are developmentally common can give rise to anxiety containing both general and specific aspects. The second two relate to specific issues that give rise to both general and specific forms of anxiety—athletic competition, and test anxiety.

Having a baby

The impact of having a baby is far-reaching. One impact can be maternal anxiety which may arise or increase in the post-natal period (Seymour et al., 2015). Seymour et al.'s 2015 study of 224 Australian mothers of infants (aged 0–12 months) identified that 18% had mild to extremely severe symptoms of anxiety. The flow on effects of this anxiety included fewer close, warm and affectionate interactions with their infants alongside less involvement in their infant's learning activities such as playing indoors and reading stories. When co-existing depression was evident, there was also a sense of lower efficacy and satisfaction as a parent, and high parental hostility. Factors that contributed to maternal anxiety included lower educational attainment, perceived need for social support, poor couple relationship, difficult child behaviour, and poor quality of sleep.

Ageing

Older people often experience anxiety alongside other issues related to both physical and mental health. Of import, according to Andreescu and Lee (2020), late-life generalised anxiety disorder, for example, has a more severe course and impact. Additionally, bidirectionality exists in the causal relationship between late-life anxiety and cognitive impairment. Impaired cognitive performance increases anxiety on one hand and chronic anxiety states may increase the risk for central nervous system damage due to the impact of chronically elevated cortisol, blood pressure, or excessive benzodiazepine prescriptions.

An earlier study by Andreescu et al. (2008) showed prevalence rates of generalised anxiety disorder for those in residential community care to be similar to the general population. In older people, however, they identified additional anxieties connected to impairments in the quality of life, cognitive impairment, increased health care utilisation, and poorer functional recovery after disabling medical events such as stroke. What is also important to note is that those people in the 60+ age group have a different profile to those under 60 years old including higher rates of uncontrolled worry and different worry content.

Athletic competition

Given Australia is such a sporting nation, it seems relevant to include something on the anxiety associated with athletic competition. Athletes experience anxiety from factors faced by the general population as well as athlete-specific factors, such as pressure to perform, public scrutiny, career uncertainty or dissatisfaction, and injury (Vu & Conant-Norville, 2021). Specific forms of anxiety that may be experienced by athletes include: injury-associated anxiety (related to the injury itself or not being able to compete); somatic state anxiety (where a fear of failure or internalizing worries is expressed physically); cognitive state anxiety (where hope for success is reduced due to the memorable expression of anxiety); and competitive anxiety (which tends to increase before and during competitions and when those contests are away from home). Vu and Conant-Norville (2021) stress the importance of responding to both the general and specific contributors to anxiety in athletes. This principle seems more widely applicable to clients who have anxiety so they are not responded to with generic interventions but ones which are tailored to their specific needs.

Learning activity 2

Please watch this video *LIAM. Anxiety doesn't stop for your AFL career* [5:00].

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=65#oembed-3

Consider how the impact of anxiety and panic attacks had on Liam's career and life in general.

- What strategies are useful for Liam?
- How might you use these strategies in your work with clients ?

Test anxiety

Test anxiety has been selected as an example as some readers of this chapter may be students affected by this form of anxiety. This specific form of anxiety is an important one to consider as it impacts on the capacity of a person to engage successfully with studies. Lotz and Sparfeldt (2017) argued that test anxiety is a transitory or state anxiety related to possible negative consequences of failure on an exam as opposed to the more stable trait test anxiety in which the predisposition is to interpret test situations as overly threatening. Understandably, high-stake assessments, such as end of semester exams or other summative tests and assessments, especially those described as capstone assessments, elicit more test anxiety than low-stake assessments. Interestingly, Lotz and Sparfeldt (2017) identified anticipatory test anxiety actually commenced at the beginning of the semester and then modestly increases as the tests approached. A useful set of study tips from Therapist Aid can assist in managing text anxiety.

CO-EXISTENCE WITH OTHER ISSUES

While we may see the statistics reported so far as indicative of anxiety alone, anxiety often co-exists with other issues in both biological and psychosocial domains (WHO, 2022b). This interplay supports a thorough approach to understanding the individual circumstances of each client. It also counters the notion that anxiety is an intrapsychic issue alone. This discussion identifies three separate forms of potential co-existence: 1. with a variety of medical issues that can contribute to, or exacerbate, anxiety; 2. as complex anxiety, i.e., one form of anxiety co-existing with other forms of anxiety (Bandelow & Michaelis, 2015); 3. with other mental health issues.

Medical issues

Medical issues can be anxiety-provoking, depending on what they are and their impact. As an example, research into rheumatoid arthritis (Covic et al., 2012) used two scales to assess the level of anxiety: Depression, Anxiety, Stress Scale (DASS) and Hospital Anxiety and Depression Scale (HADS). In the sample of 169 people in both the United Kingdom and Australia, 7.8% showed severe or extremely severe anxiety on DASS while 19.5% showed mild to moderate anxiety. This represents about a 50% increase over general population figures for

anxiety. On the HADS, 13.5% showed anxiety only while 21.8% showed possible and/or probable anxiety and depression.

Equally, cardiac issues can be anxiety-provoking. For example, Schluep et al. (2022) followed up in-hospital cardiac arrest patients at 3 and 12 months post-release from hospital. In the follow up of 3 months, 15 of the 125 people (12%) had moderate-major problems on the anxiety scale and 16 of the 108 people (14.8%) followed up at 12 months. These anxiety rates were higher than the moderate-major depression rates of 5.6% at 3 months and 11.3% at 12 months.

Other specific examples of medical issues that have shown a connection with anxiety are hypothyroidism or underactive thyroid (Craske & Stein 2016), diabetes, asthma, heart disease (Reavley et al., 2019), paediatric cardiac diagnoses including anxiety and PTSD (Patel et al., 2017), childhood absence epilepsy (i.e., epilepsy without the seizures) (Vega et al., 2011), fibromyalgia, epilepsy, and cerebral palsy (Meuret et al., 2020).

A specific and broader form of anxiety related to medical issues is health anxiety. This arises when a client has persistent and excessive fear of being seriously ill (Hedman-Lagerlöf et al., 2019). This may involve seeking more tests and examinations, using more health services and resources, and may exist with or without medical disease or diagnosis. Indicators of health anxiety include:

- worry about health that quickly and repeatedly resurfaces after reassurance
- frequent attendance
- spending excessive time online searching for health-related information (cyberchondria)
- health worries that lead to substantial functional impairment (Hedman-Lagerlöf et al., 2019, p. 1).

More recently, in light of the pandemic, a different form of anxiety has been identified which relates to health and medical conditions—coronaphobia (Asmundson & Taylor, 2020) which is fear and anxiety about COVID-19 (Lee et al., 2020). A brief screen for this form of anxiety was developed by Lee (2020).

A final form of anxiety discussed here is dental anxiety (Svensson et al., 2020). This form of anxiety is specifically mentioned as it affects between 4–20% of the populations in a number of countries and cultures. It has significant impacts on the dental health specifically but more generally the medical, psychological, and social consequences can be significant (Svensson et al., 2020).

Different forms of anxiety

Co-existence of one form of anxiety with other forms of anxiety is prevalent and may be referred to as complex anxiety (Bandelow & Michaelis, 2015). For example, health anxiety often co-exists with generalized anxiety, obsessive-compulsive, panic, and medically unexplained symptoms (Hedman-Lagerlöf et al., 2019). Health anxiety may include OCD, be a specific disease phobia, or when concerns extend beyond health alone (e.g., financial, interpersonal, occupational) it may be generalised anxiety, and may involve panic attacks (Harding et al., 2010).

Obsessive compulsive checking or obsessive behaviour are features of eco-anxiety, i.e., a chronic fear of environmental degradation due to the sense that ecological foundations of existence are collapsing (Panu, 2020). This co-existence of obsessive compulsive behaviours also exists with PTSD and CPTSD. Møller et al. (2021) found in their sample of 106 Danish outpatients:

- 42% diagnosed with PTSD or complex PTSD also had panic disorder
- 25% diagnosed with PTSD and 22% diagnosed with complex PTSD also had agoraphobia
- 4% diagnosed with PTSD and 15% diagnosed with complex PTSD had social anxiety disorder
- 21% diagnosed with PTSD and 13% diagnosed with complex PTSD had OCD.

Other mental health issues

Anxiety co-exists with a range of other mental health issues. The co-existence of anxiety and body dysmorphia has been discussed. This is a more obscure co-existence due to the low prevalence of body dysmorphia—estimated to be 2% (Swinburne University of Technology, 2022). However, other forms of mental health issues have a higher prevalence rate. For example, Reavley et al. (2019) estimated that over half of those experiencing depression also experience anxiety. They also stressed that in some cases, the presence of one can lead to the onset of the other. Choi et al. (2020) add that 45%–67% of those meeting the criteria for depression will meet the criteria for at least one anxiety issue.

Wagner (2006) found co-existence of bipolar in children and adolescents with various forms of anxiety, including OCD, GAD, social phobia, panic disorder, and PTSD. Additionally, ADHD, conduct disorder, and oppositional defiant disorder were found to co-exist with anxiety (Wagner, 2006). Autism and ADHD were also associated with higher rates of anxiety than in the general population (Avni et al., 2018).

Research suggests that anxiety forms part of many eating disorders, such as anorexia nervosa and bulimia nervosa. Anxiety has been reported in 50% of cases reviewed by Keski-Rahkonen and Mustelin (2016). Anxiety often precedes the development of an eating disorder and may, therefore, predispose a person to an eating disorder (Grave et al., 2021). Anxiety may also arise as part of the eating disorder itself. For example, avoidance of socialising may arise not due to social anxiety but because of the difficulties eating in front of others and/or exposing their body shape. Avoidance of social eating and low self-esteem were offered as potential links between from eating disorders and trait anxiety (Forrest et al., 2019). It is important to note that anxiety may resolve itself when the eating disorder is successfully treated (Grave et al., 2021).

Case Study: The Story

The case study is an amalgam of clients with whom I have worked and represents a typical presentation of a client with anxiety. As you read the case study, please take a moment to identify the biological, psychological, social, developmental, and contextual issues.

Jess presented to counselling with feelings of agitation, fears about the future, and concerns of repetitive patterns of behaviour that seemed out of their control. These thoughts of impending negative outcomes can make getting to sleep difficult due to a racing mind. Once asleep, Jess may find it difficult to remain asleep. Sometimes Jess has a nervous awakening accompanied by a racing pulse and a fearful feeling. Once awake, Jess can find it challenging to return to sleep.

Jess has researched anxiety but knowing about anxiety, associated impulsive behaviour, and difficult feelings yet having little ability to control them, frustrated Jess. This often resulted in further feelings of shame and guilt. These impacts were negatively affecting Jess's health and well-being, employment, and relationships. Interrupted sleep affects daily functioning as Jess often feels tired and easily overwhelmed as the day progresses. This affects Jess's performance at work. There are also certain situations at work where things are more difficult such as meetings in smaller rooms, with certain people who may be aggressive or judgemental in their stance, and with demanding deadlines. Relationships also suffer as Jess is sometimes very reactive when tired or overwhelmed, and avoids social situations frequently. Often friends and family decrease their connection with Jess.

Jess is now seeking assistance in order to minimise or resolve this lifelong issue.

CONCEPTUALISING ANXIETY

As seen in the introduction, conceptions of anxiety are affected by the lenses through which we view it. In this section several key counselling theories are offered first. Corey (2016) is the main source for this comparison due to his extensive writing in the field of counselling theories and practice. The main theories covered are psychoanalytic, behavioural, cognitive behavioural, acceptance commitment, gestalt, humanistic, existential, and systems theories. The section then explores the biological aspects of anxiety through the polyvagal theory.

Psychoanalytic theory identifies anxiety as a feeling of dread resulting from repressed feelings, memories, desires, and experiences that emerged in the surface of awareness. At the core of anxiety is a conflict between the id, ego, and superego for control of the psychic energy. Two forms of anxiety are reality anxiety and neurotic anxiety. Reality anxiety is proportionate to the degree of real threat from dangers in the external world. In contrast, neurotic anxiety arises when instincts (id) may get out of hand and create a scenario in which a person will be punished. Of import is the defense mechanisms a person uses to reduce anxiety (Corey, 2016). Countering defense mechanisms and strengthening the ego are central to managing neurotic anxiety.

Behavioural theory rests on conditioning: operant or classical. Operant conditioning involves learning through consequences whilst classical conditioning involves automatic associations between a conditioned stimulus and a conditioned response, e.g., Pavlov's dog. To include social factors which affect people and their conditioning, the social learning theory was developed. Anxiety is seen as a conditioned response and to counter it, new conditioning needs to take place (Corey, 2016).

Cognitive behavioural theory incorporates feelings and thoughts in addition to the behavioural aspects of conditioning (Corey, 2016). Kaczkurkin and Foa (2015) explain that anxiety results from maladaptive thinking, feelings, or behaving. This includes a tendency to overestimate the possibility of negative outcomes. These automatic thoughts are often distorted and thus challenging the thoughts, feelings, and behaving are central to this approach.

Acceptance and commitment theory takes a different approach to traditional cognitive behavioural theory. Anxiety is seen as a movement away from the present into the future. Controlling anxiety is seen as problematic so instead of focusing on the anxiety itself, acceptance and commitment theory engages the client in accepting thoughts and feelings without judgement and with curiosity, choosing directions for their life based on their values, and promoting action for change (Eifert & Forsyth, 2005). Mindfulness techniques and being present in the here and now are promoted (Corey, 2016). In this way, acceptance commitment theory aligns with gestalt theory which also focuses on the here and now.

Gestalt theory sees anxiety as resulting from the present and future being non-differentiated (Corey, 2016). In this way, something that may or may not occur in the future becomes present as anxiety. Gestalt theory focuses on the present moment including immediate thoughts, feelings, and behaviours that lead to the anxiety (Corey, 2016).

Humanistic theory suggests anxiety is a part of living. However, it can negatively impact a person when they are judgemental and apply conditional positive regard to themselves. This conditional state leads them to not accept the person they have become. It thwarts the actualising tendency of the person and creates issues such as anxiety (Corey, 2016). Self-acceptance, as well as unconditional positive regard for oneself, form the basis of countering anxiety as congruence results.

Existential theory also proposes that anxiety is a condition of living. Anxiety results from confronting the 'givens of existence'—death, freedom, choice, isolation, and meaninglessness. These givens can result in anxiety as a person realises their mortality, confronts their pain and suffering, struggles for survival, or recognises their fallibility. As with other theories, existential theory differentiates normal from neurotic anxiety. Normal anxiety is an appropriate response to the event being faced whilst neurotic anxiety is out of proportion to the event. Neurotic anxiety is seen as not being within the awareness of the person and immobilising (Corey, 2016). In relation to anxiety, existential theory suggests we reduce the neurotic anxiety whilst embracing the normal anxiety as part of life.

Systems theories are mentioned here as family systems tend to create modelling from parent/s to children, often contain patterns of behaving aimed at reducing anxiety, and feedback loops that reinforce behaviours. The impact of families was discussed in the prevalence section but here it is important to note that most systems approaches aim to destabilise the current dynamics in order to promote more functional dynamics within the family, in order to reduce anxiety (Corey, 2016).

Neuroscience has added much understanding of anxiety and other mental health issues. This is a wide-reaching set of theories and beyond the scope of this chapter to explore in depth. However, one neuroscientific theory, the polyvagal theory (Porges, 2022), is offered here as it is central to working with clients. This theory also builds on the biological aspects discussed in this chapter, e.g., genetics, temperament etc. At the heart of polyvagal theory is the notion that safety is a core determinant of human functioning. When

humans feel safe, their nervous system is downregulated or calm. This allows the homeostatic balance of the person to be supported for health, growth, and restoration. Additionally, due to safety being experienced, the person can be more fully engaged with others and their world. The opposite occurs when people perceive they are not safe. An additional feature of the polyvagal theory is the connection between calm resulting from safety and higher order thinking capacity. When in an unsafe or anxious state, the amygdala dominates processing and reacting. The amygdala also reduces or disconnects from the higher order thinking parts of the brain, leaving the person vulnerable to reactive states of being. Creating safety through connection to another person promotes downregulation of the other's physiological state and promotes trust. The higher order thinking is more likely to come back online and engage in problem solving, creativity, sociability, and optimisation of health and wellbeing.

ASSESSMENT

As discussed earlier in this chapter, WHO (2022b) suggests a biopsychosocial approach for mental health. This approach is relevant for both assessment and interventions for clients, alongside both developmental and contextual issues. These will now be discussed and applied to the case study of Jess.

Initial assessment of anxiety and its impact on the client's life can be completed through observation by a counsellor (the counsellor observes indicators of anxiety such as rapid breathing, racing thoughts, and so forth) together with client self-report (the client describes their experiences of anxiety, including history, frequency, intensity, and impact). While the client provides this self-report, the counsellor may engage in specific questions based on their understanding of the impact and type of anxiety the client may be experiencing. These questions might be based on some of the formal inventories that can be used to assess anxiety. At this stage of assessment, as the therapeutic relationship is being developed, inventories may be less helpful as they may interfere with developing the relationship. They may also feel intrusive and robotic to clients in the early stages of working together.

Subsequent assessment can involve ongoing observation and client self-report supplemented with formal inventories. The Depression, Anxiety, Stress Scales (DASS 42) is a 42 item inventory. In this full version, the anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. High scorers in the anxiety scale tend to show these characteristics:

- being apprehensive, panicky, trembly, shaky
- showing awareness of dryness of the mouth, breathing difficulties, pounding of the heart, sweatiness of the palms
- being worried about performance and possible loss of control (Psychology Foundation of Australia, 2022).

The Depression, Anxiety, Stress Scales 21 (DASS 21) is a shortened version of the full 42 item Depression, Anxiety, Stress Scales (DASS) and is more commonly used. The self-rating asks clients to assign a rating (0 = never, 1 = sometimes, 2 = often, 3 = almost always) to each statement, e.g., I find it hard to wind down, I tend to over-react to situations, I feel that I was using a lot of nervous energy. The outcomes of the scores on the DASS 21 can be normal anxiety (0–3), mild anxiety (4–5), moderate anxiety (6–7), severe anxiety (8–9), extremely severe (10+). This is a direct link to the DASS 21. It is useful to be familiar with the DASS 21 items when working with clients.

Additional inventories that can be applied in counselling include:

- Generalized Anxiety Disorder 7-Item Scale (GAD-7) – 7 item self-report related to the frequency of anxiety behaviours
- Generalized Anxiety Disorder Severity Scale (GADSS) – 6 item self-report measuring both frequency and intensity of anxiety indicators

- Beck Anxiety Inventory (BAI) – 32 item self-report measuring severity of anxiety indicators
- Hamilton Anxiety Rating Scale (HARS) – 14 item self-report measuring global anxiety in adolescents and adults
- Leibowitz Social Anxiety Scale (LSAS) – 24 item self-report measuring social anxiety or social phobia
- Overall Anxiety Severity and Impairment Scale (OASIS) – 5 item self-report measuring indicators of a broad range of anxiety issues
- Spence Children's Anxiety Scale – a 44 item self-report measure used in combination with the parent version for comparison purposes (Spence, 1998)
- Generalized Anxiety Disorder Questionnaire for Adults (GADSS) – 6 item scale to assess the severity of generalized anxiety disorder symptoms on a 5 point severity scale (0=none to 4= very severe). The 6 items are frequency of worry, distress due to worry, frequency of associated symptoms, severity and distress of associated symptoms, impairment in work, and impairment in social function.

Wagner (2006) argued that due to the potential co-existence of bi-polar (I and II) and anxiety issues, it is important to screen for both. Whilst bipolar disorder may be indicated by severe irritability or rapidly fluctuating mood, these indicators may mask underlying obsessive thoughts, worries, compulsions, and/or somatic symptoms that indicate anxiety issues.

The overall aim of assessment is to identify the forms of anxiety being faced by the client, their developmental issues (such as age, onset, trauma, etc), and which evidence and clinical based interventions may assist. It is also important to move beyond the anxiety itself and see what contextual events may be contributing and how to respond to these impactors.

Case Study: Assessment

The counsellor made a number of observations when interacting with Jess. These included fast pace speaking which appeared to be an attempt to capture the racing thoughts being experienced. Triggers included interactions with certain people, when work colleagues or friends raised their voices loudly, or provided critical feedback to Jess. Indicators anxiety was on the rise included sleep interruption due to a racing mind and circular thinking, associated fear of not being able to sleep, the general sense of concern which could quickly escalate to terror, physical indicators including wringing of the hands, shortness of breath, and affect that fluctuated from calm to agitated in a short period of time. This seemed consistent with complex post-trauma responses and associated hyperarousal.

Questions were asked to clarify the anxiety escalation including the physiological indicators of anxiety, psychological indicators of anxiety, and the affective indicators of anxiety. Jess was able to provide detailed accounts of specific instances where the anxiety was triggered. These accounts indicated that Jess was experiencing generalised anxiety that could be triggered by a large range of situations.

The assessment continued throughout the sessions, both initially and reviewed as sessions progressed. The anxiety Jess experienced was conceptualised as complex anxiety with some features of generalised, phobic (fear of certain situations and people in particular), rituals to calm the anxiety and obsessive thinking (mainly cleaning), and an inability to self-soothe. Attachment issues arose as an additional consideration to be discussed in a later session. This was focused on once a stable attachment had formed in the therapeutic relationship. Prior to this time, Jess avoided talking about her early family experiences. However, the clue this may be an issue arose in Jess's mention in initial sessions that this was a lifelong issue.

Whilst no formal inventory was used initially, the questions from the DASS 21 and other scales were incorporated into the conversation. This decision was made due to the obsessive thinking displayed by the client. The guiding thought was the client would obsess over the results being presented in number form. This was based on Jess having discussed the desire to reduce the numbers whenever a quiz or inventory had been completed in the past.

INTERVENTIONS

While we may consider the existence of anxiety to be a modern condition, its roots go back to the Ancient Greek and Latin authors who reported "pathological anxiety…as medical disorders" (Crocq, 2015). Since then, different theories have arisen based on different schools of thought within counselling. Each school of thought, as previously discussed, conceptualises anxiety in its own manner. This conceptualisation is based on the core tenants of the specific school of thought. Putting aside the different conceptions, we now turn to the most effective approaches. These approaches are evidence-based and shown to have efficacy (Reavley et al., 2019).

Learning activity 3

Before reviewing possible interventions, a special focus is placed on working with two groups of people:

1. Aboriginal and Torres Strait Islanders
2. Culturally and Linguistically Diverse people (CALD).

To work effectively with Aboriginal and Torres Strait Islander people, we need to move into healing traditions that are effective rather than only applying non-indigenous approaches. A useful guide to review is PACFA Indigenous Healing Practice Training Standards [PDF]. Please review these training standards and the approach suggested within them.

When working with people who have a CALD background, some beneficial guidelines are offered by the NSW Department of Health, *How can I support a culturally and linguistically diverse person with a mental health issue?* Please review these guidelines.

Learning activity 4

Please review *A guide to what works for anxiety: An evidence-based review* [PDF].

The table on page 19 highlights psychological interventions and offers a ranking of their usefulness and contraindications. The table on page 21 offers some complementary and lifestyle interventions. Please note the different recommendations for the various forms of anxiety.

TOP DOWN AND BOTTOM UP STRATEGIES

Depending on the client and their anxiety, as well as other issues, we need to consider whether top down or bottom up strategies or a combination are the most useful. As noted in the neuroscience conception of anxiety, not all anxiety can be reached through the 'thinking' mind and instead comes from neuroception which needs to be dealt with indirectly (Porges, 2022). Neuroception can create anxiety sensitivity as discussed earlier. Sussman et al. (2016) and Capron et al. (2017) argue for awareness of both top down and bottom-up strategies for anxiety. This responds to the:

- bottom up, sensory driven mechanism that selects stimuli based on their physical salience
- mechanism with variable selection criteria, which selects stimuli based on expectations, knowledge, and goals.

While top-down approaches, including psychoeducation and various forms of CBT, may assist in general awareness and understanding of anxiety, the challenge is that bottom up mechanisms tend to bypass these thinking processes and automatically shift resources and focus to the stimuli which is perceived as a potential threat (Porges, 2022; Sussman et al., 2016). In the counselling context, this difference may be fed back by

clients when they state that they 'know' about anxiety and 'still' cannot manage it. These quick response systems (e.g., the amygdala in the brain) have evolved to activate quickly to protect the person from threats, and the default of this process is to override conscious control (Porges, 2022). As you will see in the case study, a combination of top-down and bottom-up approaches can be helpful.

As with all mental health issues our clients face, there is potential ambivalence about change. As Westra (2012, p. 3) argued this ambivalence may arise when the negative effects of anxiety are countered by the "familiar patterns [that] have a seductive quality". In response to this ambivalence, we can use motivational interviewing and an appreciation of the stages of change as underpinning models (Westra, 2012). Further information on motivational interviewing can be found in this video while stages of change can be found in this video.

Increasing protective factors applies to anxiety interventions as well as in general counselling. Cabral and Patel (2020) identify protective factors in three areas: individual, family, and community. All combine to assist the client. As you read the lists offered by Cabral and Patel (2020), you will see that some target specific indicators of anxiety whilst others focus on broader issues:

- individual—ability to overcome adversity, adaptability, adequate sleep, conflict management skills, self-esteem, self-sufficiency, stress coping skills present
- family—affirmative parent-child relationship, cohesive family unit, higher parental education, parental employment and higher socioeconomic status, parental security, positive parenting, support from family
- community—community networks, empowered social relationships, integrated ethnic minority groups, positive environment and the school system, social awareness and involvement, social responsibility, support from friends and the community (p. 556).

TECHNOLOGY-ENHANCED INTERVENTIONS

We have many technology-enhanced interventions available for assisting with anxiety. These may be particularly appealing for younger clients who may be tech-savvy and they are also useful for clients who wish to develop autonomy. Many of these interventions are free or low cost and can be used within counselling sessions and/or by the client as self-help tools. They can also be combined with counselling interventions (Apolinário-Hagen et al., 2020). For example, anxiety sensitivity is an aspect of anxiety that can be worked on in counselling sessions using technology. Anxiety sensitivity involves fear related to the sensations and behaviours associated with anxiety or, as Capron et al. (2017) define it, fear of anxiety-related sensations. Anxiety sensitivity is a risk factor for anxiety issues (Capron et al., 2017). The difficulty in countering anxiety sensitivity is that it tends to be automatic cognitive processing which is unconscious, efficient, unintentional, and uncontrollable and focuses attention on threat-relevant information (Teachman et al., 2012).

To reduce anxiety sensitivity, the cognitive anxiety sensitivity treatment (CAST) focuses on the interoceptive conditioning that is a risk factor of panic disorders and separation anxieties (Schiele et al., 2021). This incorporates elements from two computer assisted programs:

1. anxiety sensitivity amelioration training (ASAT) which provides information on the nature of stress, effects of stress on the body, teaches participants about interoceptive conditioning along with instructions on exposure exercises, delivered via audiovisual computer presentations
2. 2. anxiety sensitivity education and reduction of training (ASERT) which includes psycho educative elements, stress reduction training, interoceptive exposure exercises focusing on respiratory distress (hyperventilation, breathing through a straw).

CAST incorporates the elements from both ASAT and ASERT in a more sophisticated computer presentation, video instructions of repeated interoceptive hyperventilation and straw breathing exercises, and quizzes testing comprehension of important material. The psychoeducation aspect of this approach is focused on the

nature of stress, its effect on the body, and dispelling the myths regarding the immediate dangers of stress. It highlights that anxiety may be a conditioned fear. This fear response elevates the anxiety sensitivity.

Other possibilities for effective programs and apps include:

- Made-4-Me program
- e-couch Social Anxiety program
- Mindspot Wellbeing course
- e-couch Anxiety and Worry program
- myCompass
- PANIC STOP!
- WorryTime app
- GAD Online program
- SAD Online program
- BeyondBlue Anxiety forum (Australian Government, Department of Health and Aged Care, 2019).

Counsellor reflection

While there is no 'one-size-fits-all' approach to intervening with anxiety and associated issues, it is useful to apply an integrative approach. That way, we can tailor interventions to incorporate both the evidence-based interventions and the clinical evidence we develop as counsellors. As an example, after 30 years in the field, I have experienced varying levels of success with clients who have anxiety using the approaches from cognitive behavioural theory. In part, this can be attributed to the complex clients I have worked with who need assistance with both their anxiety and contextual issues, including home and financial insecurity, domestic violence, and other issues.

The combination of evidence and clinical based interventions can be tailored to:

- the client's specific presentation of anxiety as each presentation of anxiety requires its own focus, e.g., responding to generalized anxiety is different to obsessive compulsive issues
- developmental issues, such as age of the client may be incorporated, e.g., counsellors work with play therapies to create safety for children while they may incorporate reminiscence therapy with older people
- specific attributes of the client, e.g., thinking biases, behavioural actions, emotional or regulation/dysregulation
- specific circumstances of the client, e.g., health and wellbeing, financial issues, substance and behavioural addictions.

The complexity of the interactions between the circumstances and the client attributes, as well as the form of anxiety that is specifically identified, provide clues for what may be effective for that client. It is also worth noting that direct focus on anxiety may lead to its escalation. This is where motivational interviewing or ACT's focus on values and present moment acceptance without judgement can be helpful. An additional clinical intervention I have found useful is the narrative therapy process of externalising the issue at hand so the client can separate themselves from the issue. It is also useful to draw on narrative therapy's alternative story which focuses on potential change rather than problem saturation.

GENERAL PRINCIPLES UNDERPINNING SPECIFIC INTERVENTIONS

One of the important aims of this book and this chapter is to offer an integrative approach in tailoring

interventions to the client. On this basis, we now turn to a number of general principles that can assist counsellors when working with clients with anxiety.

1. Establish and maintain a safe and regulated therapeutic relationship with the client. Therapeutic relationships are particularly important for clients who have anxiety as they provide safety (Porges, 2022). They can also provide a secure attachment for the client.
2. Obtain a comprehensive history from the client as this allows identification of biopsychosocial factors, developmental and contextual factors, their interrelationships, and their impact (WHO, 2022b).
3. Provide a referral to the client's GP for medical evaluation, in case specialised interventions are required.
4. Reassure the client that anxiety is an important survival response (reframing and psychoeducation can assist the client to rethink anxiety and its usefulness). A useful addition is externalising the anxiety from narrative therapy (Madigan, 2019). Externalising allows the client to gain some agency over the anxiety and appreciate its purpose in their lives.
5. Provide strategies for the client to be in the present moment rather than caught in their anxiety which is future-based. ACT and other approaches incorporating mindfulness emphasise the importance of this strategy.
6. Provide bottom-up strategies to assist the client when their anxiety is too high for top-down strategies (including grounding, breathing, relaxation, centring, expulsive such as skipping, singing, or similar) (Sussman et al., 2016). These strategies can assist the client to break the cycle of avoidance and escalation of anxiety.
7. Assist the client to identify the sources of anxiety and how to manage them more directly. An anxiety or exposure hierarchy is useful to identify the sources along with an extra column for specific strategies to assist the client. Having this in written form means the client can consult this when higher levels of anxiety exist which compromise the top-down strategies. Worry coping cards are an electronic version that can be integrated into the last column.
8. Assist clients to assess evidence for anxious thoughts and beliefs can be beneficial (CBT is the best source for this strategy). By focusing on the evidence, there is a redirection away from the anxiety and an awareness that the anxious thoughts may have no foundation.
9. Provide expanded physical awareness activities so the client moves beyond their own tendency to anxiety sensitivity (focus on areas of the body where there is no anxiety).
10. Ask the client to imagine this issue in 3 months then 6 months time and whether this aligns with what the client wants in their life. This is motivational interviewing and works to reduce the impact of the anxiety and offers the option that this can be managed. It also builds a commitment to change.
11. Refocus the client on what sort of life they wish to have (using ACT strategies of focusing on values). Focusing on strengthening protective factors can also assist.
12. Establish a broader and more nuanced vocabulary for affective states (often clients with anxiety have limited and high-intensity descriptions of their feelings, such as awful, terrible, intense) (Pine & Fox, 2015).
13. Increase emotional management strategies to intervene as low as possible when anxiety is building (dialectical behaviour therapy is useful here).

Case Study: Integrative interventions

A combination of the 'top down' and 'bottom up' interventions was employed with Jess. As Jess tended to overthink and catastrophise, cognitive strategies alone were not sufficient to assist. Additionally, the hyperarousal aspect was not effectively attended to through cognitive approaches alone. In part, this was due to the rapidity of responses to emotional stimuli. Emotions had generally been considered as negative and threatening rather than supporting Jess. Additionally, Jess had researched anxiety and could not understand why 'knowing about' anxiety was not enough.

Psychoeducation around the automatic and sometimes exaggerated perception of threat was discussed. This was externalised (a narrative therapy term) as 'anxious brain' so that Jess could distinguish between the fast-paced response of 'anxious brain' and the more deliberate and slower 'thinking brain'. An analogy of the light switch was used: when the amygdala (anxious brain) was switched on, the neocortex (thinking brain) switched off. So once the body was in an anxious and aroused state, the thinking and logical state was compromised. The importance of the anxious brain in protecting and keeping Jess safe was discussed alongside balancing that protective aspect with engaging the thinking brain to evaluate the perceived or actual threat.

Jess was particularly vulnerable to anxiety when with certain people (family members and manipulative friends), in certain social situations (groups of friends, family get togethers, work colleague gatherings), and where substances such as alcohol and marijuana were used solo or together. Jess suggested that keeping away from these situations was best. However, we discussed how avoidance actually promoted the anxiety aspect of these situations. Instead, we discussed ways that Jess could use appropriate boundaries, such as timekeeping and leaving when uncomfortable, avoiding the use of substances at these events, and ways to manage anxiety if it arose at these events. We also discussed preparation for such events through relaxation techniques such as focusing, grounding, and breathing.

MEDICATIONS

The primary psychotropic medications that are used to assist in anxiety management include SSRIs (Bandelow, 2020; Choi et al., 2020; LeDoux & Pine, 2016; Strawn et al., 2020), benzodiazepines which can assist in reduction of anxiety in some clients (Balon & Starcevic, 2020; Bandelow, 2020; Choi et al., 2020; Leoux & Pine, 2016), SNRIs (Bandelow, 2020; Choi et al., 2020; Craske & Stein, 2016; Strawn et al., 2020), and tricyclic antidepressants (Bandelow, 2020). However, we need to be clear that some medications are contra-indicated for certain forms of anxiety. As an example, Reavley et al. (2019) created a table showing the different forms of medication and the specific forms of anxiety they address. As with most medication, its efficacy alone is lower than when it is combined with counselling (Crakse & Stein, 2016). Capron et al. (2017) also highlight that medication requires careful consideration as once it is stopped, most gains from the medication are lost and may also remove the gains from counselling.

Learning activity 5

Please review*A guide to what works for anxiety* [PDF].
The table on page 20 highlights medical interventions and offers a ranking of their usefulness and contraindications.

Case Study: Returning to Jess

The use of medication as an adjunct to counselling was discussed with Jess in the first few sessions. This was to assess the openness to a holistic approach to interventions. Jess did not want to use any medication on an ongoing basis but did feel that the use of a relaxant might be of assistance when the anxiety was too high during the day or at night when sleeping was difficult. An appointment with Jess's GP was made between sessions and a script was accompanied by the GP's warning that the addictive quality of the relaxant and non-addressing of the underlying anxiety could be problematic. Jess committed to counselling in order to explore the underlying issues prompting anxiety. The counselling sessions allowed Jess to appreciate the underpinning issues causing anxiety,

misinterpretation of body signals via neuroception, strategies to challenge the anxious brain as it took over with thoughts that led to behaviours Jess did not wish to engage in, and safety was established and maintained through a secure therapeutic relationship. Healing for Jess was a longer term process given the early onset of anxiety and the reinforcing factors in Jess's relationships. Through Jess's persistence and willingness to continue in counselling, a point was reached where Jess could anticipate anxiety-provoking situations and how to manage them. Jess also learnt how to manage the immediacy of anxiety when it surfaced and how to use bottom up strategies to settle the nervous system. Jess continues to have a productive life which is less affected by anxiety and associated issues.

CONCLUSION

This chapter introduced the different forms of anxiety and highlighted that not all anxiety is neurotic or unhelpful. The chapter discussed the complexities of anxiety, including its co-existence with a variety of medical issues, other mental health issues, and between the different forms of anxiety. The impacts of anxiety in its various forms may impact all aspects of a client's life. It is therefore crucial for counsellors to understand the circumstances in which the client finds themselves. Equally important are the client's thinking, behaving, affect, and coping responses. There are multiple interventions available to clients both within a counselling context and in other healing orientations. Our role as counsellors is to appraise best fit for our client, in a collaborative and client-focused approach.

RECOMMENDED RESOURCES

This section highlights some of the resources available to you when working with anxiety issues. It is recommended that you also see the list of references for this chapter as it offers many resources for your use.

RESOURCES

- Creating a story of safety: A polyvagal guide to managing anxiety. [Video].
- Arden, J., & Lindford, L. (2009). *The heal your anxiety workbook: New techniques for moving from panic to inner peace*. Quarto Publishing Group USA. This is a useful workbook for clients as part of counselling processes. According to my own reading and that of many clients I have referred to this book, it is readable and informative.
- *Coping with anxiety [PDF]*: A useful resource for both counsellor and client use.
- Beyond Blue: As there is often a co-existence of anxiety and depression, Beyond Blue has developed resources for both.
- Black Dog Institute offers information on anxiety and also other mental health issues. This includes a mental health assessment tool.
- Centre for Clinical Interventions. clinician resources demonstration videos for counsellors.
- by Headspace
- Head to Health website which provides valuable information on technology and applications that can assist both counsellors and clients.
- Kim, Y.-K. (Ed.) (2020). Anxiety disorders: Rethinking and understanding recent discoveries. Springer. https://doi.org/10.1007/978-981-32-9705-0_28
- Queensland Government, Department of Health. (2022). *Anxiety disorders. https://www.headtohealth.gov.au/mental-health-difficulties/mental-health-conditions/anxiety-disorders*

- SANE. SANE is an organisation that works for people with complex mental health issues. This is a useful site for many clients and provides resources and communities with whom they can connect.
- The Dulwich Centre. Various videos on the application of narrative therapy to issues. Whilst narrative therapy is not mentioned in the Reavley et al. (2019) analysis offered in this chapter, it has been found effective in many domains of counselling practice. Of particular note is their work on creating cultural resonance with Aboriginal and Torres Strait Islander peoples.
- Therapist Aid is an excellent website that offers many worksheets for use in counselling. This link takes you directly to the dialectical behaviour therapy worksheets.

GLOSSARY OF TERMS

Forms of anxiety:

anxiety—a response to stressful situations accompanied by feelings of worry, nervousness, and/or apprehension

coronaphobia—fear and anxiety about COVID-19

eco-anxiety—a chronic fear of environmental degradation due to the sense that ecological foundations of existence are collapsing

generalised anxiety—a free-floating form of anxiety that something is just not right

phobic anxiety—anxiety associated with situations such as giving a speech, sensations such as fear of falling, or fear of animals or insects such as cats or spiders

complex post-traumatic stress disorder (CPTSD) and post-traumatic stress disorder (PTSD)—episodic and acute anxiety, associated with flashbacks, and can be triggered to the level of the panic attack by stimulus like a car backfiring

health anxiety—persistent and excessive fear of being seriously ill

obsessive compulsive disorder (OCD)—fear that a catastrophe is waiting to happen and can be forestalled by the use of rituals, such as putting things in a particular order or scrubbing the hands

psychotropic medication—any medication that affects behaviour, mood, thoughts, or perception, including anti-depressants, anti-psychotics, and mood stabilisers

separation anxiety—anxiety arising when separation from major attachment figures occurs

test anxiety—a transitory state anxiety related to possible negative consequences of failure on an exam

Diagnostic tools:

DSM—the DSM is the abbreviation for the Diagnostic and Statistical Manual of Mental Disorders. This text is a classification guide for psychiatric disorders and is used within clinical psychology, psychiatry, and research. The current manual is in its 5-TR edition.

ICD—the ICD is the abbreviation for the International Classification of Diseases. It is now in its 11th edition.

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AUTHOR INFORMATION

Dr Christine Chinchen has been engaged as an educator, academic researcher, and writer for over three decades. Her background in adult education featured in her 2020 PhD on learning in tertiary education and is applied in learning processes in counselling education. During her career, Christine has been an educator in both VET and Higher Education, teaching from Diploma to Masters levels, in both independent higher education providers and universities. She worked for agencies and non-government organisations for over a decade before setting up private practice on the Northern Beaches of Sydney. Clinical supervision of organisations and individual counsellors and psychologists has been part of her practice for over fifteen years.

As an experienced counsellor, Christine specialised in issues such as trauma, crisis, complex family issues including domestic violence, loss and grief, and suicide prevention.

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Child Maltreatment

GOVIND KRISHNAMOORTHY; KAY AYRE; BRONWYN REES; AND SAMANTHA BROWN

ABSTRACT

Research across several decades has repeatedly pointed to the high prevalence of child maltreatment in our communities, and its life-long impact on our physical and mental health. This chapter will: provide an overview of key theoretical models of the nature and impact of child maltreatment; explore key principles of practice and treatment modalities when working with at-risk families; and conclude with a discussion of the need for counsellors to practice self-awareness, self-reflection, and self-care when working with such vulnerable populations.

Learning Objectives

- Identify the prevalence and aetiology of child maltreatment.
- Explore the impact of child abuse and neglect on physical and mental health.
- Identify general principles of trauma-informed care as it relates to screening, assessment, and intervention.
- Identify common interventions and programs utilised with children and families where there are concerns of child maltreatment.
- Evaluate the impact of traumatic stress on counsellors and organisations.

INTRODUCTION

Bowlby (1977) argued that humans need to make strong emotional bonds and these bonds are initially with their caregivers. What happens when this is disrupted and becomes unsafe? What can we, as counsellors, do to support children and families in situations where their fundamental needs aren't being met?

Research across several decades has exposed a high prevalence of child maltreatment in communities around the world, and shone new light on the far-reaching impact on health and wellbeing across the lifespan. Adversity and maltreatment in childhood may be the result of intentional or unintentional caregiving behaviours, and can include acts of omission (e.g., neglecting to provide sufficient food or shelter) and commission (e.g., physical abuse in the form of excessive physical discipline) (Bromfield et al., 2007). Fraught with heart-breaking situations that are complex and multilayered, working in the area of child maltreatment requires counsellors to not only be aware of best practice standards, but also reflective of their own reactions and wellbeing. Furthermore, given the high prevalence and deleterious impact of child maltreatment, *all* counsellors irrespective of their chosen area of practice, have a responsibility to be familiar with the complex nature of child maltreatment and how to best support these vulnerable families.

HOW ARE CHILD ABUSE AND NEGLECT DEFINED?

In the early 1960s, Dr. C. Henry Kempe and his associates identified the 'battered child syndrome' after encountering a number of children presenting to hospital with unexplained fractures and subdural hematomas, and speculated that they may have been inflicted by the parents (Kempe et al., 1962). The published findings described the scope of child abuse, and the report shocked many medical and social service professionals. The identification of this phenomenon drew significant attention to the problem. Since this time, definitions of various forms of child maltreatment have changed and have been debated around the world. Child maltreatment includes physical maltreatment, emotional maltreatment, sexual abuse, and/or neglect. These forms result in actual or potential harm to the child including to their health, development, dignity, and in extreme cases, survival (Butchart et al., 2006).

There are several forms of child maltreatment. The physical abuse of a child is defined as those acts of commission by a caregiver that cause actual physical harm or have the potential for harm (Mikton & Butchart, 2009). Sexual abuse is defined as those acts where caregivers use a child for sexual gratification (WHO, 2006). Definitions of emotional abuse include the failure of a caregiver to provide an appropriate and supportive environment, and include acts that have adverse effects on the emotional health and development of a child (WHO, 2006). Such acts include restricting a child's movements, denigration, ridicule, threats and intimidation, discrimination, rejection, and other non-physical forms of hostile treatment. Neglect refers to the failure of a caregiver to provide for the development of the child – where the caregiver is in a position to do so – in one or more of the following areas: health, education, emotional development, nutrition, shelter, and safe living conditions (WHO, 2006). Neglect is thus distinguished from circumstances of poverty in that neglect can occur only in cases where reasonable resources are available to the family and caregiver. Emerging research has also pointed to the adverse impact of witnessing domestic and family violence on children, with several scholars suggesting it as a form of child maltreatment in and of itself (Bromfield et al., 2007). The research literature demonstrates that witnessing can involve a much broader range of incidents, including the child hearing the violence; being used as a physical weapon; being forced to watch or participate in assaults, or being informed that they are to blame for the violence because of their behaviour (Humphreys, 2007). Children's exposure to domestic and family violence has been found to have both short-term and long-term impacts on their development. Indeed, several studies indicate that the relation between exposure to violence and child adjustment problems is evident for periods of 10 years or more (e.g., Narayan et al., 2013).

EPIDEMIOLOGY: THE EXTENT OF THE PROBLEM

While child maltreatment was previously believed to be a rare or infrequent occurrence, large-scale epidemiological studies have discovered higher rates of child maltreatment in the general population. The Adverse Childhood Experiences (ACE) Study (Felitti, 1998) in the United States found that up to two thirds of the adults surveyed in the study reported the experience of one or more types of adverse childhood events, and up to 87% of the sample reported the experience of two or more types of such events (Anda et al., 2006). Prevalence estimates ranged from 5%-18%, with the majority of studies finding rates between 5% and 10%. Three contemporary Australian studies have measured child neglect in community samples (Price-Robertson et al., 2010). Prevalence estimates of neglect ranged from 1.6% to 4%. Three recent Australian studies and one Australian systematic review have estimated the prevalence of emotional maltreatment. Although the studies were all conducted with relatively large community samples, their prevalence estimates were quite different, ranging from 6% (Rosenman & Rodgers, 2004) to 17% (Price-Robertson et al., 2010). The best available evidence suggests that the prevalence rate for emotional maltreatment in Australia is between 9% and 14% (Chu et al., 2013; Moore et al., 2015). Community-based studies have estimated the extent to which Australian children are exposed to family violence – ranging from 4% to 23% of children (Price-Robertson et al., 2010).

THEORIES OF CHILD MALTREATMENT

The first major movement to protect children began during the early 1800s the doctrine of *parens patriae* (literally, the "state as the father") was introduced into English law to protect the rights of children. It allowed children to "emancipate" into adulthood at age 21 and protected the property rights of minors when the caregiver was abusing these rights. Since this time, many theories have been used to explain child maltreatment. The historical evolution of theories about child maltreatment falls into four progressive stages. The first is the "speculation" period of the 1960s when the phenomenon of child abuse and neglect first came into public awareness. The second is the "introspection" period of the 1970s when unidimensionality theories were prevalent. Third is the "diversity" period that explored more ecologically based theoretical explanations. Fourth was the 1990s classified as "multidisciplinary integration" with the embrace of the ecological-transactional model of child maltreatment that guides much of maltreatment practice and research today.

Bronfenbrenner (1979) first proposed an ecological perspective of human development, and Belsky (1980) applied the model to child maltreatment. What separates the ecological model from other theoretical models is its deviation from single-focused processes to a transactional and multilevel explanation. Belsky (1980) coupled the theoretical models of Bronfenbrenner and Tinbergen to develop the ecological model. It is explained in four levels: (1) ontogenic; (2) microsystem; (3) exosystem; and (4) macrosystem (See Figure 1). Ontogenic factors relate to the childhood histories of abusive caregivers (Belsky, 1980). The purpose of this exploration is to assess how a particular caregiver grows to behave in an abusive manner. The occurrence of abuse or neglect in childhood alone is insufficient to explain the phenomenon of child maltreatment because the majority of those who were maltreated fail to maltreat their own children. Yet the developmental history of the caregivers may predispose them to respond to certain situations in the microsystem or exosystem. The microsystem refers to the immediate context in which child maltreatment takes place and includes the family system, the maltreatment itself, and both caregiver and child characteristics. The exosystem encompasses the individual and family within larger social structures, including both formal and informal structures.

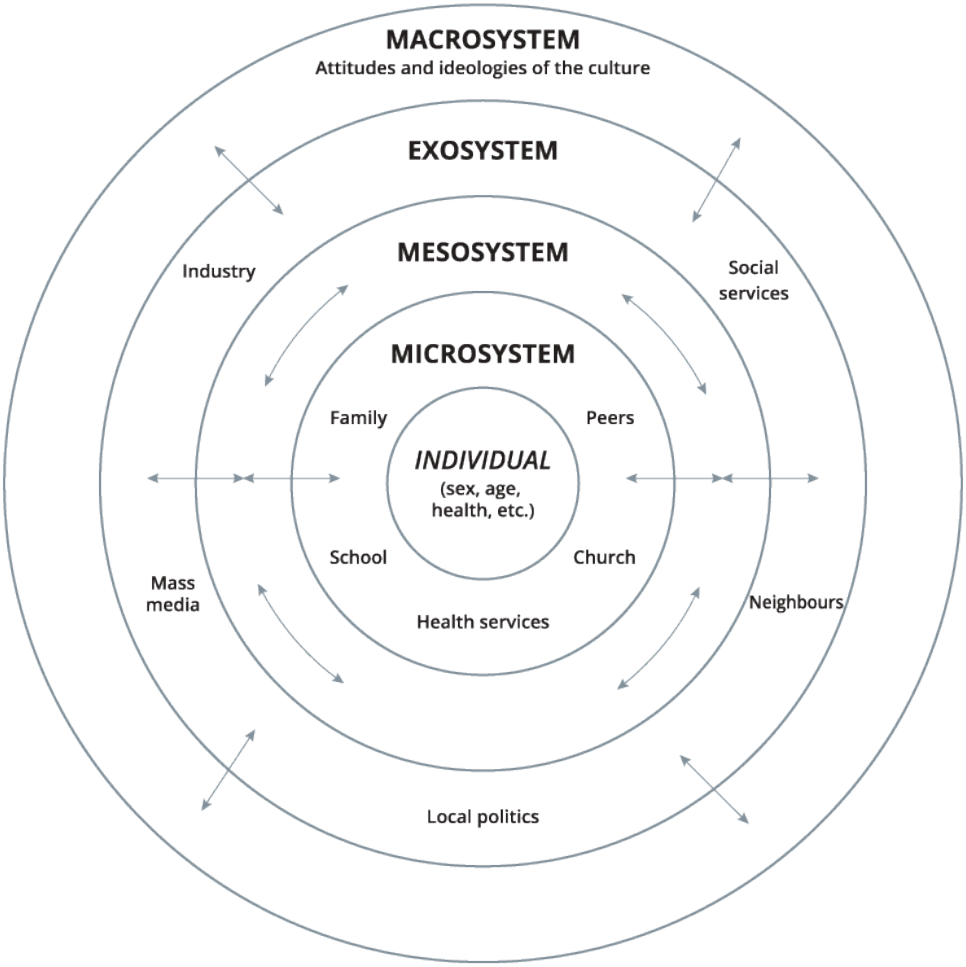

Figure 1: Bronfenbrenner's ecological systems theory by Hchokr is licensed under CC BY-SA 3.0

More recently, researchers have focused on the cumulative risk hypothesis that posits that human development may be jeopardized by "constellations of risk" rather than isolated adverse events (see Figure 1; Evans et al., 2013). Referred to as the cumulative ecological transactional models of child maltreatment, such models suggest that the psychological health outcomes of children are dependent on the accumulation of risk factors across contexts (e.g., home, school) and time (e.g., during infancy, early childhood, adolescence) (Bryce, 2018). Measures of the effects of such cumulative harm have been found to be predictive of a wide range of physical and mental health problems, such as paediatric asthma (Everhart et al., 2008), obesity (Evans et al., 2013), stroke (Mohan et al., 2011), and psychiatric disorders (Gruhn & Compas, 2020). These risk and protective factors are discussed further in the next section.

Learning activity 1

Listen to Professor Cicchetti speak about Child Maltreatment [47:42].

One or more interactive elements has been excluded from this version of the text. You can view them online here:
https://usq.pressbooks.pub/counselling/?p=57#oembed-1

AETIOLOGY: WHAT ARE THE RISK FACTORS FOR CHILD ABUSE AND NEGLECT?

As discussed in the earlier section, there is no single factor which causes child abuse and neglect. Factors related to the characteristics of the child that increase the risk of maltreatment include the age, sex, and presence of a disability. Fatal cases of physical abuse are found largely among young infants (Berkowitz, 2017). Physical abuse seems to peak for children at the age of 6 to 12 years (Fingarson et al., 2019). Sexual abuse rates, on the other hand, tend to rise after the onset of puberty, with the highest rates occurring during adolescence (Fingarson et al., 2019). In most countries around the world, girls are at higher risk than boys for infanticide, sexual abuse, educational and nutritional neglect, and forced prostitution. Male children have been identified as being at greater risk of harsh physical punishment (Berkowitz, 2017). Premature infants, twins, and children with disabilities have been shown to be at increased risk for physical abuse and neglect (Henry, 2020).

The multiple determinants of child maltreatment have important implications for how counsellors understand a child and family's needs and how they plan their interventions. Lay explanations of why child maltreatment occurs may be overly simplistic, (e.g., blaming caregivers for not taking sufficient responsibility, or blaming societal trends and incidences on the increased incidence). Assessment of a child and a family's needs across multiple domains and systems may highlight to the counsellor the systemic needs of both the child and the family that may need to be addressed, either before or in conjunction with, the counselling provided to the family.

THE IMPACT OF CHILD ABUSE AND NEGLECT: BIOPSYCHOSOCIAL EFFECTS

Children are impacted by maltreatment in various ways. Bromfield et al. (2007) describe key dimensions by which children may vary in their experience of abuse and neglect:

- the types of abuse and neglect the child is exposed to (e.g., sexual abuse, physical abuse, neglect)
- the frequency, severity, and duration of the maltreatment
- the age and developmental status of the child when the abuse occurred
- the relationship between the child and those who are seen as linked to the maltreatment occurring.

Child abuse and neglect that occurred over different development stages has been found to have a profound and exponential impact over a child's life, with adverse consequences felt throughout the life course (Masten, 2018). Such findings highlight the importance of considering the history of maltreatment and its impact on the individual, rather than just an isolated episode of abuse. Referred to as 'multitype maltreatment', vulnerable children are most often exposed to a number of different forms of maltreatment experiences across their

development (Higgins & McCabe, 2003). This is an important consideration to understand the cumulative harm experienced by children, and their ongoing cumulative and chronic risk into the future (Sheehan, 2019).

Neurobiological development

Infancy and early childhood are marked by rapid growth of the brain. Between birth and two years of age, the number of neurons, the cells that make up the brain, are said to have increased by 500% (McCrory et al., 2017). This rapid development of the brain is dependent on the child's early experiences and the environments they live in. Thus, appropriate and responsive care and stimulation are important in order to allow for optimal growth of brain circuitry (Sheridan & Nelson, 2009). Researchers studying young children who were deprived of appropriate care have found significant decreases in overall brain size and volume (Perry, 2008). A decrease was particularly noted in children's prefrontal cortex, often associated with complex cognitive tasks, such as decision making and controlling emotions (McCrory et al., 2017; Perry, 2008). Research on the physiological effects of maltreatment have focused on changes to the human stress response – a complex phenomenon involving multiple human organs, designed to help us respond to threats and danger in our environment (LeDoux & Pine, 2016). This stress response is said to have evolved as a survival mechanism, enabling people and other mammals to fight the threat off or flee to safety. Unfortunately, chronic exposure to stressful experiences may mean that our bodies overreact to stressors that are not life-threatening, such as traffic jams, work pressure, and family difficulties (LeDoux & Pine, 2016). Findings have consistently shown that prolonged and chronic exposure to stress, sometimes referred to as 'toxic stress', alters the function and pattern of the physiological stress systems in children. This causes the child to either react with excessive feelings of stress to potentially benign situations and/or to not identify or act protectively in situations of potential danger and threat (Cicchetti et al., 2011).

Resource: For an introduction to the impact of child maltreatment on the brain, be sure to read Dr. Bruce Perry's seminal book, 'The Boy Who Was Raised as a Dog: What traumatised children can teach us about loss, love and healing'.

Cognitive and language development

Research has repeatedly found that exposure to adverse experiences early in childhood is consistently associated with critical lags in cognitive development and numerous academic difficulties (Chugani et al., 2001; Gould et al., 2012) associated with attention, language skills and working memory. Cognitive and language competencies are strong indicators of a child's school readiness with respect to literacy, capacity to follow instructions, receptivity to performance evaluations, and ability to navigate peer interactions (Spratt et al., 2012). As early childhood is a sensitive period for language development, maltreated children are at particular risk for language delays. In a meta-analytic review examining maltreatment and language, Sylvestre et al. (2016) found that the language skills of children who have experienced abuse or neglect are delayed when compared to children without such experience with young children being particularly vulnerable to the language effects of maltreatment.

Social and emotional development

Social and emotional development involves the capacity to understand the self and others, to form relationships and to experience, regulate and express emotions. The development of such skills depends on the quality of relationships and the childhood caregiving environment (Thompson, 2016). Attachment theory, first formulated by the psychoanalyst John Bowlby, emphasised the need for infants to have an attachment to their caregivers. This attachment is a strong emotional bond, where caregivers were perceived as a source of comfort and reassurance, rather than just a source of fear and harm (Bowlby, 1977). Bowlby hypothesised that attachment relationships had evolved to maintain proximity between infants and their caregivers, to increase the chance of protection – particularly in times of danger and threat.

Building on Bowlby's work, and utilising observations of separations and reunions among infants and their caregivers, Mary Ainsworth identified three distinct patterns of infant attachment or attachment styles. The three styles were secure, anxious-resistant and avoidant. Children classified as secure attached were found to welcome their caregiver's return after separations, and if distressed, sought proximity and comfort from them (Ainsworth et al., 1978). In contrast, infants classified as having 'insecure attachments' were found to either follow an anxious-resistant or anxious-avoidant pattern. Anxious-resistant infants were found to show ambivalent behaviours towards their caregiver and an inability to be comforted during reunions with their caregivers. Infants classified as anxious-avoidant were found to avoid proximity or interaction with the caretaker on reunion (Ainsworth et al., 1978). More recent research has pointed to the presence of a fourth attachment style, commonly observed in maltreated children, labelled as 'disorganised'. It is a mix of anxious-ambivalent and anxious-avoidant attachment styles – frequently observed amongst infant and children exposed to unpredictable, chaotic, and frightening caregiving relationships and environments (Main & Solomon, 1990). Population level studies on attachment styles have found that up to 55-59% of children have secure attachment styles, avoidant attachment styles constitute up to 25% and anxious attachment in 11 to 20% of the population. The disorganised attachment styles have been found to be prevalent in the general population between 1 to 5%, with up to 85% of children in foster care displaying behaviours consistent with a disorganised attachment style (Mickelson et al., 1997).

Learning activity 2

For an illustration of the importance of healthy childhood attachment, watch this video of Professor Edward Tronick's landmark research utilising the 'still face' paradigm [2:49].

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=57#oembed-2

Children's mental health

The impact of maltreatment on mental health has primarily been studied through its manifestations in symptoms of post-traumatic stress disorder (PTSD). Childhood trauma, and the resultant 'toxic stress' response, has been defined as the emotional reaction to exposure to an event that threatens or causes harm to a child's emotional and physical wellbeing (NCTSN, 2015). PTSD symptoms can manifest themselves in the form of: re-experiencing the traumatic event (often through play in children); avoidance of triggers that serve as reminders of the frightening and traumatic experience; hyper-arousal; disturbed sleep; increased irritability, aggression, and alertness; temper tantrums; and startled and extreme responses to stimuli (Scheeringa et al., 2015). Individuals with a history of childhood maltreatment were found to have poor response to treatment compared to non-maltreated individuals with similar mental health diagnoses (Teicher & Samson, 2016).

SCREENING AND ASSESSMENT

The first step in helping children who have been maltreated is to recognise signs of maltreatment as part of the screening and assessment process. The presence of a single sign does not necessarily mean that child

maltreatment is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination. The assessment of the presence and impact of child maltreatment is crucial as part of a rigorous screening and assessment process. For children and adolescents, identifying the signs of maltreatment and acting protectively addresses immediate safety concerns and stops the continuing victimisation of the child or adolescent.

A child may directly disclose to you that he or she has experienced abuse or neglect. In such cases, it is important that you are acquainted with the relevant child protection legislative requirements of the jurisdiction in which you are working, and be aware of your organisation's child reporting requirements. In Queensland, Australia, the *Child Protection Act 1999* (Qld) requires certain professionals, referred to as 'mandatory reporters', to make a report to child protection services, if they form a reasonable suspicion that a child has suffered, is suffering, or is at an unacceptable risk of suffering significant harm caused abuse, and may not have a caregiver able and willing to protect them. Please note that counsellors may or may not be considered mandatory reporters – depending on your occupational setting and state or territory level legislation. As requirements are different across states in Australia, and across services, it is advised that you seek clarifications regarding your role in reporting child protection concerns.

Learning activity 3

Making decisions about removing a child from a potentially unsafe home environment can be complex. The Australian Broadcasting Corporation (ABC) offer an interactive news article to illustrate the complexities of decisions in child protection: You decide: Would you remove these children from their families?

Prior to assessing the impact of child maltreatment, it is worth considering your role in the service within which you work, and how you may explain your role to the children and families with whom you are working. For example, some young clients might assume that counsellors are the police or child protective services and that they may get into trouble or removed for making disclosures or discussions of the impact of traumatic experiences. The process of assessment can require more than a single session to complete and should also use multiple avenues to obtain the necessary clinical information, including self-assessment tools (see Resource section below), past and present clinical and medical records, structured clinical interviews, assessment measures, and collateral information from significant others, other behavioural health and child protection professionals and agencies.

Learning activity 4

There are a number of psychometric assessment tools that can support your assessment and monitoring of trauma symptoms in children and adolescents. The National Child Traumatic Stress Network (NCTSN) from the United States offers a contemporary review of a number of reliable and valid measures: All measure reviews

PRACTICE IMPLICATIONS

The following are some considerations when conducting assessments with clients exposed to child maltreatment.

Clarify for the client what to expect in the screening and assessment process

Inform the client, in a developmentally appropriate manner, that the screening and assessment phase focuses on identifying issues that might benefit from treatment. Inform them that during the interview, uncomfortable

thoughts and feelings can arise. Provide reassurance that, if they do, you will assist in dealing with this distress, but also let them know that, even with your assistance, some psychological and physical reactions to the interview may last for a few hours or perhaps as long as a few days after the interview, and be sure to highlight the fact that such reactions are normal (Read et al., 2003).

Approach the client in a matter-of-fact yet supportive manner

Such an approach helps create an atmosphere of trust, respect, acceptance, and thoughtfulness (Melnick & Bassuk, 2000). Doing so helps to normalise symptoms and experiences generated by the maltreatment; consider informing clients that such events are common but can cause continued emotional distress if they are not treated. Clients may also find it helpful for you to explain the purpose of certain difficult questions. Demonstrate kindness and directness in equal measure when assessing clients (Najavits, 2002).

Respect the client's personal space

Cultural and ethnic factors vary greatly regarding the appropriate physical distance to maintain during the interview. You should respect the client's personal space, sitting neither too far from nor too close to the client. Let your observations of the client's comfort level during the screening and assessment process guide the amount distance and position in the room. Clients with trauma may have particular sensitivity about their bodies, personal space, and boundaries.

Adjust tone and volume of speech to suit the client's level of engagement and degree of comfort in the interview process

Strive to maintain a calm and quiet demeanour. Be sensitive to how the client might hear what you have to say in response to personal disclosures. Clients who have been experiencing symptoms of trauma may be more reactive even to benign or well-intended questions. Avoid phrases that imply judgement about the maltreatment. For example, questions such as "why didn't you tell someone when it happened?" may imply blame and not sufficiently acknowledge complex psychological processes linked to shame, shock and stigma related to experiences of abuse and neglect.

Provide appropriate symbols of safety in the physical environment

These include paintings, posters and other room decorations that symbolise the safety of the surroundings to the client population. Such considerations may be particularly pertinent for children with autism and developmental disabilities, who may experience sensory issues. This can involve both hyper-sensitivities (over-responsiveness) and hypo-sensitivities (under-responsiveness) to a wide range of stimuli, including particular lights, sounds, and smells in the counselling setting. An assessment of such sensory sensitivities and preferences with such children may be advised.

Give the client as much personal control as possible during the assessment

Present a rationale for the interview and its stress-inducing potential, making clear that the client has the right to refuse to answer any and all questions. Giving the client (where staffing permits) the option of being interviewed by someone of the gender with whom he or she is most comfortable, postponing the interview if necessary (Harris & Fallot, 2001).

Allow time for clients to become calm and oriented to the present if they experienced very intense emotional responses when recalling or acknowledging feelings of distress

At such times, avoid responding in excessively emotive ways (Bernstein, 2000). If the client has difficulty self-soothing, guide them through strategies to help them with their distress (e.g., grounding exercises).

Be mindful of barriers to disclosing child maltreatment

There are two main barriers to the evaluation of child maltreatment and its impact on clients. The first is related to differences in the perceptions between the client and the counsellor in regard to what is considered abuse and neglect. Some clients might not have ever thought of a particular event as abusive, or their response to it as traumatic, and thus might not report or even recall the event. Some clients might feel a reluctance to discuss something that they sense might bring up uncomfortable feelings (especially with a counsellor whom they have only recently met). Clients may avoid openly discussing traumatic events or have difficulty recognising or articulating their experience of trauma for other reasons, including a feeling unsafe to share experiences, feelings of shame, guilt, or fear of retribution by others associated with the event (e.g., in cases of interpersonal or domestic violence). Still others may deny their history because they are tired of being interviewed or asked to fill out forms and may believe it does not matter anyway.

Cultural considerations

Finally, as with all other presenting concerns, the screening and assessments of child maltreatment must take adequate consideration of culture, ethnicity, and race. Factors, such as norms for expressing psychological distress and the stigma associated with seeking help may influence engagement with the assessment process.

INTERVENTION: TRAUMA-INFORMED CARE AND SPECIFIC INTERVENTION MODALITIES

TRAUMA-INFORMED CARE

With increasing recognition of the pervasiveness of child abuse and neglect, and the impact of traumatic stress on children and families, awareness is growing of the importance of 'trauma-informed' approaches to psychological interventions. Trauma-informed care refers to the understanding, anticipating, and responding to issues, expectations, and special needs that a person who has been victimised may have in a particular setting (Lang et al., 2016). At a minimum, trauma-informed practitioners must endeavour to do no harm—that is, to avoid re-traumatising or blaming clients for their efforts to manage their traumatic reactions (Fallot & Harris, 2008). Trauma-informed care requires a commitment from practitioners and services to understanding traumatic stress and to developing strategies for responding to the complex needs of survivors.

PRACTICE IMPLICATIONS: TRAUMA-INFORMED CARE PRINCIPLES

Harris and Fallot (2001) have summarised trauma-informed care as being grounded in eight key principles. These are:

1. Understanding trauma and its impact

Understanding traumatic stress and how it impacts people and recognising that many behaviours and

responses that may seem ineffective and unhealthy in the present, represent adaptive responses to past traumatic experiences.

2. Promoting safety

Establishing a safe physical and emotional environment where basic needs are met, safety measures are in place, and provider responses are consistent, predictable, and respectful.

3. Ensuring cultural competence

Understanding how cultural context influences one's perception of and response to traumatic events and the recovery process; respecting diversity, providing opportunities for clients to engage in cultural rituals, and using interventions respectful of and specific to cultural backgrounds.

4. Supporting control, choice, and autonomy

Helping clients regain a sense of control over their daily lives and build competencies that will strengthen their sense of autonomy; keeping consumers well-informed about all aspects of the system, outlining clear expectations, providing opportunities for clients to make daily decisions and participate in the creation of personal goals, and maintaining awareness and respect for basic human rights and freedoms.

5. Sharing power and responsibility

Promoting democracy and equalisation of the power differentials across the program; and sharing power and decision-making across all levels of an organization, whether related to daily decisions or in the review and creation of policies and procedures.

6. Integrating care

Maintaining a holistic view of consumers and their process of healing and facilitating communication within and among service providers and systems.

7. Healing happens in relationships

Believing that establishing safe, authentic, and positive relationships can be corrective and restorative to survivors of trauma.

8. Recovery is possible

Understanding that recovery is possible for everyone regardless of how vulnerable they may appear; instilling hope by providing opportunities for consumer and former consumer involvement at all levels of the system, facilitating peer support, focusing on strength and resiliency, and establishing future-oriented goals.

In this way, trauma-informed care is grounded in an understanding of and responsiveness to the impact of trauma. Such practices emphasise the physical, psychological, and emotional safety for both providers and survivors, and that creates opportunities for survivors to rebuild a sense of control and empowerment. Given the prevalence of childhood adversity, and the complex nature of assessing for these concerns, the principles of trauma-informed care form a standard for how interventions and practices are delivered to *all* clients – not simply those who are diagnosed with PTSD, or have disclosed being exposed to traumatic experiences.

PREVENTION AND INTERVENTION

Counsellors have an important role to play in designing and implementing primary prevention programmes for child maltreatment. At present, there are relatively few evidence-based interventions available for children exposed to child maltreatment, and their families (Altafim & Linhares, 2016). Research on efficacious interventions following concerns of child abuse and neglect involves a multi-systemic approach – with a focus on interventions targeted at both the child and significant adults in the child's life. While it is beyond the scope of this chapter to provide a detailed of interventions in detail, the remainder of this section will briefly review some promising approaches and programs for children of various ages.

Children under five years

For young children, attachment-based interventions focused on improving the relationships between children and their key attachment figures (often, caregiver) are recommended. Programs such as the attachment and biobehavioural catch-up (Dozier et al., 2017) help the caregiver to respond more sensitively to children. Another example of such promising intervention is the circle of security parenting program (Cooper et al., 2009). The program focuses on attachment. COSP takes an innovative approach to help caregivers increase their capacities to serve as a source of security for their children (i.e., to provide a secure base) (Bowlby, 1988), with the idea that this increases caregiver sensitivity and reduces the risk of insecure and disorganised attachment. This intervention was designed with implementation efficiencies and value in mind, in collaboration with staff from the real-world contexts in which it is to be implemented and the diverse at-risk families it is intended to serve (e.g., early childhood programs) (Cooper et al., 2009). Similarly, the program child-parent psychotherapy (CPP) (Lieberman et al., 2006) uses the attachment relationship as the vehicle for improving the child's emotional, cognitive, and social functioning. The child and caregiver are seen in joint sessions that focus on promoting emotion regulation in both the child and the caregiver (Lieberman et al., 2006).

Children aged 12 and under

Significant research has focused on interventions aimed at improving parenting/caregiving skills amongst families using principles of behavioural theory and operant conditioning (Skinner, 1972). For example, Pathways' triple P (Petra & Kohl, 2010), a modified version of the evidence-based parenting program triple P (Sanders et al., 2003), has shown promise in improving parenting/caregiving skills and attitudes, increasing parenting/caregiving efficacy, and reducing child behaviour problems of at-risk children and families (Sanders et al., 2004). Certain interventions have aimed to help parents/caregivers with other psychological problems which are not exclusively associated with the parenting/caregiving role, such as anger management, mood regulation, and addressing drug abuse. For example, the parenting under pressure (PUP) program (Harnett & Dawe, 2008) is an intensive, home-based intervention underpinned by two key constructs: (i) that child wellbeing is dependent on the parent/caregiver's capacity to provide a sensitive, responsive and nurturing caregiving environment; and (ii) that in order for this to occur, a parent/caregiver needs to be able to understand and manage their own affect both in relation to parenting/caregiving and to managing substance abuse problems (Barlow et al., 2013).

The emergence of neuroscientific impacts of child maltreatment on the brain has spurred the development of programs such as the neurosequential model of therapeutics (NMT) (Perry, 2006). NMT offers assessments to children exposed to maltreatment and other forms of trauma, to support the sequencing of interventions (educational, enrichment, and therapeutic) in a way that reflects the child's specific developmental needs in a variety of key domains, and is sensitive to core principles of neurodevelopment (Perry, 2008). With older children, the negative self-evaluative beliefs and beliefs about power and violence in relationships that evolve in response to the experience of abuse may be addressed in individual therapy (e.g., trauma focused cognitive

behaviour therapy (TF-CBT) (Cohen et al., 2012), or even group therapy (e.g., dialectical behaviour therapy for adolescents (DBT-A) (Rathus & Miller, 2014).

Children and young people aged 17 and under

Interventions for older adolescents have focused on the wider system and aim to reduce stress and increase social support. Programs such as the multisystem therapy for child abuse and neglect (MST-CAN) (Swenson & Schaeffer, 2014) offer interventions that are tailored to the ecology of the family as mapped out during the assessment process. Some examples of interventions are working with the extended family to increase the amount of support they offer the child's primary caretaker; arranging a befriender, a home help or a counsellor home-visiting service for an isolated parent; arranging participation in a local parent support self-help group; or organising a place for the child and caretaker in a local mother and toddler group (Swenson & Schaeffer, 2014). In this way, the program acknowledges the factors across various systems impacting a child and their family, and works to modify aspects of these environments to mitigate the risks of child maltreatment in the future.

PROFESSIONAL ISSUES: SECONDARY TRAUMATIC STRESS AND SELF-CARE

Learning about child maltreatment often invokes strong feelings among health professionals. For example, some counsellors develop a strong urge to protect the child at all costs – minimising or denying any loyalty the child may have towards their caregivers, or any potential for change on the part of the caregivers. Another common reaction can be a strong urge to protect or rescue the caregivers. In these cases, the counsellor may defend criticisms raised about the caregivers by other professionals, explain away or deny any caregiving shortcomings. These reactions may get in the way of professionals cooperating with each other and working in the best interests of the family. For example, many counsellors have had some personal loss or even traumatic experience in their own life (e.g., loss of a family member, death of a close friend). To some extent, the pain of experiences can be "re-activated." Therefore, when professionals work with an individual who has suffered similar trauma, the experience often triggers painful reminders of their own trauma. Developing self-awareness of such reactions and finding ways of being reflective of our work and thoughtful in our interactions, are important for working in cases involving child maltreatment. The following section will briefly describe common reactions to working with child maltreatment and childhood trauma. Strategies to manage one's own reactions will be reviewed, and practical strategies for self-care to prevent burnout among counsellors.

SECONDARY TRAUMATIC STRESS AND COUNSELLORS

Secondary traumatic stress is a risk we incur when we engage empathically with an adult or child who has been traumatised. Secondary traumatic stress is commonly defined as a set of natural, consequent behaviours resulting from knowledge about a traumatising event experienced by a significant other (Figley, 1995). It is the stress resulting from wanting to help a traumatised or suffering person. It has only been recently that researchers and practitioners have acknowledged that professionals who work with or help people with childhood maltreatment or trauma are indirectly or secondarily at risk of developing the same symptoms as persons directly affected by the traumatic events. Counsellors who listen to adults or children describe the trauma are at risk of absorbing a portion of the trauma (Carr, 2015).

PRACTICE IMPLICATIONS: SELF-CARE FOR INDIVIDUALS; PREVENTION AND MANAGEMENT

Training, support, and professional supervision can all reduce the risk of counsellors developing secondary traumatic stress disorder. Understanding what secondary trauma is and what causes it reduces a person's

vulnerability and increases resilience. Training in managing stress will increase a counsellor's ability to respond to stress in ways that are less damaging. Similarly, training aimed at personal development also increases the counsellor's sense of having an identity outside of work. Improving skills in a sport, or some other pursuit such as music or dance, increases the sense of joy in living which helps to protect us from the effects of stress (Brady, 2012). An audit of one's social support network, and methods to increase the quality of the support one is receiving, is possibly the most useful exercise in self-care. Informal support may come from people within the individual's network who are familiar with the concept of secondary traumatic stress disorder and who recognise the signs. Regular de-briefing or feedback session that looks for any changes that might indicate that the person is developing a secondary stress disorder is critical for good self-care (Salloum et al., 2015). For counsellors in Australia, professional development and involvement with counselling associations, such as Psychotherapy and Counselling Federation of Australia (PACFA) or Australian Counselling Association (ACA), offer counsellors opportunities to network with other counsellors, seek peer support, and participate in group supervision.

SECONDARY TRAUMATIC STRESS AND ORGANISATIONS

It is important to note here that self-care is not solely the responsibility of the counsellors themselves. In fact, without sufficient recognition or support from service, teams, or organisations, many of the self-care strategies fall short of protecting counsellors from burnout. Social services and counselling organisations working in the child welfare sector often find themselves operating in the face of recurrent or constant crises. When left unchecked, such chronic stress has been found to influence organisational culture, leading to staff being unable to constructively confront problems, engage in complex problem-solving, and be involved in all levels of staff decision making processes (Bloom, 2008). In her seminal work on the impact of traumatic stress on organisations, Sandra Bloom (Bloom & Farragher, 2013) describes 'parallel processes' within organisations, where communication networks tend to break down under stress, much like they do within vulnerable families that are the clients of the services. When communication networks break down in these services, so too do the feedback loops that are necessary for consistent and timely error correction (Bloom, 2008). As decision-making becomes increasingly non-participatory and problem-solving more reactive, an increasing number of short-sighted policy decisions are made that appear to compound existing problems. Fallot and Harris (2008) describe a process by which organisations can start by looking at shared assumptions, goals, and existing practices with staff from various levels of the organisation. Trauma-informed processes have been found to improve staff morale, as the leadership is seen as being open to new sources of information. Such organisational practices emphasise the development of more democratic, participatory processes is critical as these are the processes most likely to lend themselves to promoting self-awareness amongst staff, and support in the development of solutions to the often complex problems facing the organisation (Bloom, 2008).

Learning activity 5

Learn more about the impact of traumatic stress on organisations in our interview with Dr. Sandra Bloom on the trauma-informed education podcast.

CONCLUSION

Child maltreatment is a complex and multifactorial phenomenon. This chapter provides a cursory overview of some of the key considerations for counsellors in their work with children and their families. Counsellors are encouraged to be mindful of key risk factors associated with child maltreatment, and the cumulative impact of these problems and challenges faced by children and their families. From assessment to ongoing counselling, the provision of trauma-informed care is characterised by practices that ensure the physical and psychological

safety of children and their families. By collaborating effectively with families and key stakeholders, counsellors can support children in their recovery from child abuse and neglect. The sustainable provision of support requires practitioners to attend to their own wellbeing, while being equally supported by the organisations that employ them. Despite the devastating impact of child maltreatment, the presence of a calm, caring and reflective adult is often the key ingredient to a child's journey of healing from a traumatic past.

Learning activity 6

Watch this video of a clinician conducting an interview to assess for concerns of maltreatment [16:19]. Despite being an instructional video, there are aspects of the interview that could be done different.

As you watch the video, consider the following questions:

What do you think of the physical environment in which the session is being conducted? How do you think it helps and in what way might it hinder the session?

What do you think of the language used and the communication style? Are there similarities or differences to how you may phrase questions and statements?

In what way might the interview be more "trauma-informed"?

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=57#oembed-3

Learning activity 7

Watch this video of the interview being conducted with the child [11:41]. As you are watching, consider the questions listed in learning activity 6. Consider how the interview with the adult is different to that of the child.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=57#oembed-4

GLOSSARY OF TERMS

aetiology—the cause, set of causes, or manner of causation of a disease and/or other factors relating to health

attachment—a strong emotional bond that an infant forms with a caregiver (such as a mother) especially when viewed as a basis for normal emotional and social development

burnout—a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed

caregiver—an adult who is responsible for the care of a child, including parent, step-parent, adult sibling, grandparent, other family or kin member, or other appointed adult

child maltreatment—all forms of physical and/or emotional ill-treatment, sexual abuse, neglect, or negligent treatment or commercial or other exploitation, results in actual or potential harm to the child's health, survival, development, or dignity in the context of a relationship of responsibility, trust, or power

emotional abuse—failure of a caregiver to provide an appropriate and supportive environment, and include acts that have an adverse effect on the emotional health and development of a child

exosystem—factors related to the individual and family within larger social structures, including both formal and informal structures

neglect—the failure of a caregiver to provide for the development of the child – where the caregiver is in a position to do so – in one or more of the following areas: health, education, emotional development, nutrition, shelter, and safe living conditions

microsystem—the immediate context in which child maltreatment takes place and includes the family system, the maltreatment itself, and both caregiver and child characteristics

macrosystem—factors related to the embeddedness of the individual, community, and family within the larger cultural fabric

neurobiology—the study of cells of the nervous system and the organisation of these cells into functional circuits that process information and mediate behaviour. It is a sub-discipline of both biology and neuroscience.

ontogenic factors—factors related to the childhood histories of abusive parents/caregivers

physical abuse—acts of commission by a caregiver that cause actual physical harm or have the potential for harm

post-traumatic stress disorder—a particular set of reactions that can develop in people who have been through a traumatic event which threatened their life or safety, or that of others around them

secondary traumatic stress—a set of natural, consequent behaviours resulting from knowledge about a traumatising event experienced by a significant other

self-care—the practice of taking an active role in protecting one's own wellbeing and happiness, in particular during periods of stress

sexual abuse—acts where caregivers use a child for sexual gratification

supervision—a formal working alliance that is generally, but not necessarily, between a more experienced and a less experienced worker, in which the supervisee's clinical work is reviewed and reflected upon with a view to improve one's performance

trauma—reactions to the exposure to events that posed a threat to one life, or the lives of others around them

trauma-informed care—a framework for human service delivery that is based on knowledge and understanding of how trauma affects people's lives and their service needs

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Crisis

CLAIRE MALENGRET AND CLAIRE DALL'OSTO

ABSTRACT

This chapter provides a foundation for understanding the nature of a crisis, how a person may be impacted by a crisis, and the models, processes, and strategies a crisis counsellor uses to assess and intervene when people in crisis seek help and support. With an emphasis on how crisis intervention differs from other counselling interventions, a case study is provided with the aim to help the reader reflect on and apply relevant crisis models of assessment and intervention learned in this chapter. Further differentiation is made between crisis stressors resulting in exposure to a traumatic event and ongoing traumatic stress responses requiring long-term counselling, psychiatric services, or specialised mental health intervention. Due to the nature of crisis work, there is a high prevalence of burnout and work-related stress in this field. As such, counsellors working in crisis work need to practice self-care, regular clinical supervision, and the continuing maintenance of the counsellor's general health and wellbeing.

Learning Objectives

- Describe the nature of crisis.
- Identify the types of crisis.
- Recognise and understand common emotional, physical, behavioural, and cognitive reactions of people in crisis.
- Analyse the major theories underpinning crisis counselling interventions.
- Examine the importance and role of the therapeutic relationship within crisis counselling.
- Apprehend the ethical implications and professional issues of crisis intervention.
- Identify trauma definitions, assessment, and treatment approaches.
- Identify and reflect on your own personal history and experiences of crisis, including responses.
- Recognise and understand the impact of crisis counselling work on the counsellor and the need to implement self-care practices and stress management strategies.

INTRODUCTION

We live in a world where millions of people are confronted with crisis-provoking events each year that they cannot cope with or resolve on their own and, therefore, will often seek help from counsellors. Examples of crisis-inducing events include natural disasters such as bushfires, sexual assaults, terrorist attacks, the death

of a loved one, a suicide attempt, domestic violence, relationship breakdown, retirement, promotion, and demotion, change in school status, pregnancy, divorce, physical illness, unemployment, and more recently, a world pandemic. These situations can be a turning point in a person's life—either one of growth, strength, and opportunity or health decline, dysfunction, and emotional illness (Roberts & Dziegielewski, 1995; Roberts, 2005; Hoff et al., 2009). When people experience a crisis, it is the support they receive during and immediately after the crisis that often plays a crucial part in determining the impact of the crisis on their lives (France, 2014). Therefore, it is imperative crisis counsellors have the understanding, skills, and knowledge to offer a short-term intervention that assists people in crisis to cope, stabilise and receive the support and resources they need.

WHAT IS A CRISIS?

When a person experiences a crisis, they experience severe disruption of their psychological equilibrium and are unable to use their usual ways of coping. This then results in a state of disequilibrium and impaired functioning (Lewis & Roberts, 2001; Roberts, 2005). Because the person is unable to draw on their everyday problem-solving methods during a crisis, and there is a sense of diminished control over the events and limited options, they may experience confusion or bewilderment (Hendricks, 1985; Pollio, 1995).

Crisis states are temporary, lasting from hours through to an estimated six weeks, as the body cannot sustain being 'off balance' or in a state of disequilibrium, indefinitely. Resolving a crisis effectively may take some months, and this may involve learning new skills, reappraising the situation differently, or adapting to the new situation. Because people may resolve the crisis in a maladaptive or adaptive manner, some may be impacted by various mental health conditions such as depression, substance abuse, or post-traumatic stress disorder (PTSD) (Roberts, 2005).

There are four types of crises that a person may experience and include:

1. developmental crisis or crisis in the life cycle (adjustments to transitions such as ageing, parenting)
2. situational crisis (sexual assault, natural disaster, car accident)
3. existential crisis (inner turmoil or conflicts in relation to the way a person lives their life, and views of their meaning and purpose)
4. systemic crisis (the impact of colonisation on our First nations' people or the 2009 Victorian 'Black Saturday' bushfires) (James & Myer, 2008).

CRISIS IS IN THE EYE OF THE BEHOLDER

It is important to note the difficult task of defining a crisis. This is due to the subjectivity of the concept. Although the main reason for a crisis is usually preceded by a traumatic or hazardous event, it is imperative to realise that the individual's perception of the event and their inability to cope with the event are two other conditions to consider. Focusing only on the event itself also suggests that one can categorise a crisis but that all people may respond in the same manner to a particular event. Thus, it is not the actual event that activates a crisis state, but how a person interprets or perceives these events, how they cope, and the degree to which they have access to social resources, that determine how they respond. In other words, crisis is in the eye of the beholder (Hoff et al., 2009; Hoffer & Martin, 2020).

This perception is influenced by several factors in a person's life, such as personal characteristics, biological, gender, culture, attachment style, previous life experiences, social context, personal values, level of resilience, influences, availability of social support, previous trauma, and history of major mental illness (Loughran, 2011; Roberts & Ottens, 2005). It is also important to understand that people who are reacting to a crisis are not necessarily showing pathological responses but normal crisis responses to an abnormal event (Bateman, 2010; Hobfoll et al., 2007; James, 2008).

PRINCIPLES AND CHARACTERISTICS OF CRISIS

The following principles and characteristics help to create an understanding of the nature of a crisis, and emphasise not only the important work of a crisis counsellor but the values and philosophical assumptions that need to guide their practice:

- crisis embodies both danger and opportunity for the person experiencing the crisis
- crisis contains the seeds of growth and impetus for change
- crisis is usually time limited but may develop into a prolonged crisis if the person experiences a series of stressful situations after the crisis
- crisis is often complex and difficult to resolve
- a crisis counsellor's experiences of crisis in their personal life may greatly enhance their effectiveness in crisis intervention
- quick fixes may not be applicable to many crisis situations
- crisis confronts people with choices
- emotional disequilibrium or disorganization accompany crisis
- the resolution of crisis and the personhood of crisis workers interrelate (James, 2008, p. 19).

Learning activity 1

1. How do you think your previous life experiences of crisis may increase your effectiveness as a crisis counsellor?
2. What personal qualities do you possess that may enhance an intervention that you use with a person who has experienced a crisis?
3. What are the risks of having unresolved crisis experiences as a counsellor, and how might this impact your effectiveness in crisis work?

COMMON REACTIONS TO A CRISIS

Listed here are some of the common reactions a person might experience, which are normal responses given the abnormality of the event they have experienced.

Table 1: Common reactions to a crisis

Emotional • disbelief, shock, feeling numb • sadness, grief • helplessness and hopelessness • anger, irritability • shame • anxiety	Physical • headaches • exhaustion, fatigue • difficulty sleeping • easily startled • hot or cold sensations • loss of appetite or increase in appetite • breathing difficulties • nausea • trembling, heart palpitations
Behavioural • subdued • withdrawn • crying • increased use of alcohol and drugs • avoidance of the reminders of the trauma • unable to express emotions • unmotivated, not wanting to go to work	Cognitive • flashbacks of the event • confusion and disorientation • dreams and nightmares about the event • poor memory • difficulty in making simple decisions • struggle to concentrate

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Learning activity 2

Imagine your life on a timeline from when you were born up until today. On this timeline, plot the most important or critical events (positive or negative) in your life that were turning points or changed you in some way.

1. Looking at the critical events on your timeline, which events would you see as a crisis?
2. How did those events change you?

WHAT IS CRISIS COUNSELLING?

Crisis counselling is an immediate response to people experiencing overwhelming events and may prevent the potential negative impact of psychological trauma. It focuses on the here and now, dealing with the immediate presenting needs at the point of crisis, and providing emergency psychological care to assist in helping the person return to an adaptive level of functioning (Flannery & Everly, 2000; Hobfoll et al., 2007).

The key goals that underpin crisis counselling frameworks and models are:

- meeting the person who is experiencing a crisis where they are at
- assessing and monitoring the person's level of risk
- assisting them in mobilising of resources
- stabilising (by reducing distress
- improved or restored adaptive functioning (where possible) (Roberts & Ottens, 2005).

THE DIFFERENCE BETWEEN CRISIS COUNSELLING AND OTHER COUNSELLING INTERVENTIONS

Crisis counselling is different to the provision of ongoing therapeutic support. Because crisis counselling offers short-term strategies to prevent damage during and immediately after the person has experienced a crisis or devastating event, it requires that the counsellor be more active and directive than usual (James, 2008). Ongoing counselling may follow on from crisis to ensure the long-term improvement of a person's mental health and wellbeing, but this is not the goal of crisis counselling. Instead, the goal is to provide a responsive and timely intervention to return a person to previous levels of functioning through the implementation of mobilising necessary resources, including the facilitation of links to these resources (Flannery & Everly, 2000). Given crisis counselling is the implementation of a short-term measure of support, it is often referred to as brief intervention or brief therapy. The timeframe for crisis counselling is between six to ten weeks and is guided by specific relevant models, guiding principles, and actions (Hendricks, 1985).

Case study: A bushfire crisis

You are part of a mobile service team who travels to a fire-affected area to provide support to individuals, families and emergency services workers affected by the recent bushfires. You arrive at a regional town that has just been devastated by catastrophic bushfires. A recovery centre has been set up at the local town hall and 700 individuals and families are presently seeking support at this recovery centre. You are assigned to Brett (35), a cattle farmer whose property, livestock, and beloved dog were lost in the fires. Brett is a third-generation cattle farmer on his family property. Within the first few minutes of meeting him, you observe that recalling these events for him results in constant tearfulness, and a questioning of what he could have done to be more prepared to have a different outcome. Brett explains that he has not slept in several days, and if he does sleep, he has nightmares. He also expresses to you that he does not know what the future holds for him now. Brett explains that he cannot focus for very long because he finds it difficult to believe this has happened to him. You observe that Brett appears to be numb and detached and unable to articulate his narrative in a linear and clear manner. Brett explains that he feels concerned for his ten employees who are no longer able to support their families. He also mentions that recently he went through a divorce which he felt devastated by at the time.

Learning activity 3

1. From Brett's reactions, what suggests that he is experiencing a crisis?
2. What is the contributing factor that disrupts Brett's equilibrium most? Is it the nature of the crisis event itself or the way Brett responds?
3. Are there any risk factors to consider in Brett's case?

TRAUMATIC STRESS, CRISIS, AND TRAUMA

The term crisis is not interchangeable with traumatic stress and trauma. Dulmus and Hilarski (2003) explain a person is in a crisis state when they have experienced a situation or event and they have been unable to cope with it by utilising their usual coping mechanisms to lessen the impact of the event. This results in the person entering a state of disequilibrium (Roberts & Ottens, 2005).

Traumatic stress is when a crisis or event, such as child abuse, rape, combat trauma, and catastrophic natural disasters, overwhelms normal coping skills and is perceived as life-threatening (Behrman & Reid, 2002).

Trauma can be defined as '... an experience of extreme stress or shock that is/or was, at some point, part of life' (Gomes, 2014).

It is adaptive and normal for a person who has been exposed to a traumatic event to exhibit some anxiety in the early stages as this enables them to maintain vigilance as a way to increase safety. Others may feel numb after being exposed to a traumatic event. This is also an adaptive and normal response as much-needed insulation is provided to a person's psychological system after the traumatic event (McNally et al., 2003). Those who do experience a traumatic injury can suffer from long-lasting consequences that impact them physically, cognitively, emotionally, and financially (Herrera-Escobar et al., 2021).

It is common for acute stress symptoms to be experienced after a traumatic event. When a person is exposed to a threat, neurotransmitters and hormones inform a physical response. The sympathetic nervous system is activated through a series of interconnected neurons that initiate a fight or flight response. The body releases glucose and adrenalin, increases heart rate and respiration, and remains in a state of high alert to manage any additional threat. At this point in time, the person is trying to make sense of their experience and is often feeling afraid and vulnerable as they attempt to rationalise what just occurred. Anxiety, loss of appetite, irritability, sleep difficulties, concentration difficulties, and hypervigilance can occur whilst in this physiological state. Warchal and Graham (2011) further explain that a person can have recurrent and involuntary memories of the traumatic event. A heightened state of arousal makes it difficult for them to respond normally, make decisions, and complete paperwork to link them to resources. Walsh (2007) explains that most people adapt and cope and therefore do not suffer long-term disturbance.

POST-TRAUMATIC STRESS DISORDER

Ongoing therapeutic support is required if a person continues to experience feelings of helplessness, intense fear or horror, re-living the traumatic event, hypervigilance, or emotional numbness. Norris et al. (2002) identified ongoing support to include long-term counselling or psychiatric services, or specialised mental health intervention. People generally possess enough resilience to circumvent the development of trauma symptoms that inform a formal trauma diagnosis, such as post-traumatic stress disorder. The DSM5-TR classifies PTSD as an anxiety disorder that can develop after exposure to a traumatic event (American Psychiatric Association [APA], 2022). Rosenman (2002) reported that 57% of the Australian population reported a lifetime experience of a specified trauma. There are four different categories PTSD can be clustered into: (1) recurrent re-experiences of the traumatic event in the form of intrusive thoughts, nightmares, or flashbacks; (2) numbing and avoidance of trauma-related stimuli; (3) hyperarousal and reactivity; and (4) alterations in cognitions and mood (APA, 2022).

THE ORIGINS AND DEVELOPMENT OF CRISIS COUNSELLING INTERVENTIONS

The research and development of crisis intervention originates in the 1940's when the reactions of people whose loved ones had died in a fire at a nightclub in Boston in 1943 were recorded and studied by psychiatrist Erich Lindemann and his colleagues (Lindemann, 1944). Another psychiatrist, Gerald Caplan, expanded on this work and developed a four-stage model of crisis reactions (or phases of reactions that a person in a crisis may experience) which have formed the foundation for later contributions from theorists in crisis counselling. Caplan (1961, 1964) describes these phases as follows:

Phase 1: increase in tension and distress from the crisis-inducing event

Phase 2: there is an escalation in the disruption of the person's life as they are stuck and cannot resolve the crisis quickly

Phase 3: the person cannot resolve the crisis through their usual problem-solving methods

Phase 4: the person resolves the crisis by mental collapse or deterioration, or they partially resolve it by adopting new ways of coping.

Erikson's (1963) stage model of developmental crises and Roberts' (1995) seven-stage crisis intervention

model have led to the development of numerous crisis intervention models, particularly in the last two decades. Erikson's focus was on World War II veterans' disconnect from their culture together with the confusion associated with the traumatic war experiences rather than focusing on men suffering from repressed conflicts. Erikson assessed that veterans were experiencing confusion of identity about what they were and who they were in direct opposition to the lens of repressed conflict being used during this time period.

CHARACTERISTICS OF THE CRISIS COUNSELLOR

The crisis counsellor's ability to remain calm and simultaneously avoid subjective involvement in the crisis is crucial. This means that crisis counselling may not be suitable for every counsellor (Shapiro & Koocher, 1996). A crisis counsellor should communicate in a manner that is patient, sensitive, self-aware, and compassionate. Other characteristics and behaviours include warmth, understanding and acceptance, being available but not intrusive or controlling, trustworthy, empathic, caring, displaying effective listening skills, encouraging the person seeking appropriate referrals and support, and being able to maintain confidentiality (Bateman, 2010; Rainer & Brown, 2011; Westefeld & Heckman-Stone, 2003).

The crisis counsellor aims to establish a therapeutic relationship as they do in general counselling, however in crisis counselling, they do so in a shorter time-frame period. Other crisis intervention skills include encouragement, basic attending and listening skills, reflection of emotions, and instilling hope (cf. Ivey & Ivey, 2007; James, 2008).

KEY CRISIS INTERVENTIONS

As mentioned previously, crisis intervention provides the opportunity for the crisis counsellor to help facilitate an independent decision-making process with the client by promoting them as the agent of change in their life and assisting them to identify and utilise their own resources (France, 2014).

When determining if crisis intervention is the most relevant intervention, several categories are to be considered. These include:

- a cumulative effect
- the impact on a person
- their family and community
- the unexpectedness and duration of the event or situation; and
- a person's level of control over the event or situation (Hendricks, 1985).

CRITICAL INCIDENT STRESS DEBRIEFING

Developed in 1974 by Jeffrey T. Mitchell, critical incident stress debriefing (CISD) or psychological debriefing is a seven-phase supportive crisis intervention process that was initially used with small groups of first responders such as firefighters, paramedics, and police officers to help them manage their reactions and

distress following their exposure to a traumatic event (Mitchell, 1983). Over time, CISD became an intervention used with groups outside of emergency services, such as hospitals, businesses, schools, community groups and churches. However, although CISD is used extensively, current research shows mixed results for the use of this intervention with some findings suggesting that it is ineffective in preventing post-traumatic stress disorder (PTSD) symptoms and even contributing to the worsening of stress-related symptoms in individuals who received this type of intervention (Bledsoe, 2003).

The next section will address assessment in crisis intervention followed by an outline of two key crisis interventions, Roberts' seven-stage model of crisis intervention and psychological first aid, and an application of these interventions to Brett's case.

ASSESSMENT IN CRISIS INTERVENTION

The responsibility of the crisis counsellor is to conduct a structured assessment in a timely and responsive manner to assess whether psychological homeostasis has been disrupted, there is evidence of dysfunction and distress, and usual coping mechanisms are not able to be utilised. Assessment is ongoing throughout the intervention process and allows the crisis counsellor to evaluate the person's affective and cognitive state, and behavioural functioning. By assessing these three areas, the crisis counsellor can evaluate and monitor how adaptively or maladaptively the person is functioning, including whether they are a danger to themselves or others, and then apply the most appropriate intervention (James, 2008).

Listed below are examples of what a crisis counsellor is looking for across the three domains when assessing people who have experienced a crisis:

- Do they appear to be emotionally overwhelmed or severely withdrawn?
- Is what they are saying coherent and logical or are they not making sense?
- When observing their behaviours, are they pacing? Are they having difficulty breathing?
- Are they able to sit calmly?
- Are they unresponsive?

When people express suicidal ideation or have a plan to suicide, it is crucial to conduct a rapid suicide risk assessment which includes gathering information by inquiring about the following:

- How long they have been having suicidal thoughts?
- Have they made any suicide attempts in the past?
- Have they recently sought help?
- Do they have a plan to suicide?
- If they do have a plan, do they have access to the means to carry out this plan?

Further information and guidelines on suicide risk assessment can be found at the end of this chapter in the Recommended referral and resources list section. There is also a specific chapter in this book related to suicide.

Helplines – phone counselling and support

There is a range of organisations in Australia that provide support for people who are in crisis and need to talk to someone about their distress. Due to their *convenience, accessibility, affordability, and relative anonymity, these helplines are a common form of crisis support.*

Lifeline Australia 13 11 14
beyondblue 1300 22 4636
Mensline Australia 1300 78 99 78
Kids Help Line 1800 55 1800
1800RESPECT 1800 737 732

ROBERTS' SEVEN-STAGE CRISIS MODEL

Roberts' (1995, 2005) seven-stage model of crisis intervention is a cognitive-behaviourally based, systematic, and structured model used for crisis assessment and intervention. It is a common model used by crisis counsellors to help people build and restore their ways of coping and improve their problem-solving skills that a crisis may evoke.

With a focus on strengths and resiliency, these sequential stages can be applied to a broad range of crisis situations and are as follows:

1. **plan and conduct a thorough assessment** including, danger to self and others, imminent danger, lethality
2. **make psychological contact, establish rapport and rapidly establish the collaborative relationship** by showing genuine respect for the individual and having a non-judgmental attitude
3. **identify major problems or the dimensions of the problems** including the precipitating event
4. **encourage exploration of feelings and emotions** including active listening, reassurance and validation
5. **generate and explore alternatives** including untapped resources and new coping strategies
6. **develop and formulate an action plan**
7. **plan follow-up and leave the door open for booster sessions which may occur three to six months later** (Roberts, 2005, p. 21).

PSYCHOLOGICAL FIRST AID

Identified as the first level of post-incident short-term care, psychological first aid is an evidenced-based model that provides emotional and practical support to individuals, groups, and communities impacted by a natural disaster, catastrophic event, traumatic or terrorist event, or another emergency situation (Australian Red Cross & Australian Psychological Society, 2010; Ruzek et al., 2007). The aim of psychological first aid is to help people

reduce their initial symptoms, have their current needs met, and support them in implementing adaptive coping strategies.

Psychological first aid meets the following four basic standards:

1. Consistent with evidence and research on risk and resilience following trauma (that is, evidence-informed)
2. Applicable and practical in field settings (compared with a medical/health professional office somewhere)
3. Appropriate for developmental levels across the lifespan (e.g., there are different techniques available for supporting children, adolescents, and adults)
4. Culturally informed and delivered in a flexible manner, as it is often offered by members of the same community as the supported individuals (Ruzek et al., 2007).

Psychological first aid is based on the understanding that, just as natural disasters, catastrophic events, traumatic or terrorist events, or other emergency situation differ vastly from each other, so do the psychological reactions of individuals, groups and communities experiencing them. Because some of these reactions can interfere with an individual's ability to cope and manage the crisis, psychological first aid can help in their recovery. Psychological first aid has five basic elements that are to promote:

1. safety
2. calmness
3. self-efficacy (self-empowerment)
4. connectedness
5. hope (Hobfoll et al., 2007).

Case study: Crisis intervention

Roberts' seven-stage model of crisis intervention

Using Roberts' (2005) seven-stage model as an intervention with Brett, your first step is to conduct a psychosocial and lethality assessment. As he tells his story to you, you need to gather information such as whether he has any emotional support, any medical needs, how he is coping, and whether he is currently using any drugs and/or alcohol. Assessing any imminent danger and ascertaining whether Brett may be at risk of suicide is also a priority in this initial stage. Although in this case, Brett may not talk about having suicidal thoughts (i.e., suicidal ideation) or have a suicide plan, he does say, "I don't know what the future holds for me now", which at this point would prompt a probing question in checking what he means. It would be important to consider other risk factors, such as previous mental health issues, being socially isolated, or recently experienced a significant loss (for example, Brett has recently divorced which may be a risk factor in his case).

The second stage is about building rapport with Brett which you may have established already from taking the time to be present and hear his story in the assessment stage. This stage is crucial in developing a therapeutic relationship with Brett and, therefore, it is important you show a genuine interest in his story, respect and accept him, and also display fundamental qualities and characteristics of a crisis counsellor as discussed earlier in the chapter.

Crisis intervention is focused on the major problems, so in this next stage, you are wanting to find out why Brett has sought help now. This might seem obvious as you might assume it is the devastation of the fire. This may not be the priority issue, therefore, at this point you are not only finding out about the event that 'was the last straw' but you are also helping Brett prioritise the problems to work through. It is important that you gain an understanding of why those problems make it a crisis for him.

In stage four of this model (i.e., encourage exploration of feelings and emotions) you are actively listening to Brett's

story, allowing him to express and vent his feelings, and giving him the opportunity to articulate what it is about the situation that is making it difficult for him to cope. You may challenge some of his responses by giving him correct information and reframing his statements and interpretations about the situation.

Generating and exploring alternatives (stage 5) can be 'tricky' as the timing needs to be appropriate to help Brett explore options in moving forward to resolve the crisis. If you have established rapport, listened to his story, and Brett feels heard and understood, he may be more open to this. A strategy may include asking Brett, "How have you coped in the past when you've been through a crisis and felt the same way you do now?".

Stage six includes implementing an action plan to address some of the problems he has identified, for example, making an appointment with his general practitioner regarding the poor sleep patterns he is experiencing. This stage also involves asking questions that may help Brett make meaning from the crisis such as, "Why did this happen?", "What does it mean?", "What are the alternatives that could have been put in place to prevent the event?", "Who was involved?", and "What responses to the crisis potentially made it worse (cognitively and behaviourally)?" (Roberts & Ottens, 2005).

The final stage is planning to follow up with Brett two to six weeks later in order to evaluate if the crisis is being resolved, and to also check his physical and cognitive state, how his overall functioning is, any stressors and how he is handling them, and any referrals to external agencies such as housing, medical, legal etc. You may also schedule a 'booster' session a month after this crisis intervention has been completed.

Psychological first aid

The application of psychological first aid to the case study requires an expansion of the five core principles of psychological first aid. In your immediate work with Brett, the intervention includes efforts to:

- reduce his distress by modelling calm, and making Brett feel safe and secure
- identify and assist Brett with his current needs
- establish a human connection with Brett
- facilitate Brett's social support
- help Brett understand the disaster and its context
- help Brett identify his own strengths and abilities to cope
- foster belief in Brett's ability to cope
- give Brett hope
- assist with early screening for Brett needing further or specialised help
- promote adaptive functioning in Brett
- get Brett through the first period of high-intensity and uncertainty
- set Brett up to be able to naturally recover from an event
- reduce the chance of post-traumatic stress disorder for Brett (Australian Red Cross & Australian Psychological Society, 2010, p. 11).

Brett is a 35-year-old independent Australian male farmer who may believe that expressing emotions or feelings is a sign of weakness. Bleich et al. (2003) explain that when an individual believes they are weak, "going crazy" or believes there is "something wrong with me", an effective strategy in the intervention is to normalise and reassure Brett "you are neither sick nor crazy; you are going through a crisis, and having a normal reaction to an abnormal situation". It is important to remind Brett that he is safe in order to minimise his vigilance. Promoting calm for Brett, immediately after his rural town was devastated by catastrophic bush fires, can assist Brett to foster positive emotions. It is advisable to intervene and limit Brett's exposure to media coverage as this may trigger negative emotional states. The challenge

for you is to convince Brett that he does not need to be as vigilant and limit media exposure as all day exposure is too much (Fredrickson, 2001).

THE CRISIS COUNSELLOR AND SELF-CARE

In their book, *The Resilient Practitioner,* Skovholt and Trotter-Mathison (2016) offer their insights and research on burnout and compassion fatigue for those in the helping profession and emphasise the importance of implementing self-care strategies in its prevention. Given the demands of the work of a crisis counsellor and the risk of vicarious traumatisation, protective and proactive approaches are imperative in the sustainability and vitality of a career where one is working intensely with human suffering and adversity. Tools and approaches, such as frequent supervision, high commitment to self-care, creating a personal balance of caring for self and caring for others, proactively and directly confronting stressors at work and at home, and ensuring that one has enriching relationships and activities outside of the work environment, are essential components in professional wellness and in the prevention of burnout and compassion fatigue (Adamson et al., 2014; Skovholt & Trotter-Mathison, 2016).

Learning activity 4

The development of a self-care plan can assist the crisis counsellor in supporting their wellbeing, reducing stress, and sustaining positive mental health in the long-term.

List five self-care strategies that you might use to promote and enhance your mental health and wellbeing

Counsellor reflections

Due to the nature and intensity of the role, crisis counselling may not be a suitable specialisation of counselling for every counsellor. Based on my experience, this type of work requires a counsellor to have the ability to remain calm and operate in a systematic and rational manner whilst assessing a client's level of instability and distress. Building rapport quickly with a client facing a crisis is vital to the effectiveness of the intervention, which highlights again how important it is for the crisis counsellor to show acceptance, empathy, and genuineness to the client.

Working as a frontline crisis counsellor is demanding, and, therefore, it is imperative that ongoing support and clinical supervision are received to minimise and manage compassion fatigue and vicarious trauma. Additionally, I have found that a strong commitment to self-practices such as mindfulness, yoga, and muscle relaxation have reduced work-related stress and burnout over the years.

CONCLUSION

This chapter has provided a brief foundation for intervening with people who have experienced a crisis. With a primary focus on psychological first aid and Roberts' seven-stage model of crisis intervention, and an application of these models to a case study, this chapter has covered the essentials in understanding the nature and types of crisis, the common reactions of a person who has experienced a crisis, and the impact of ongoing traumatic stress responses that require long-term counselling intervention. A list of other supports available, referrals and resources are included at the end of this chapter for your information and further reading.

RECOMMENDED REFERRAL AND RESOURCES LIST

Australian Psychological Society: Psychological first aid. This resource is a useful guide to supporting people affected by a disaster. The guide provides an overview of the implementation of best practices in psychological first aid as an immediate intervention following a traumatic event or disaster.

Suicide risk assessment. Working with the suicidal person Clinical practice guidelines for emergency departments and mental health services (Department of Health, Melbourne, Victoria, 2010).

Guidelines for integrated suicide-related crisis and follow-up care in emergency departments and other acute settings (2017).

Other Resources for telephone and online crisis support:

- Life in Mind: Australian suicide prevention services.
- Standby: Support after suicide. Face-to-face and telephone support.

Other counselling resources

Psychological first aid: This video [11:07] provides information on the application of psychological first aid to assist individuals to reduce stress symptoms and assist in meeting an individual's basic needs and identify resources to aid in a healthy recovery, immediately following a crisis, such as a personal crisis, natural disaster, traumatic event or natural disaster.

GLOSSARY OF TERMS

compassion fatigue—a state of feeling emotional and physically exhausted from helping people who are distressed or traumatised resulting in a diminished ability to show compassion or empathise

crisis—a time of intense difficulty or danger

hypervigilance—being in a state of increased alertness where one is sensitive to surroundings

intervention—the action or process of intervening

model—describes how counsellors can implement theories

stress—a state of mental or emotional strain or tension resulting from adverse or demanding circumstances

principles—a fundamental truth or proposition that serves as the foundation for a system of belief or behaviour or for a chain of reasoning

reaction—something done, felt, or thought in response to a situation or event

suicidal ideation—thoughts of wanting to take one's own life or suicide

theory—a plausible or scientifically acceptable general principle offered to explain a hypothesis or belief

therapeutic relationship—refers to the consistent and close association that exists between the counsellor and client. This is also known as a therapeutic alliance.

trauma—a deeply distressing or disturbing experience

vicarious trauma—trauma symptoms that a counsellor may experience as a result of the ongoing exposure to trauma stories from their clients

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Depression

JAMES BROWN AND NATHAN BEEL

ABSTRACT

Depression is a mood condition that is the second largest cause of disability globally. This chapter describes the characteristics and associated features of depression. It considers different ways of viewing depression, such as whether it is a medical disorder or a stress response. The chapter explores the relationship of both grief and suicidality with depression. Different responses to depression are described, including medical, psychological, and lifestyle interventions as well as the rationales for key interventions. Finally, this chapter describes generic recommendations for counsellors to consider when working with clients showing signs of depression.

Learning Objectives

- Identify and define depression.
- Explore the different theoretical models for depression.
- Evaluate the relationship between depression and suicide.
- Explore a framework for the responses to depression in a counselling setting.

INTRODUCTION

The words ‘depression’ or ‘depressed’ are often used by the public (and clients) to indicate a passing feeling or mood of sadness, lethargy, guilt, grief, or a low mood. In common usage, they are synonyms for feeling flat, down, or ‘having the blues’. The word depression, originating in Latin, literally means “to press down” (Reevy et al., 2010, p. 192). Depression is also used as a clinical term to suggest a particular type of mental disorder category, as described in the ICD-11 (World Health Organization, 2022), or DSM-5-TR (American Psychiatric Association [APA], 2022). The variation between the types of depression is usually related to duration, intensity, frequency, or contexts (e.g., post-partum depression that may occur with early motherhood). Depression is regarded to be globally the most prevalent mental disorder (Gotlib & Hammen, 2009) and the second largest cause of disability internationally (Ferrari et al., 2013). In counselling practice, clients often present with features associated with depression, whether these be severe enough to be classified as a disorder, or various degrees under the diagnostic threshold.

Depression is characterised by periods of low mood or sadness and/or a loss of pleasure or interest in previously enjoyed activities (APA, 2022). While it can lead to significant stress and impairment in life, it is most commonly a response to various difficulties or stressful life experiences that most people are likely to encounter at some stage in life (Reevy et al., 2010). These features were described as far back as Hippocrates

(Radden, 2003) as being part of melancholia, and while other disorders have come and gone, descriptions of depression remain consistent throughout the modern diagnostic editions (Frances, 2013). Indicators of depression typically include low mood, low interest in activities, or low ability to experience pleasure, weight changes, sleep disturbance, increased or decreased arousal, low energy, feelings of worthlessness (e.g., low self-esteem), diminished concentration, and preoccupation with death (APA, 2022). Many of these indicators will be experienced daily for at least a fortnight (World Health Organization, 2022) for it to be recognised as meeting the threshold for a depressive disorder. Additional features may be social withdrawal, negative thinking, irritability, rumination, worry, changes in levels of sexual motivation, and increased concern with physical complaints (APA, 2000, 2013, 2022).

Case study: The story

Note: Key details have been altered to preserve anonymity.

Tony had been a loyal, hard-working employee for the same company for 33 years. In fact, Tony came from a long line of hard workers, with his family owning a small grocery store when he was a child, which he started to work in by doing small jobs when he was six years old. Tony's reputation was well known to his fellow workers and customers, and he took pride in putting their needs first. Rarely would he take sick leave and would often take his work with him on holidays. Alice, Tony's spouse for nearly 17 years, has always been understanding of Tony's work ethic, and has been supportive. Tony gained weight and suffered from knee pain. This led to a double knee-placement and an extended time away from work. During this period, he became anxious about his future and whether he would be able to continue his work. Tony also started to feel a sense of worthlessness during this time, wondering if his employer would still need him, given that they had been 'surviving without him'. Over the previous two months prior to seeing his GP, Tony started to feel very low, despondent, and would find himself becoming tearful easily over little things. Tony was also having some thoughts about whether he was worth anything to others if he wasn't able to work, which lead to some 'scary thoughts' of suicide. Alice picked up on these things, and they both agreed to speak with Tony's GP.

DISTINGUISHING BETWEEN DEPRESSION AND GRIEF

Historically, mental health practitioners and researchers have had difficulty distinguishing between grief or bereavement, and clinical depression as per the criteria of the DSM (Cacciatore & Theilman, 2014). Like depression, grief can negatively impact functioning, have marked increases in negative emotions including sadness and guilt, sleep disturbances, lack of ability to experience pleasure, and may involve thoughts about death (Hall, 2013). Although they overlap in features and client experience, grief is understood as a natural adjustment response to loss, while major depressive disorder is viewed as a pathological syndrome. Grief and depression typically differ in that those with depression may have symptoms of low self-worth, excessive self-criticism, and intractable sadness whereas these are not normally present with grief. Grieving does not preclude the possibility of a depressive disorder, and the stress and grief of the loss can trigger major depression, but counsellors need to be careful that they do not automatically assume grieving people are depressed. To add to the complexity of assessment, counsellors also need to be aware of the concept of complicated grief that may have depression as a symptom. These grief reactions occur most of the day, nearly every day for at least a month. The individual experiences clinically significant distress or impairment in social, occupational, or other important areas of functioning (APA, 2022). Interpersonal Psychotherapy, an approach discussed later in this chapter, provides a simple formulation and way forward with complicated grief, by considering one's indicators of depression being 'caused' by unresolved grief, and that interventions that target this will help to relieve the person's depression (Weissman et al., 2018).

DEPRESSION AND SUICIDE

Suicide is a significant risk factor for clients with depression, with 90% of those who had completed suicides being retrospectively diagnosed with a psychiatric disorder, and two thirds of these being diagnosed with depression (Tanner, 2000, as cited in Berman, 2009). For people who have been hospitalised for mood disorders, the lifetime risk of suicide is 4%. For those who have been diagnosed but not hospitalised for mood disorders, including depression, the lifetime risk for completed suicide is 2%. The public lifetime risk is .5% (Bostwick & Pankratz, 2000). This would suggest that clients with depression are between four to eight times more likely to suicide in their lifetime than non-depressed individuals. Suicide risk assessment and prevention should be prioritised with depressed clients given their elevated risks.

DEPRESSION AND VARIOUS POPULATIONS

As a rule, rates of depression are higher for women than men (Chentsova-Dutton & Tsai, 2009). In Australia, 5.3% of men had symptoms of an affective disorder in a twelve-month period compared to 7.1% of females (ABS, 2008). This difference increases in more traditional gender role societies, however when the rates are closer, research has not yet clarified whether this is due to decreased depression in females or increased depression rates in men (Helgeson, 2012). One theory for the lower rates of depression identified in males is that the measures used might be increased sensitivity to depression symptoms more commonly expressed by females than more externalising expressions such as anger, aggression, and substance use that more men might display (Flaskerud, 2014).

Depression also affects children and adolescents, with 2.8% of children in Australia, from the ages between 4-17, reporting symptoms in a 12-month period (Lawrence et al., 2015). The symptoms are generally the same as adult depression, however more likely to be displayed as irritability or flat affect than a depressed mood, and their moods are more variable due to their ability to be influenced by what is happening around them (Stark et al., 2006). Children and adolescents may also display anger, guilt, and misery. They may withdraw from others, be difficult to soothe, and find it hard to be motivated, such as finding the energy to do homework. Additionally, they may display low self-esteem, and become suicidal (Huberty, 2012).

Indigenous Australians typically have higher rates of psychological distress (i.e., depression and anxiety), in contrast to non-Indigenous counterparts (Jorm et al., 2012). These higher rates of symptoms of depression and anxiety are believed to be related to social disadvantage, chronic physical health problems, unemployment, lower incomes, inter-generational trauma, and educational levels.

Depression rates vary depending on region and culture. Western cultures have higher incidents of depression than do many Asian cultures (Chentsova-Dutton & Tsai, 2009). Of those who move to Australia, refugees typically have double the rates of depression and anxiety than do labour migrants (Lindert et al., 2009). This increased incidence may be associated with higher rates of trauma from their country of origin.

It should be noted that depression is understood or spoken about differently in some other cultures. For example, several cultures report depression using physical rather than psychological language, such as focusing on changes in appetite, sleep, or the presence of headaches. Western clients tend to report their depressive psychological symptoms more so than referring to the physical symptoms (Chentsova-Dutton & Tsai, 2009). Some intercultural clients may refer to depressive symptoms as ‘problems of the heart’, nerves, or fatigue (Nezu et al., 2009).

MULTIFACED NATURE OF DEPRESSION

Depression interacts with biological and psychosocial domains. There is evidence of physiological pathways and vulnerabilities with depression, and it has been identified as being between 31% and 42% heritable (Sullivan et al., 2000). Additionally, depression has been associated with a range of life experiences and issues, such as addictions, suicidality, anxiety, stress, trauma, particular adverse early life experiences (such as abuse/

neglect/parental depression) (Bilfulco, 2009), personality, chronic pain and/or illness, some medical conditions and hormone changes, and some medications (APA, 2013; Berman, 2009; Goodman & Brand, 2009; Hammen, 2009; Hopko & Robertson, 2008; Johnson, 2009; Mustata & Gregory, 2009; Reevy et al., 2010; Sachdeva et al., 2009; Schwartz, 2009; Schwartz & Tripp, 2009). Additionally, while depression can be understood as a disorder in its own right, it can also be viewed as a symptom of other conditions, physical, chemical, and psychological (Gautam et al., 2017).

Depression's many potential pathways contribute in varying degrees to each presentation (Fang & Mao, 2019; Roose et al., 2013). It is important that counsellors are mindful potential contributors when doing assessments. Counsellors might refer clients to their GPs for medical evaluations in case the depression is predominantly linked with a medical condition. When depressive symptoms are presented with other life stressors or problems (e.g., such as addiction), the counsellor might collaboratively negotiate with the client what treatment needs to prioritise. Often addressing one area cascades a positive effect into other areas. For instance, addressing substance abuse may reduce the depression, and vice versa. The important thing is that the counsellor develops the treatment focus with the client, monitors treatment response, and adjusts as needed. An alternative is to address more than one area at a time, either as the sole intervention provider or as part of an intervention team where resources are available.

Depression is predominantly recognised and treated as a primary mental disorder within Western mental health systems, and is often treated with medication. Frances (2013), the former Chair of the DSM-IV Task Force, critiqued the diagnostic criteria for depression and how this has been used. He highlighted that while a diagnosis of major depressive disorder (MDD) is quite beneficial at helping people with severe depression gain access to treatment; it also readily captures people with normal emotional experiences (e.g., mild depression) and ignores the contextual role of life stressors. Sadness and stress have become medicalized and treated with medication, and in his mind, it has created a "false epidemic of MDD" (p. 154). Frances noted that the DSM-5 (APA, 2013) made progress in making the diagnosis harder for milder symptoms. A report by the United Nations Human Rights Council (2017) stated that the biological model of mental health disorders, including depression, have not shown sufficient evidence, claiming that "we have been sold a myth that the best solutions for addressing mental health challenges are medications" (p. 5-7). The report goes on further to say that "the crisis in mental health should be managed not as a crisis of individual conditions but as a crisis of social obstacles which hinders individual rights" (p.19). The DSM5-TR (APA, 2022) and ICD11 (WHO, 2022) have provided a common language and descriptions that enable classification of mental health issues including depression. This classification greatly assists in research, diagnosis, demarcating eligibility for services; and assists practitioners to varying degrees with case conceptualisation and treatment planning. An unfortunate by-product can be a form of medical reductionism that predominantly locates the pathology in the individual and decontextualises the symptoms.

Discuss with your class the potential benefits and risks associated with viewing and treating depression as a medical disorder or alternatively, viewing it primarily as a stress response? Is there a middle ground?

Case study: Returning to Tony's story

When we look at cases such as Tony's, would it not be reasonable to describe his experience of depression as also being a normal human reaction to a significant stressor in his life?

Initially, Tony needed a lot of support to address the loss of purpose in his life from his abrupt cessation of work. Tony had placed a lot of emphasis on his career over his adult life, and 'work' was a primary source of his identity. This resulted in a sense of hopelessness and worthlessness, and at times some suicidal thoughts. Tony felt very troubled by having these thoughts, and harshly judged himself for thinking in this way. He especially felt ashamed to tell Alice, who he had enjoyed a loving and happy partnership with for many years. Opening up to others helped to normalise his experience, and Tony began to see that support was there for him. Some sense of hope started to grow.

INTERVENTIONS FOR DEPRESSION

There have been many proposed theories of the aetiology (i.e., causes) of depression, and a few interventions associated with these theories. For this chapter, we will review several the more well-regarded and evidenced-based approaches from medication to different models of counselling. Some attention will also be given to alternative approaches, including those that address lifestyle factors associated with depressive symptoms.

MEDICATION

The most widely known medical treatment for depression is anti-depressants prescribed by general practitioners and psychiatrists. They are commonly the first treatment offered in medical contexts and may also be offered in combination with therapy. In terms of effectiveness with depression, medication is generally as effective as counselling, while it outperforms counselling with more prolonged or severe depression (Imel et al., 2008).

Antidepressants have come under criticism as researchers are recognising that typically only research that shows positive large effects are published, thus giving inflated average effect size across studies (Hougaard, 2010). In addition, antidepressant and psychotherapy outperform placebo pills slightly (Cuijpers et al., 2014). Both concerns seem to indicate that there is very little effect of the active ingredients in addition to placebo. Further evidence of the possible placebo nature of medication is the large effect of the prescriber of medication on outcome. Who the psychiatrist is has at least, if not more, impact on the outcomes of the treatment by medication or placebo pill (McKay et al., 2006). In other words, depending on which doctor the client is seeing will determine how effective their anti-depressant medication is. In the study just cited, the psychiatrist with the best results had better results with their placebo pill than 80% of the doctors who prescribed the active medication.

COUNSELLING FOR DEPRESSION

Counselling for depression is generally effective at reducing symptoms and improving life quality (Cuijpers et al., 2008; Hoyer et al., 2006; Lambert, 2013). While the debate over which specific therapy is most effective for depression continues, meta-analyses demonstrate that no bona fide therapy has been proven better than others (Cuijpers et al., 2012; Wampold et al., 2002; Weisz et al., 2006) despite various claims. Let us review some of the main counselling models and approaches.

Psychoanalytic model

The psychoanalytic model proposes that depression is the consequence of various forms of unconscious coping strategies in response to psychic pain (Leuzinger-Bohleber, 2015). Freud believed depression was an alternative manner of mourning the loss of a significant other. Rather than a progressive resolution to the loss of a loved one as most do in grief, the person gets stuck in ambivalence and inner conflict towards the object of loss, may lose awareness that they are mourning, and punishes a part of their ego (Mustata & Gregory, 2009; Taylor, 2008, 2015). This is where we get the saying that depression is anger turned inwards (Rehm, 2010). The aim of treatment is to help raise the awareness and insight of clients into their range of unconscious internal reactions and processes towards the loss and help them process their grief. Psychodynamic approaches comprise the more recent developments in the psychoanalytic word, to help clients to address specific internal or interpersonal conflicts. These psychodynamic psychotherapy approaches use the therapeutic alliance actively and constructively, such as the purposeful use of transference, to explore current or past dilemmas or conflicts collaboratively in the therapeutic process. This approach is more often long-term; however, short-term approaches have been developed and show efficacy in treating depression. Confrontation, as well as therapist interpretation, while ensuring an alliance is maintained, are core elements in this approach, with the goal to increase self-awareness, and the resolution of conflicts in the client's life.

Behavioural model

According to behaviourists, people choose behaviours to help them gain rewards and/or avoid distress. In this model, the assumption is that depressed people fail to receive sufficient positive incentives for healthy behaviours and will tend to withdraw from certain other behaviours and activities to avoid short term unpleasant events. Avoidance can additionally be problematic because avoiding potential for distress may also mean they fail to place themselves into situations whereby they gain longer term benefit (Spiegler & Guevremont, 2010).

The aim of the interventions is to help clients stop practising behaviours consistent with depression, and act more with behaviours that are inconsistent with depression. Staying home from work may avoid the risks of facing one's work pressures, but it may also reinforce feelings of hopelessness, thus feeding feelings of depression. Practicing depressive behaviour will simply become a self-defeating cycle, whereas practicing what might be deemed 'healthy behaviours' are more likely to lead to enhanced thinking and moods (Lejuez et al., 2001).

Intervention consists of having clients identify the various situations they avoid and the behaviours that are reinforced through such avoidance, identifying life goals, and then identifying strategies to engage in positive behaviours that are likely to be reinforced and lead to the clients' longer-term goals (Spiegler & Guevremont, 2010). For instance, job seekers can become demoralised and depressed when their efforts at finding work continue to be unsuccessful. They may engage in behaviours that avoid the short-term risk of rejection, but in doing so, may find themselves less likely to achieve the longer-term satisfaction accompanied by securing employment. The behavioural counsellor, using the strategy of **behavioural activation**, might help them develop a stronger awareness of the longer-term goals, activities to help them progress towards the goals, and also develop or identify reinforcements associated with activities that contribute to finding employment. In contemporary psychotherapy, most behavioural approaches have been absorbed into the more well-known cognitive behaviour therapy tradition.

Learned helplessness

Learned helplessness is a variant in the behavioural school. Martin Seligman discovered that when dogs were taught that a tone was accompanied by a shock, rather than trying to avoid the shock, the dogs took no evasive action but simply whimpered. He speculated that they were conditioned to expect they could avoid the shocks and hence resigned themselves to receive them. Seligman generalised the implications of this to depression, in that humans who believed that their actions, based on previous learning, were ineffective and could not reduce suffering, would simply resign themselves and choose to be helpless. Given that this generalising and depression does not apply to all people who experience uncontrollable events, Seligman proposed that it was linked to whether a person believed the negative experience was somehow linked to their self-worth (Reevy et al., 2010).

Intervention involves helping the client learn new skills to gain more mastery over situations, helping them exercise greater control where they can, helping them aim for achievable rather than unrealistic goals. It helps them appraise cause and effect for positive and negative situations more realistically (Rehm, 2010).

Case study: Tony begins to move towards a rich and meaningful life

Initial stabilisation was achieved through increased exercise and pleasurable activities such as gardening and cooking. Tony was willing to progress further in therapy by clarifying his values. Tony identified strong connections with family and friends and found a lot of satisfaction in regularly gathering with those he loved and cared about. Social gatherings or visits were planned for weekends.

Cognitive behaviour therapy models

Cognitive therapy (founded by Aaron Beck) and rational emotive behaviour therapy (founded by Albert Ellis) are the two main schools of cognitive behaviour therapy approaches. Aaron Beck proposed that faulty cognition with a bias towards negativity causes and maintains depression. Cognitive therapy argues that it is not so much what happens to a person that makes them depressed, but that people feel depressed as a result of tending to engage in patterns of thinking and beliefs about the events, themselves, and the world generally, with a negative bias (Blackburn et al., 2006). While one person may experience failing in an exam as disappointing but nonetheless a prompt to study harder, a depressed person might view it as evidence that they are never going to succeed, that they might as well give up, and that they are a born loser. Cognitive behaviour therapy (CBT) is the umbrella label for cognitive and behavioural approaches, and combines aspects of both. CBT is often described as a focussed approach, where counsellors work with clients to address their faulty cognitions, which are the basis for their difficult emotions, or maladaptive behaviours. Cognitive techniques include addressing the person's faulty thinking patterns through cognitive restructuring. For example, treatment may involve helping clients learn to recognise the difference between functional and dysfunctional thoughts, helping them monitor their thoughts, and learn to replace their dysfunctional thinking and beliefs with more adaptive alternatives. The behavioural aspects of this approach are drawn from behaviourist theory, and use techniques such as exposure, activity scheduling, and behaviour modification. Relaxation training is also prescribed. Skills training, like assertiveness, or stress management, are also key components of this approach. An important initial step when intervening with depression is pleasant activity scheduling (also referred to as behavioural activation). This involves helping the client to identify pleasant activities, and those that also provide challenge, and then setting goals together to increase these by creating a weekly schedule comprising these activities. Although this seems like a very behaviourally oriented approach (and it is!), it has become a standard in treatment for depression in CBT. While it has been acknowledged previously that all approaches hold similar efficacy, it must be noted that CBT has demonstrated especially good efficacy with treating depression and is supported in Australia under Medicare as a recommended approach (The Australian Psychological Society [APS], 2018).

Mindfulness-based cognitive therapy (MBCT) is a newer approach, derived from CBT, which emphasises mindfulness-based meditation as a core treatment for depression, and has shown promising signs especially for treating recurrent depression (Kahl et al., 2012). It focusses on interrupting ruminative patterns of thinking which are often associated with depressive relapse. The main difference between traditional CBT and MBCT is that the latter focuses more on changing one's relationship with their thoughts, by noticing and observing inner dialogues, rather than challenging or changing thinking patterns through cognitive restructuring. Clients are helped to see themselves as 'having' thoughts, or experiencing difficult emotions, rather than believing their thoughts as being real or factual.

Acceptance and commitment therapy (pronounced ACT), similar to MBCT, is regarded as part of the third wave of cognitive behavioural therapies. ACT was developed by Stephen Hayes and colleagues, following their work on relational frame theory, which explored the contextual theory of language and cognition. While acknowledging, and in some cases borrowing, from already efficacious approaches in CBT, its primary difference is in the way that it approaches thoughts, feelings, and behaviours. ACT sees the context and function of private experiences as the primary target of intervention, helping a client to develop greater acceptance for their subjective distress, rather than working towards symptom reduction. ACT argues that clients can work towards improved quality of life, as opposed to a life restricted by avoidance of painful thoughts and experiences. Specifically, when applied to depression, rather than focusing on the content of the

depressed person's thoughts, ACT focuses on helping to develop a different relationship with their thoughts. It does not aim to replace dysfunctional thoughts with functional thoughts as does traditional CBT, but rather, clients are taught to dispassionately observe both their thoughts and feelings. This skill is referred to as cognitive defusion. In ACT, the goal is not to directly 'reduce' depressive symptoms, but to assist clients to accept their inner experiences regardless of how undesirable they might be (rather than adjusting their lives trying to avoid such experiences), and to see them simply as experiences rather than evidence of something more important. For instance, if the client has a thought "you will never be any good", rather than fighting with it, trying to ignore it, or worse, believing it as a truth, the client might simply say "Thank you mind for that thought" and get on with what they were doing. This deemphasises the speculated significance of internal experiences and frees up energy for the client to live life according to their life values (Siddiqui et al., 2009). Being more values-guided also enables clients to relinquish destructive patterns of behaviour and make decisions that are consistent with their values. A simple example of this for a client experiencing depression might be, rather than withdrawal from friends and family, clients might learn to take action toward a more rich and meaningful life, and be more socially engaged with those that matter. This might be despite some difficult feelings persisting when clients initially try to re-engage with their world. Clients are challenged to be willing to work towards a life of purpose, and at times, allow space for any difficult feelings or thoughts that might accompany them.

Interpersonal therapy

Interpersonal therapy (IPT) was initially developed in the 1970s as a control treatment for research on the effectiveness of anti-depressants (Klerman et al., 2017). However, unexpectedly, the approach itself was shown to have effectiveness, and was further developed into the model now referred to as IPT (Klerman et al., 2017). The assumption of IPT is that problems in a person's interpersonal relationships are interrelated with depression, and if specifically targeted interventions, will see an amelioration of depressive symptoms (Klerman et al., 2017). IPT is a structured approach, often described as a brief intervention, lasting for a prescribed number of sessions, commonly up to 10. The time limited nature of IPT is seen as an active ingredient in the treatment (Klerman, et al., 2017). The main goal is to help clients understand that their current interpersonal difficulties are directly associated with their depression. Its main emphasis is to help clients develop more effective communication skills, more effective mechanisms for expressing emotions, and more realistic expectations of relationships (Robertson et al., 2008). Sessions often include skills training for resolving interpersonal disputes, managing role transitions, dealing with grief or loss, and addressing interpersonal and social deficits by such strategies as improving communications skills through practice and role play with the counsellor. IPT has been found to have good efficacy in treating depression and is supported in Australia under Medicare as a recommended approach (APS, 2018).

Case study: Small steps

Tony identified how much his health had declined, and his recent knee surgery and obesity, caused him to see how little care he had given to himself over the years. This was often due to work over-prioritisation. Tony chose to take committed action towards improving his health through better exercise and diet. Progress was slow, and it was a hard battle, but over time Tony increased his exercise through regular walking, developed a good diet supported by his GP, and lost a significant amount of weight. Over time, Tony also decided to start playing social badminton, which he had discovered in his local area. This also helped to increase his social connection.

ALTERNATIVE INTERVENTIONS

Not every client wants to seek psychological or medical treatment alone but may want to add or seek alternative interventions for depression.

Exercise is viewed by some as a form of intervention that can be used by itself or in conjunction with medication or counselling. It provides similar depressive symptom reducing effects to antidepressant medication (Daley, 2008; Dinas et al., 2011) at moderate levels of aerobic exercise, and is recommended for community mental health services, and placebo effects only for lower levels of exercise (Dunn et al., 2005). Pollock (2001) strongly recommends incorporating it as homework for most counselling approaches, although depressed clients understandably have issues initiating and sustaining exercise. Given that there may be health concerns that might inhibit a client's physical activity, it is suggested that they do so after consulting their GP or physical instructor first.

Some clients may prefer nutritional interventions to help reduce depression. There has been a gathering of strong support for interventions in diet (see foodandmoodcenter.org) as an additional intervention for depression, or something that can be done in conjunction with counselling. Other options might include supplements, such as St John's Wart, folic acid, and Omega-3. Typically, they are used in conjunction with other interventions. Some display mild benefit while others have not yet been established to be beneficial (Sarris et al., 2009).

Acupuncture has some evidence to suggest it may be effective in responding to depression (Wang et al., 2008) however the strength of the evidence and the research designs cannot provide any conclusiveness at this time (Wu et al., 2012).

Over the last decade, there has been a sharp rise in the availability of print and online self-help resources. Many of these have a strong evidence base, and a counsellor may choose to advocate these to their clients. Mobile Apps designed to help alleviate depression are also available such as the Headspace or MoodKit apps. Self-help without a therapist is helpful with depression, often giving equivalent results to psychotherapy (Norcross, 2000), though complicating factors such as severe depression or suicidality may lead to negative outcomes (Mains & Scogin, 2003).

Counsellor reflections

Over time, I have found addressing lifestyle factors to be a primary concern when working with clients experiencing depression. In the future, options like exercise and diet will no longer be considered adjuncts to counselling, or alternatives, but will be considered consistent with most approaches reviewed in this chapter. It will be commonplace in the initial stages of counselling to address any of these factors as a part of a course of intervening with depression. Whatever your approach, educating clients about the benefits of increasing exercise, eating a more wholesome diet, or getting better sleep, will assist in reducing depressive symptoms and improving overall well-being. [James]

GENERIC COUNSELLING SUGGESTIONS

Up until this point, specific treatment approaches have been considered, drawn from the basis of evidence in the literature. This section will address general principles that all counsellors might consider, irrespective of their therapeutic modality. These suggestions are given from the perspective of the author, on account of their experience in the counselling field.

Counsellors will commonly see clients experiencing depression. Some of these clients may be receiving treatment for depression from other mental health providers such as general practitioners and psychologists. Others will seek counsellors as the sole or primary mental health provider to address depression. They may seek counsellors to deal with other stressors in their life or perhaps they seek a different approach, such as a client centred approach in comparison to more prescriptive approaches. Some may seek counselling as an

alternative to medication or possibly to replace their existing anti-depressant medication. Counsellors who become aware of clients seeking to withdraw from medication without medical supervision should highlight that there can be negative health risks of unsupervised medication withdrawal and recommend that any changes to medication be discussed with their medical provider.

Counsellors may also see clients who have not been given a diagnosis of depression, yet the counsellor might suspect the client is impacted by depression. When counsellors suspect depression, they can follow up with the two Whooley screening questions (Whooley et al., 1997) . If the answer is affirmative to either question, the counsellor should consider recommending that the client consult with a medical doctor for further assessment, to screen for direct biological causes or other medical conditions that might be relevant.

Counsellors should regularly monitor for suicidality with depressed clients given that depression increases risk in this area. In addition, counsellors need to be mindful that when depressed clients appear to improve and have enhanced energy, this may be an indicator of increased suicidal risk (Rogers et al., 2018).

Counsellors can make two key mistakes working with clients with depression. The first is the attempt to help lift them out of depression by attempting to 'cheer them up' or encouraging them to 'look on the bright side'. While the goals of seeking to enhance mood and help reduce negative thinking are both worthy, any such attempts are naïve and will often meet with resistance and communicate to the client that the counsellor is unwilling to understand and empathise.

The second mistake is almost the opposite. In this scenario, the counsellor joins with the client and actively reflects and paraphrases the client as they talk about their depression. As the counsellor reflects the feelings accurately, the client's mood in the session lowers and the depressive thinking and feeling increase. While closely tracking clients with many issues is helpful, close reflective listening with clients with depressed moods can intensify the experience of depression and hopelessness. An alternative is to balance paraphrasing of depressive content with reframing towards what they implicitly hope for. If a client comments that they feel as though they are spiralling into hopelessness, rather than reflecting and amplifying the hopeless feelings, the counsellor might reframe "you're wanting things to start improving" thereby tapping into the implied hope for change. By strategically choosing when to paraphrase and when to reframe towards client goals, the counsellor can balance hearing the 'depression story' and inviting interest in the story of the client's desire for change.

When working with a client with depression, we would recommend that practitioners monitor the client's experience and response to treatment. Is the counselling having a positive impact on the client? There are various formal feedback measures that counsellors can use to gather this evidence. The Outcome Rating Scale (ORS) (Miller & Duncan, 2000, 2004) and Session Rating Scales (SRS) (Miller & Duncan, 2000, 2004) enable counsellors to track client outcomes and also to measure the strength of the therapeutic relationship, each and every session. Utilising these measures enables counsellors to check the client's progress and also the client's satisfaction with the intervention itself. This enables the counsellor and client to collaboratively discuss adjustments if positive change or treatment fit is not occurring. A recommended text to become familiar with the use of the ORS and SRS is *On becoming a better therapist* (Duncan, 2014).

Case study: Every story has an ending and a beginning

Tony continued to attend therapy following his initial recovery and stabilisation. These sessions were used to support the changes that Tony had made, and to help prevent relapse. After a six-month period of meeting at 4 to 6 week intervals, it was agreed that no further sessions were required. Of course, ending therapy may be the beginning of a new approach to life for our clients. Managing mental health is an ongoing challenge. The following email from Tony best describes this:

> This is Tony. If you remember me, you helped me heaps, to deal with my depression & anxiety. I just wanted to give you a quick update on me.
> If you remember, I had double knee replacements (both at same time) which were a success. I finally was able to get back on my bike end of Jan (after approx 7 years).

> I ride downtown and home again twice a week now.
> I am traveling quite well, and more of a happy chappy these days. Still enjoying the same things as when I saw you last – gardening, cooking, some reading, and my weekly Thursday morning badminton (it's great fun and very social). I also recently joined a walking group on a Tues morning.
> As I wanted to do some volunteer work that wasn't too taxing, I'm in the process of becoming a volunteer driver which just involves drivers to pick elderly people up from their homes and drive them to medical appointments or shopping centers, etc. It may be 3 or 4 hrs once or twice a week. I'll see how I go.
> Anyway, enough about me. Hope you and your family are well,
> Thanks again for all your help.
> Tony

CONCLUSION

The impacts of depression can be very disabling and distressing for both the sufferer and their loved ones. With an expectation that depression will be on the rise in western society, counsellors need to be well equipped to help those who are suffering. There are multiple treatments available to clients both within a counselling context and in other healing orientations. Counsellors should appraise the literature and develop a range of options to find the best fit for clients, in a collaborative and client-focused approach.

RECOMMENDED RESOURCES

This chapter has introduced students to some basic general information and principles for working with clients with depression. We would recommend students gain deeper knowledge by reading more thorough texts on counselling for depression (For example, see Gilbert, 2007; Sanders & Hill, 2014). This current chapter serves only as an introduction.

BOOKS ON COUNSELLING FOR DEPRESSION

Gilbert, P. (2007). *Psychotherapy and counselling for depression* (3rd ed.). Sage Publications.

Sanders, P., & Hill, A. (2014). *Counselling for depression: A person-centred and experiential approach to practice.* Sage Publications.

BOOK ON FEEDBACK INFORMED TREATMENT

Duncan, B. L. (2014). *On becoming a better therapist* (2nd ed.). American Psychological Association

WEBSITE LISTING MOBILE APPS FOR DEPRESSION AND OTHER DISORDERS

The Best Depression Apps

Learning activities

What about you?

1. What do you think are the strengths and weaknesses of each counselling approach?
2. Which of the above counselling models do you feel most aligns with you?

3. What do you know about the role that lifestyle factors such as sleep, diet, and exercise play in the experience of depressive symptoms?

GLOSSARY OF TERMS

DSM—the DSM is the abbreviation for the Diagnostic and Statistical Manual of Mental Disorders. This text is classification guide for psychiatric disorders and is used within clinical psychology, psychiatry, and research. The current manual is in its 5-TR edition.

ICD—the ICD is the abbreviation for the International Classification of Diseases. It is now in its 11th edition. It is accessible from World Health Organization ICD web page.

medical model—this is the paradigm that approaches mental health with similar assumptions as used in treating physical medical conditions. It assumes specific clusters of psychological distress and impairment reflect underlying disorders that must be correctly diagnosed and treated.

melancholia—this is an ancient term used to describe what is understood as depression. It is rarely used in modern times.

rumination—a negative emotional mood state with a process of repetitive mental focus on one's problems without resolving them

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Currently, James' focus is on his private practice work, specialising in assisting men with improving their mental health and relationships. James is especially passionate about advocacy for better physical and mental well-being amongst men and is a member of the Australian Men's Health Forum. James also serves as a non-executive board member of The Fathering Project. In addition to his therapy work, James also provides supervision to psychologists and enjoys supporting professionals working in health and allied health to assist with preventing burnout and compassion fatigue.

James enjoys family time with his wife Michelle and their four children. In his spare time, James enjoys music, cooking, bushwalking, and travel. He is a member of an award winning a 'Capella singing group, Monday Nights.

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Domestic Violence

NATHAN BEEL

ABSTRACT

This chapter explores domestic violence, its prevalence, impacts, and risk factors. It describes two major paradigms that inform the research and practice of domestic violence responses, and delineates between systematic and situational violence. Key interventions and models of counselling effective in working with victims-survivors and perpetrators are described.

Learning Objectives

- Identify definitions and impacts of domestic violence.
- Analyse the gendered feminist model and family violence model.
- Identify general principles for screening, assessment, and intervention with domestic violence perpetrators and victims-survivors.
- Recognise the importance of supervision and self-care.

INTRODUCTION

Public awareness of domestic and family violence has increased in contemporary society, with a regular stream of news stories reporting murders of young women and mothers by partners with whom they were currently or formerly in committed relationships. What was historically viewed as a private family affair has been made visible as a criminal and public health issue. Counsellors will see clients who come specifically for help from domestic and family violence situations, may have it as a background issue, or alternatively the counsellor may work in specialist programs specifically focussed on working with perpetrators and/or survivors of family violence.

This chapter will provide a brief and basic overview of what is an extensive and nuanced topic. It will provide introductory knowledge in key areas required to identify, support, and refer clients, though developing more expertise is strongly recommended. The chapter reflects the historical and contemporary gendered discourses that emphasise women's vulnerability and introduces gender-inclusive perspectives and language to support appropriate assessment and intervention practices. Additionally, this chapter will address intimate partner abuse and violence while child abuse and neglect will be treated in a separate chapter in this book.

DEFINITIONS

There are several key definitions that are used when referring to violence and intimidation that occurs within

families and intimate relationships. Earlier terms were specific to married women, such as **wife abuse** and **wife beating**, however current terminology is more inclusive. **Domestic abuse (DA)** is the term given for a range of abusive behaviours without physical violence (Summers, 2015) and is commonly used in literature from the United States. **Domestic violence** (DV), **partner violence**, and **intimate partner violenc**e (IPV) are often used interchangeably to refer to violence and intimidation that occurs by partners and former partners, while the term **family violence** includes adolescent to parent abuse, elder abuse and child abuse and neglect. Family violence may be preferred over domestic violence by Indigenous peoples, due to their wider and more connected kinship relationships (Backhouse & Toivonen, 2018). **Victims** and **survivors** are both used as identifiers of those who have been abused, however, the former may denote passive, innocent helplessness, while the latter is usually preferred due to the inferred agency in surviving despite abuse. In this chapter, victim-survivor will be used. **Perpetrator** has historically been the term for those who use abuse, however, is increasingly superseded by **Person Using Family Violence (PUFV)** to reduce stigmatisation, which can be a barrier to help seeking. A list of contemporary terminology for family, domestic, and sexual violence can be found at the Australian Institute of Health and Welfare [AIHW] (2019a).

WHAT IS DOMESTIC VIOLENCE?

DV is interpersonal maltreatment that may psychologically and/or physically harm one's intimate partner (or ex-partner) and potentially others (such as children and pets). This includes acts and threats of acts, and negligence. It is a violation of the emotional contract based on an implicit or explicit commitment to each other's welfare, and a demonstration of a disrespect for the other's rights and boundaries. A common belief about domestic violence is a loss of control, and that persons using violence need anger management, or that victims/survivors provoke the aggression. However, it is most commonly understood as exerting power and control (AIHW, 2019a; Gottman, 1999).

A significant number of people have experienced relationship aggression. In Australia, one in six women and one in sixteen men reportedly experienced physical and/or sexual violence from a current or former partner since 15 years of age (Australian Bureau of Statistics [ABS], 2017). The same survey showed one in six men and one in four women reported receiving emotional abuse from a current or former partner since age 15. In relation to partner violence over a twelve-month period in 2016, 1.5% of women, and .8% of men experienced partner violence (ABS, 2017). While at a population level these percentages may seem relatively small, counsellors will see higher percentages in their practice due to the associated issues they treat such as depression, anxiety and trauma, and relationship difficulties.

Case study: Julie

The following case study provides a simple scenario to introduce students to domestic violence. Note that DV cases can range in complexity and dangerousness (e.g., single incident or pattern of abuse, severity of violence, harm, and trauma, exposure of children, threats to counsellor safety, length of abuse histories, etc).

Julie, a 23-year-old female, came to see a counsellor after breaking up with her boyfriend. She reported he had regularly criticised her, and on a recent occasion, had physically assaulted her after an argument. She reached out to see a counsellor as she was confused about whether to resume the relationship. She reported never being in a relationship like this before.

Consider how you might respond to Julie if she was your client.

FORMS OF DOMESTIC VIOLENCE

There are many behaviours that fall under the umbrella of violence. One of the common misconceptions with clients is that unless physical violence is involved, relationship aggression cannot be called domestic violence (Bagshaw et al., 2000). However, physical assaults are just one of several forms of domestic violence.

Counsellors need to be aware of the various ways relationship aggression is enacted. Below is a selection of various forms of violence and abuse:

- **Physical violence:** assault, hitting, pushing, choking, burning, hurting pets, or using weapons
- **Sexual violence:** non-consensual sexual contact including unwanted sex acts and rape
- **Financial abuse:** withholding access to finances, controlling all financial decisions, providing insufficient funds for essentials
- **Psychological and emotional abuse:** intimidation, controlling behaviour, making threats, belittling, yelling, verbally abusing loved ones or pets, gaslighting, emotional blackmail, blaming, stalking, threatening suicide
- **Social abuse:** isolating from family, friends, and other social supports, publicly humiliating
- **Cyber abuse:** online stalking, revenge porn, bugging devices with tracking software
- **Spiritual:** denial of religious freedom, use of religious beliefs or practices to control behaviour or movement.

One of the most widely known gender-based graphical representations of clusters of abusive behaviour is the Power and Control Wheel (Pence & Paymar, 1993b). This wagon-wheel design centralises power and control as the primary motivation for men who use violence, from which patterns of behaviour emanate. The conceptual model was based on information provided in focus groups of female survivors, though has also been adapted for the LGBTQI+ community (see Roe & Jagodinsky, n. d.). The model is used to make transparent to batterers the dynamics and tactics of abusive men. An additional diagram named the Equality Wheel was added later to depict what behaviours battering men should replace the abusive behaviours with (Domestic Abuse Intervention Programs, 2017). Counsellors who suspect DV may show clients these two wheels as a means of assessment and of awareness-raising.

TYPOLOGIES OF DOMESTIC VIOLENCE

Johnson (1995) suggested that not all DV is motivated by control, but that there were four different identifiable patterns. The first is **intimate terrorism** (earlier was termed patriarchal terrorism) (Johnson, 1995, 2011). This is where one partner systematically and comprehensively controls the other, irrespective of the other partner's attempts to appease and placate the violent partner. The second is **violent resistance**, whereby the victim of intimate terrorism fights back using violence. It may be defensive, payback, or an attempt to escape (e.g., a type of defensive homicide). The third form of DV is called **situational couple violence** (or **common couple violence**). This type of violence is not indicative of a pattern of control like intimate terrorism. Rather, it is due to situational stressors, varying motivations, and conflict management deficits. It can be used by one or both partners, may be one off or chronic, may be relatively minor or lethal. The fourth is **mutual violent control**. This is the rarest pattern whereby both partners systematically seek to control the other partner.

These four different types of domestic violence are important to understand in assessing risk and considering interventions. Counsellors need to know that intimate terrorists may attempt to manipulate the counsellor to collude with them against the victim. While the dominant understanding defers to believe women and hold suspicion towards males claiming victimisation, counsellors need to be mindful women can also be intimate terrorists (Laroche, 2005). Counsellors also need to determine whether the dynamics are control-based or conflict-based, and whether the power in the relationship is relatively equal or unequal. Clients who use conflict-based, stress triggered DV may benefit from teaching emotion regulation and conflict management strategies to the individual/s perpetrating the abusive reactions. Control-based DV may require more mandated, community, and legal interventions to protect those at risk, and aim to restrain offenders via legal means (e.g., protection orders).

IMPACTS OF DOMESTIC VIOLENCE

Clients affected by DV can present with a range of symptoms and issues, including psychological, physical, social, and financial. Presenting issues in counselling can include low self-esteem, shame, self-reproach, depression, anxiety, relationship distress, trauma symptoms, suicidal thoughts, eating problems, substance abuse, and somatic symptoms (Coker et al., 2002; Randle & Graham, 2011; Shannon, 2009). In addition, physical injuries may also be visible or revealed by the client to the counsellor. As a psychological trauma, DV negatively impacts one's ability to develop and maintain healthy boundaries in interpersonal relationships. This can manifest in the counselling relationship as being overly reliant or dependent on the counsellor. Guilt, shame, and avoidance are proponents of trauma symptomatology that cause victim-survivors to conceal, minimise, or deny DV (Lawson, 2013). Besides the impacts already listed, women experiencing DV have higher rates of unplanned pregnancies (Dahlen et al., 2018). Babies of women experiencing DV are more likely to be premature, smaller, and have a lower birthweight (Donovan et al., 2016). Clients in DV situations may be more socially isolated, and have limited social supports available to them, often due to their partner controlling their movements and attempting to seclude them. They often have less access to financial resources, which makes escaping harder without the support of social mechanisms to assist.

Children who witness DV have similar symptoms as those directly abused (Bedi & Goddard, 2007). They also experience similar symptoms to adults' direct experiences of DA, including lowered self-esteem, depression, anxiety, and trauma symptoms (Bedi & Goddard, 2007). In addition, DV has been associated with elevated risks of aggression for both male and female adolescents (McCloskey & Lichter, 2003) and increased the risk for both sexes for referrals to juvenile courts, with girls being at higher risk of DV offenses and boys for violence against non-family members (Herrera & McCloskey, 2001). There is also a substantial co-occurrence with child abuse in DV homes (Sammut Scerri et al., 2018), hence counsellors need to also assess for child abuse and neglect.

Arguably, the most significant impact is death, potentially the homicide of the partner, children, and at times, includes the suicide of the perpetrator. The risk of being murdered is higher for women who were abused in pregnancy, who initiate or complete separation, or have their own substance abuse issues. For males who perpetrate intimate partner violence, higher risk factors for committing intimate partner homicide are that they are younger, are unemployed, have lower levels of education, are controlling, show jealousy, have anger problems, have used non-fatal strangulation, have forcibly used sex, have threatened harm, have addiction and mental health issues, and/or have access to firearms (Campbell et al., 2003; Martin et al., 2007; Spencer & Stith, 2018). Counsellors need to ensure they do not lose awareness of this potentiality when assessing risks. DV is potentially lethal, and counsellors need to maintain awareness of this risk. The take-home message in exploring the impacts of DV, is that whether experienced directly or witnessed, DV is harmful to both adults and children, and that due to these risks and its prevalence, it is important for all counsellors to be competent in identifying and addressing DV.

SPECIAL POPULATIONS AND RISK FACTORS

Clients can have factors that increase vulnerability to harm, increase likelihood of experiencing abuse, and/or decrease access to support. In Australia, women and children are deemed to be special populations and the Council of Australian Governments (COAG) has dedicated a national strategy to address domestic violence (COAG, 2010). Backhouse and Toivonen (2018) state that being a woman is a risk factor. Besides this, being pregnant and/or being a mother further increases the risk and intensity of domestic violence (Taft et al., 2004; Vatnar & Bjørkly, 2009).

Indigenous Australians are at higher risk of family violence compared to non-indigenous Australians, with Indigenous women being 35 times, and Indigenous men 22 times more likely to be hospitalised for family violence in comparison to non-indigenous people (Al-Yaman et al., 2006). Other higher than average risk groups include culturally and linguistically diverse populations, people with disabilities (AIHW, 2019b;

Ghafournia, 2011), LGBTQI people (AIHW, 2019b; Jackson, 2007; Messinger, 2017), and people living in rural and remote areas (AIHW, 2019b; Wendt & Hornosty, 2010), and socioeconomic area of residence (AIHW, 2019b). Counsellors need to understand the risks and impact of domestic violence on children. The impact of witnessing family violence on children is becoming increasingly recognised. In the 2016 Safety Survey, of those who reported domestic violence in their current relationship, 50% reported that children had witnessed it. In addition, slightly over half of children living with domestic violence also are abused, from fathers and to a lesser extent, mothers (Bedi & Goddard, 2007; Margolin et al., 2003). Children living with domestic violence can experience a range of developmental, psychological, behavioural, and social problems (Bedi & Goddard, 2007), and all States in Australia contain legislation that addresses children's exposure to domestic violence (Richards, 2011). Children who experience DV are also at risk of homelessness, making up 33% of children accessing supported accommodation services in Australia (Campo, 2015a).

Male victims of DV are rarely mentioned or systematically overlooked in most government literature on DV, however, counsellors will see males who report victimisation. Some may be in highly conflictual relationships, some will be a primary victim of a female or male aggressor, and some might be the primary PUFV. Given social priming to view men as perpetrators, victimised men will often be sceptical about whether they will be believed or supported, and may experience blame, ridicule, disbelief or even treated as the abuser (Shannon, 2009).

DOMESTIC VIOLENCE METATHEORIES

There are multiple theoretical frameworks for understanding DV (Gelles, 2017; Hanson Frieze et al., 2020) which are beyond the scope of this chapter. However, there are two main metatheoretical frameworks that have shaped DV understandings and research, with the first tending to emphasise socio-political perspectives, and the latter emphasising psychological perspectives. These two approaches are described below.

FEMINIST GENDER-BASED VIOLENCE MODEL

The most influential and mainstream approach to viewing DV is interpreting it as a gender-based issue. This approach emerged from early feminism as a key issue of women's rights, both in relationships and in society. Its primary focus has historically been on women's safety within the context of heterosexual relationships, though more recently has increasingly emphasised the impacts on children, and recognition of the diversity of identities associated with DV abuse and victimisation (Becker et al., 2022). Feminism has a large diversity of thought and has also undergone four waves of change. At its core, feminism believes DV is fuelled by, and symptomatic of gender inequality sustained by patriarchy. Patriarchy can be understood that men broadly dominate and misuse power over women at all levels of society, including politically, institutionally, socially, morally, economically, and relationally. According to this model, DV is the use of violence to control and dominate women (Pence & Paymar, 1993a), and is symptomatic of attitudes of male entitlement stemming from patriarchal culture.

More contemporary feminism has been adapting to more nuanced understandings of DV, including recognition of male victims, female PUV, and intersectional experiences in a range of diverse social identities, including race, disability, sexuality, and social class (Becker et al., 2022). The LGBTQI+ movement has questioned the emphasis on binary male female, heterosexual, cisgender relationships, to ensure theorising and social responses ensure visibility, research, and appropriate responses with DV in gender and sexually diverse relationships.

The gendered approach, while adapting with time, primarily seeks to raise awareness of violence against women and emphasise holding men accountable for violence. It advocates for coordinated community and government responses to provide integrated legal, financial, advocacy, emotional, and housing assistance to women and their children. To reduce the risk of DV, society level interventions such as public and community campaigns are used to help influence attitudes towards gender equality. For male PUV, legal and rehabilitation-focused interventions are recommended (COAG, 2010). For Australian resources, research, and

framework that aligns with a gendered approach, see Family Violence Multi-Agency Risk Assessment and Management Framework (Family Safety Victoria, 2018).

FAMILY VIOLENCE MODEL

The family violence model for DV is a gender-inclusive approach proposed by conflict researchers. This approach aims to study the usage of aggression in relationships from psychological science, similar to how other forms of criminal aggression are studied (Dixon & Graham-Kevan, 2020). The gender-inclusive paradigm proponents question the legitimacy of viewing DV through a gendered lens, and suggest it prevents a more scientific and objective analysis of available evidence, and leads to biased research, assessments, interventions, and policies. They emphasise researching and theorising DV based on individual contributory factors, such as the contribution of personality disorders, substance abuse, mental illness, and other risk factors that are correlated with abusive behaviour and hence argue that assessment and treatment design strive to be thorough, nuanced, evidence based, and impartial (Dixon & Graham-Kevan, 2011, 2020; Graham-Kevan & Bates, 2020).

The gender-inclusive model has received criticism, particularly its promotion of research showing gender symmetry in the rates of violence (See Archer, 2000). While quantitative measures of aggressive actions may be more symmetrical between the sexes, the Conflict Tactics Scale that is commonly used in population-based DV research, does not measure qualitative differences that show that men's motivations, and risk of harm is different to women's motivations, use of violence, and risk of harm. The measures are not nuanced enough to distinguish the more gendered, at-risk subpopulations, such as those experiencing intimate terrorism (Johnson, 2006; Kimmel, 2002). In addition, feminists would argue that taking a gender-neutral approach would fail to adequately recognise gendered power differences, and this would place women at greater risk.

How can counsellors reconcile these different positions on DV? The feminist approach amplifies awareness of risk factors and vulnerabilities specifically associated with women (and increasingly children and minority group members), encourages counsellors to consider gender and power dynamics, and consider attitudes and beliefs associated with abusive behaviour. The family violence model encourages counsellors to address violence and abuse as the central problem, and to impartially assess for comorbidities and risk factors associated with DV, and customise responses accordingly. While counsellors may lean more towards one or the other paradigm, they can draw on the strengths of both.

For more information on international research informing the family violence approach, see domestic violence research

COUNSELLING AND DV

DV, as highlighted earlier, does harm and can be lethal. Counsellors need to be sufficiently prepared to conduct screening to help reduce risks of further harm, to enhance safety, and be able to work therapeutically with those who have experienced, witnessed, and/or perpetrated DV. Counsellors have ethical obligations to support all client's rights to safety, dignified and non-discriminatory treatment, and equally to do no harm (Australian Counselling Association [ACA], 2022; Psychotherapy and Counselling Federation of Australia [PACFA], 2017].

Contemporary approaches to DV focus on an integrated multi-service approach to holding perpetrators accountable and aiding victims/survivors. Dedicated DV services, police, courts, legal services, refuges, child protection agencies, schools, counselling services, disability services, welfare services, and health services, aim to work together to work towards behaviour change for perpetrators, and support safety, welfare, and autonomy for victims-survivors. Counsellors may play an initial screening and educational role for assisting clients to engage within the network of assistance or may offer therapeutic services within (or as an adjunct role) to this broader service system.

SCREENING

Clients who are experiencing DV do not always disclose it. Clients may not recognise the abuse as DV, may not see it as related to their presenting issues, or may be concerned about risks in disclosing it. These risks may include feeling ashamed, embarrassed, being judged and blamed, or concern that disclosure may lead to the escalation of the abuse (Vesna et al., 2017), as well as legal implications.

Clients presenting with symptoms of low self-esteem, depression, anxiety, and/or trauma should be screened for DV (Seeley & Plunkett, 2002). There is evidence to suggest direct questions about abuse, rather than indirect questions about relationship quality, are perceived as more helpful by clients (Bagshaw et al., 2000). Counsellors should be mindful of warning signs such as frequent conflict, the presence of fear, a history of DV in childhood, a history of DV in previous relationships, aggression and/or control, substance abuse, higher risk mental/personality disorders (e.g. borderline personality disorder, antisocial personality disorder, bipolar disorder etc), and physical discipline of children (Hamel & Nicholls, 2006). There are several screening tools and recommendations available for counsellors and other helping professionals, of which readers are encouraged to familiarise themselves, such as the Domestic Violence Safety Assessment Tool (e.g., see Ramaswamy et al., 2019; Robinson & Moloney, 2010).

Couple counselling is not recommended for couples where there is power inequality, unilateral abuse, or the nature of abuse is severe (Hurless & Cottone, 2018). To progress irrespective may place the more vulnerable partner at greater risk of harm. However, couples who register for counselling may not disclose abuse dynamics, therefore it is the counsellor's responsibility to screen to determine whether to proceed with the dyadic format. Counsellors need to develop strategies about inquiring about safety without increasing the risk of perpetration or disengagement. One approach is to do the screening in the initial intake assessment for all couples. While the counsellor may see both partners in the initial part of the interview, the counsellor will separate both partners to interview them privately to 'assess readiness for couple counselling', and to screen for DV. The counsellor would only disclose to the couple that they are checking their relationship readiness for couple counselling. When DV risk is evident and current, the counsellor would report back to the couple that they do not believe the couple is ready for couple counselling at this time. The counsellor might offer confidential individual counselling for each partner to help prepare them for couple work should they wish to proceed. In agencies with more than one counsellor, typically the counsellor will work with one partner and refer the other to another counsellor. An example of guidelines, options, and a case study of how couples therapy might proceed within a systems framework is offered by Mayer (2017), however neophyte counsellors should consult with their clinical supervisor for guidance to help determine if couple counselling is appropriate if abuse has been identified.

ASSESSMENT

Should DV be indicated, the counsellor might validate the client for disclosing it, may reaffirm that abusive behaviour is unacceptable, and seek further information about the abuse and its impact (Ely & Flaherty, 2009; Gerbert et al., 2002). As highlighted earlier, this information gathering needs to be done privately from the perpetrating partner.

Early in the discussion, the counsellor needs to assess whether there is imminent risk of serious harm to the client and their children, and if it is safe for the client to return home. If it is not safe and the client is willing to leave, the counsellor can assist the client to contact a domestic violence specialist service, such as a dedicated help line. If children's welfare is at risk, the relevant region's statutory child protection service is contacted (See Australian Institute of Family Studies, 2020, for various State-based requirements). The service can provide specialist guidance to the client, may organise entry into a refuge, and advise of community and legal resources to support safety. If the client identifies as a male, other accommodation options may be explored, such as men's homeless shelters. It is recommended counsellors have ready access to DV crisis service contact details, including services dedicated for women, for men, and for LGBTQI+ clients.

If the risk is not imminent, the counsellor can inquire about the history and nature of the abuse, and its

impact on the client and any children. Counsellors can inquire about what knowledge the client already has about this issue, and can also provide information, such as risks associated choking, with pregnancy, the progressive worsening over time, or any other salient areas that are raised. The counsellor can also explore with the client their strengths, their coping, their resourcefulness, and availability of external resources. The purpose of this assessment is to help raise client awareness of both the risks and available resources they may have. The counsellor would usually encourage the client to develop a safety plan in case the DV escalates and the client and dependents need to exit quickly (Sammut Scerri et al., 2018). Safety plans often involve clients secretly storing money, key documents, identifying key support people, and securing a place to stay should an exit be required. Various safety planning guides can be found online (for example, see DVConnect, 2022), and if researching these, aim to search for guides that are both contemporary and relevant to the jurisdiction. There is a learning activity towards the end of this chapter where students are encouraged to increase familiarisation with safety planning concepts. Students can design or download a safety planning template (see pages 178-181 in Family Safety Victoria, 2021).

GENERAL COUNSELLING PRINCIPLES

At the heart of working with both victim-survivors and users of family violence is the ability to develop a positive therapeutic alliance, including a warm and unconditionally accepting bond, and agreement on goals and tasks in the counselling process itself. The therapist needs to model respect and protection of the psychological and physical boundaries of the client and their autonomy. This includes providing information about the service offered, respecting client ambivalence about whether to stay or leave a relationship, and helping support their own processing of their situation, concerns, and goals.

Counsellors may help in the following areas:

- helping clarify what clients want and evaluate options on how to reach goals
- addressing one's own abusive and/or dysfunctional beliefs and behaviour
- assisting the client to reduce risk and enhance psychological and physical safety, while also highlighting that the responsibility for violent behaviour solely rests with the person using violence
- assisting the client to gain information about DV and services that can assist
- assisting the client to develop enhanced assertiveness and emotion regulation
- assisting the client to address parenting and post-separation parenting concerns
- supporting the client through key events (e.g., separation, court proceedings)
- addressing trauma-related symptoms from the relationship abuse and earlier childhood abuse
- addressing grief and loss
- enhancing stress management skills
- addressing self-confidence and self-esteem issues
- addressing relationship and boundary issues
- addressing other areas that warrant attention (e.g. depression, substance abuse, anxiety) (Sanderson, 2008; Taft et al., 2016).

COUNSELLING MODALITIES

There are several modalities that have been adapted for working with victims-survivors and for people who use DV. Some of them are described below.

Feminist therapy emphasises raising consciousness around personal and relational power, and particularly challenging power that is understood as patriarchally-based and oppressive. It has at its core an underlying

goal of empowerment, and uses therapy processes to help support greater awareness and empowerment (Brown, 2010). Therapists aim to promote an egalitarian environment with their clients, and also promote egalitarian romantic relationships where people share power (Evans et al., 2011). Male perpetrator treatment is most commonly delivered in group formats, based on a combination of the Duluth model and cognitive behaviour therapy. The Duluth model underpinned by feminism, emphasises male socialisation, entitlement and privilege as primary factors behind men's controlling and abusive behaviour, so the focus is on making the abusive attitudes and behaviours transparent and challenging men to take responsibility for them, and to commit to relinquishing them (Pence & Paymar, 1993a).

Strength-based counselling aims to avoid pathologising clients, and to help them recognise their resourcefulness, strengths, resilience and existing solutions that can be further developed (Lipchick & Kubicki, 1996; Milner & Singleton, 2008). This can be particularly relevant for survivors who struggle with shame and low self-esteem, and users of violence who may also present with shame in addition to defensiveness and mistrust.

Motivational interviewing is a model developed from working with addictions but has also been applied to domestic violence. Motivational interviewing helps enhance motivation to change through processes including helping clients examine the costs and benefits of not changing and of changing, and reducing resistance and ambivalence towards positive behavioural change that aligns with the client's own deeper values (Miller & Rollnick, 2013). This approach may be particularly helpful in helping victim-survivors who are ambivalent about actions that may help reduce risk, and also assist perpetrators to more fully commit to reducing abuse (Dia et al., 2009). An example of counselling using motivational interviewing is below (Wahab, 2015).

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=61#oembed-1

Cognitive behavioural therapy (CBT) assumes that individuals may lack knowledge and skills to stabilise and change their behaviour. For all clients, CBT can help provide psychoeducation in relation to abusive dynamics, trauma, and the impact of beliefs and cognitions on behaviours and emotions. It can offer practical skills in emotional regulation and stabilisation, problem-solving, stress management, assertion and communication skills (Condino et al., 2016; Potter-Efron, 2015). For users of violence, CBT can raise awareness of one's ability to control their own behaviour and to identify alternatives to aggressive behaviour (Eckhardt & Schram, 2009).

Case study: Working therapeutically with Julie

Julie indicated her partner had never hit her before and that he'd promised never to do it again. The counsellor explored a brief history of the relationship and a pattern emerged that the DV was escalating over time. The counsellor showed the Cycle of Abuse and Power and Control Wheel, which helped Julie to decide in her mind that this was a DV relationship. The counsellor used a motivational interviewing approach to explore with her the good and less good things about the relationship, and the good and less good things about leaving the relationship (known as the decisional balance). The counsellor was careful not to take a side with leaving or a side against Julie's partner but to help Julie come to her own decisions after considering her own values and the DV information provided. Julie decided to leave the relationship as she noted that she used to be happy but now felt she had lost her joy and self-esteem since being with her boyfriend. The counsellor was aware that separation is a time when violence can escalate and discussed this as something to factor into the planning. The counselling also helped Julie clarify the principles that are important to her for future relationships, and also helped build her self-confidence again via strength-based interviewing.

The counsellor provided Julie an empathic environment to express her concerns and confusion. Julie's goal for counselling was to work out whether to remain or leave the relationship. The counsellor did a safety check with Julie and helped Julie form a safety plan in case she felt at risk and her safety was at threat. As part of this process, the counsellor informed her about the free call domestic violence phone number and recommended that if she had any questions at any time for more specialised information about DV and the support services available that she could call.

Reflective activity

This case scenario was based on a real client (with key details changed) and was relatively simple with few complicated details. Analyse the counsellor's responses with your fellow students. What interventions would you do the same or differently, and why? Is there anything else you might do if you were the counsellor?

COUNSELLOR SELF-CARE AND SUPERVISION

Working with victims-survivors and/or perpetrators can be stressful for many reasons. Counsellors can be impacted by harrowing accounts of abuse and trauma, by the minimisation and justifications, by frustrations associated with client choices or the choices of others impacting on the clients (e.g., abuser, legal system), limited social resources, and finally, by falling into roles whereby they over or under-identify with clients (Vetere, 2012). DV counsellors may also be threatened by perpetrators, particularly if they perceive the counsellor to be undermining their control. Given the prevalence of DV/FV, it is common that counsellors might have a personal history (Lewis, 2004). Therefore, counsellors who specialise in DV can be at risk of developing vicarious traumatisation whereby they become traumatised or re-traumatised from exposure to traumatic stories, and burnout from stress over time from the work and the under-resources or low support in the workplace (Murray & Graves, 2012).

Strategies that counsellors can use to reduce the risks of stress related impairment include:

- ensure low proportions of high stress cases in caseload
- ensure sufficient life balance, social support, and rest
- address unresolved trauma in one's own life
- enhancing knowledge and competencies in working with trauma, communities over-represented by traumatic and adverse events, and the principles of trauma-informed care
- monitor personal/professional boundaries
- develop and maintain a higher purpose or spirituality
- seek regular clinical supervision, professional debriefing with peers, and engage in reflective practice
- develop cognitive stress reduction skills, such as ensuring realistic expectations (Murray & Graves, 2012; Trippany et al., 2004; Vetere, 2012).

CONCLUSION

This chapter has attempted to provide a cursory overview of theory and frameworks associated with DV as it relates to counsellors. DV is harmful to the direct stakeholders and to those who witness it, including children, with significant social, economic, and cultural impacts. There are two main approaches to DV – the feminist approach that primarily focusses attention to male abuse of females in heterosexual relationships, and the family violence model that applies a gender-inclusive approach to assessment and intervention. Counsellors are encouraged to screen for DV, and assess the risks, provide support and psychoeducation to inform decision making, and work collaboratively with specialist services as required. A commitment to client

welfare and the physical and psychological safety of current and former intimates underpins and is a priority of DV counselling. Finally, counsellors are recommended to attend to their own psychological and professional health using a combination of education, clinical supervision, and self-care as a means for staying resilient when working with the stresses of DV work.

RECOMMENDED RESOURCES

Domestic violence: Issues and policy challenges (Campo, 2015a). Provides an overview of Australian prevention and intervention level strategies to domestic violence including links to state-based legislation.

Domestic and family violence in pregnancy and early parenthood (Campo, 2015b). Introduces the risks and impacts of DV on women and children in utero, and recommends a range of interventions.

COUNSELLING BOOKS FOR DOMESTIC VIOLENCE

Devaney, J. (2016). *Domestic violence perpetrators: Evidence-informed responses.* Routledge.

Murray, C. E., & Graves, K. N. (2012). *Responding to family violence: A comprehensive, research-based guide for therapists*. Routledge.

Sammut Scerri, C., Vetere, A., Abela, A., & Cooper, J. (2018). *Intervening after violence: Therapy for couples and families.* Springer.

Sanderson, C. (2008). *Counselling survivors of domestic violence.* Jessica Kingsley Publishers.

LEARNING ACTIVITIES

Learning activity 1: Johnson's typology

Consider Johnson's typology of types of domestic violence (Johnson, 2008). What influence, if any, might this typology have for counsellors in responding to each type.

Learning activity 2: Screening

After reading 'Family violence: Towards a holistic approach to screening and risk assessment in family support services' (Robinson & Moloney, 2010), consider your own approach to screening in your current or future roles. What questions might you ask, and when might you ask them?

Learning activity 3: Safety planning

In a small group, brainstorm key considerations when collaboratively developing a safety plan with a client. After completing this, compare with safety plan guides available on the internet.

Learning activity 4: Resource discovery

Individually, identify reference resources in your locality and territory, that you can compile for your own preparedness. This may include police, domestic violence helplines, child protection contacts, local welfare services,

DV screening and interviewing protocols, safety planning guides, medical services, Legal Aid, homeless hostels working with survivor guidelines, and working with people who perpetrate guidelines. Familiarise yourself with current DV legislature for your state/territory. These resources are for reference, not necessarily with every client affected by DV. Some may need to be updated over time.

Learning activity 5: Analysis of counsellor interventions

Please watch SCENE 16 Working with a client in a domestic-violence situation. What did the counsellor do that appeared to work well? What did the counsellor do that you don't think was as helpful? What other interventions might you use in such an interview?

Learning activity 6: Analysis of DV victims who don't leave

Please watch Why domestic violence victims don't leave| Leslie Morgan Steiner. How might this inform how you view victims-survivors choosing to stay?

Learning activity 7: Essay

Trauma is becoming more recognised in the aetiology of domestic violence perpetration (Taft et al., 2016). How might a trauma-informed understanding influence a counsellor's work with PUVs? What are the benefits, risks, and how might the risks be mitigated?

GLOSSARY OF TERMS

abuser—a word to describe those who administer domestic violence
batterer—a person who uses violence as part of their controlling behaviour
burnout—chronic exhaustion, depersonalisation, negativity, and demoralisation experienced in the helping professions, related to emotional fatigue
common couple violence—situational violence that occurs primarily due to the escalation of conflict, but does not have a systematic control aspect as found in intimate terrorism
domestic violence—this phrase is generally used to include both physical and non-physical violence
Duluth model—a feminist-based model that emphasises an integrated services response to violence against women, and which provides programs for men's behaviour change groups
elder abuse—the maltreatment, exploitation, or neglect of an older person (e.g., 60 years plus) by a trusted other, such as a relative, friend, neighbour, or service provider
equality wheel—this Duluth model resource describes gender-equal behaviour. It is the contrast to the behaviours described in the Power and Control Wheel.
family violence—this phase includes violence towards partners and ex-partners, children, elders, and other dependents who are or have been involved in the family system
intimate partner violence (IPV)—IPV is another phrase used to describe physical partner violence and may include recognition of non-physical abusive behaviours
perpetrator—those who commit domestic violence are labelled as perpetrators. It is most commonly used to describe male abusers who unilaterally abuse their female partners, however, in this chapter is used to describe anyone who commits domestic violence irrespective of gender or motivation.

power and control wheel—the Power and Control Wheel describes abusive and controlling behaviours as described by female victims of domestic violence

survivor—a term used for people experiencing or who have experienced relational abuse, that emphasises a sense of competency to survive abusive dynamics

vicarious trauma—this is a form of trauma that comes from exposure to traumatic stories and most commonly affects helping professionals

victim—a term used for people experiencing or who have experienced relational abuse, which highlights implies the recipient of abuse was not in any way responsible for the abusive behaviour of the perpetrator.

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Grief and Loss

JUDITH MURRAY

ABSTRACT

The experience of loss and its consequent grief are integral and unavoidable aspects of life. Loss is also implicit in nearly all adverse life experiences; however, it is not often specifically recognised within psychological formulations except in situations of bereavement. This universal nature of the suffering of grief means that loss can provide a key integrating concept of care for adverse life events. As such, an understanding of loss and grief is essential knowledge for every counsellor. This chapter is an overview of loss and grief theory and research and discusses the process of grieving and when grieving becomes problematic. It will show how this knowledge can guide an integrative approach to care.

Learning objectives

- To define loss and other associated concepts
- to gain an understanding of the different theories that have been used to describe the process of grieving
- to consider how grieving becomes problematic and the assessment of such difficulties
- to use loss and grief theory and research to support an integrative person-centred approach to intervening with people experiencing loss.

INTRODUCTION

In counselling and other mental health disciplines, loss and grief have often failed to be a focus of care compared to the search for empirically supported interventions for more 'serious' diagnosed disorders. Loss has largely only been considered when dealing with death and bereavement. As with many other conditions we have sought the most appropriate means of 'fixing' grief. But grief has not been a 'condition' that fitted the mould of clear definable symptoms, single definitive theories and targeted session specific interventions.

So why would we argue that grief and loss is fundamental to our work in counselling? There are many reasons why knowledge of loss and grief is vital for counsellors.

- Grief is universal and inevitable irrespective of age, culture, socio-economic status (SES), gender, or context; independent of all ways of categorising people. As such loss and grief offer a shared language and a shared experience among us all, including counsellor and client. Loss and grief are not confined to situations of death and includes whenever someone is separated from something of importance to him or her.
- Grief is commonly comorbid with, or integral to understanding other disorders.

- Grief and loss as a universal experience offers a key integrating concept that can underpin prevention and early intervention when dealing with adverse life events.

Besides these above reasons for knowing about loss and grief, there is ample evidence that failure to deal with issues of loss and grief can lead to long term problems of diagnosable disorders. These include Prolonged Grief Disorder as defined in the ICD11 (WHO, 2019; Killikelly & Maercker, 2018). This diagnosis is also proposed for the DSM-V-TR version (Prigerson et al., 2021) but is currently termed Persistent Complex Bereavement-Related Disorder within the current DSM-V section on Conditions for Further Study (APA, 2013). Other disorders such as mood disorders (Hensley, 2006) and Post Traumatic Stress Disorder ([PTSD] Horowitz, 2011) have been associated with grieving. In particular there has existed a blurring between the symptoms of depression and the sadness of grief leading to misdiagnosis of grieving as a disorder or confusion as to a differentiation of the conditions (Zisook & Kendler, 2007).

Case Study: The Story

Mr K is a 45 year old man who owns his own small but successful plumbing business. He is the father of two adolescents. He presented to counselling on the demands of his wife due to a serious risk of relationship breakdown. Fifteen months previous Mr K and his family had experienced the death of his 17 year old son to suicide by a drug overdose. Mr K had found his son's body and suicide note. Initially Mr K was seen as a great support to his wife and remaining 15 year old daughter. Over time he has found himself very angry and pulling away from his wife and daughter. Three of his staff have left following disputes with Mr K and his business is suffering from not being able to replace these workers. He is thinking of simply selling the business and 'just checking out'.

In discussing Mr K's background it was noted that he was brought up in an environment in which his father, while not abusive, was lacking in affection and was highly critical of both his children and Mr K's mother. Mr K left home as soon as he could at age 16 and took up an apprenticeship in a nearby town. He met his wife at age 20 and they married young. He had found great joy in being a family man. While he admitted to being a 'tough' Dad, he believed his children knew they were loved, something he had not felt growing up.

TOPIC DESCRIPTION

Before we go any further, let us gain some consensus around some of the concepts we will use in this chapter.

Change: Besides death and taxes, change is about the only other thing that can be guaranteed in this life. Sometimes change alters our world in ways that we do not wish to occur. We ache to return to the world as it used to be. Such a change involves loss.

Loss: Loss is not a particular event but a lived experience, a sense of 'being kicked in the guts', a desire to want the hands of time to turn back to a time where our world hadn't come crashing down around us. Miller and Omarzu (1998) offer a useful definition of this experience as: "Loss is produced by an event which is perceived to be negative by the individuals involved and results in long term changes to one's social situations, relationships or cognitions" (p. 12). This definition recognises that loss is a) experienced, b) perceived and defined by the person experiencing it, c) involves many adverse life events; and d) has far reaching effects.

Grief: Put most simply, grief is the reaction to loss; whatever that reaction happens to be. The reported symptoms of grief can be manifest across all domains of the biopsychosocial-spiritual model (Engel, 1977; Sulmasy, 2002). Biological effects may include crying, headaches, tremors, appetite changes, sexual problems and a compromised immune system. Psychologically, people may report anxiety, sadness, anger, confusion, concentration difficulties, suicide ideation, among other symptoms, while socially, those in grief can report loneliness, estrangement from others, role confusion, and social network changes. When we speak of spiritual and existential effects, these often move beyond religious crises of faith to more general effects such as loss of purpose and meaning, and questions about life and death. The symptoms across all the domains also interact

leading to an even greater sense of confusion and feeling overwhelmed. Grief affects the whole person and may manifest itself very differently in people even if they are facing the same type of loss or situation of loss.

Mourning/Grieving: Grief is the manifestation of an internal process as people try to deal with varying levels of disarray and struggle to find some stability in this altered world. This internal process is what we call grieving. Mourning then is this process in situations of bereavement. Consistent with the theorists such as Raphael (1984) and Rando (1993), I prefer to use the terms grieving and mourning to reflect this internal process of adjusting to loss. Some prefer to define mourning in terms of the public expressions of grief, including culturally relevant rituals (Stroebe et al., 2001).

Grieving is a natural healing process experienced in all cultures and societal groups. It is a process that has been part of the human experience ever since people became attached to things or people of importance in their lives and lost those things. It is reflected in the art, music, stories and rituals of all peoples around the world. In considering grieving from a medical model viewpoint that sees grief as a condition to be treated, it may be more useful to see grieving as being a natural healing process rather than a disease in need of treatment.

COMPLICATED GRIEF/PROLONGED GRIEF (ICD11; DSM-V-TR)

For most people, the process of grieving proceeds to the point where people are able to re-establish themselves in their lives; although in many ways, changed. For a significant minority of grieving people, this natural process of healing does not proceed toward restoration but rather leads to some form of perceived deterioration. Common patterns of symptoms are associated with problems in grieving a death. Few areas of adversity besides death have been defined in terms of grieving a loss and hence attempts to categorise problematic patterns in adjustment have been confined to the area of bereavement. In the area of bereavement, these patterns of symptoms have been defined by terms such as Complicated Grief, Prolonged Grief Disorder or Persistent Complex Bereavement-Related Disorder.

While intense distress after a death is normal and anticipated, symptoms that persist at least six months after the death become concerning. The patterns of symptoms indicating problems in grieving a bereavement include:

- a searching or yearning for the deceased that preoccupies the person to a disabling degree
- severe distress when reminded of the deceased or circumstances of the death
- avoidance of reminders
- a loss of the sense of self and role in life
- ongoing impaired functioning in life domains
- patterns of distress that are outside what is expected from usual cultural, social or religious norms.

(Killikelly & Maercker, 2018; Shear, 2015).

The prevalence of such problems in grieving following a death is difficult to determine. Unlike other mental disorders where only those diagnosed with the condition meet the full diagnostic criteria for the range of symptoms, all those grieving a death display intense symptoms in the early days following the bereavement. Hence determining when normal grieving becomes problem grieving can be difficult to ascertain clearly. Shear (2015) and Aoun et al. (2015) estimate between 2-3% and 6-7% display these patterns of symptoms, and this appears consistent across a number of different national studies (Fujisawa et al., 2010; Kersting et al. 2011; Williams et al., 2017).

Problems associated with non-death losses have been less likely studied in terms of grief responses. In such cases grieving people may be diagnosed with other disorders such as depression, anxiety, adjustment disorder, PTSD or substance use disorder (Kendler et al., 2008). Problems associated with grieving losses may be underestimated, with their impact spread across many disorders.

RISKS FOR PROBLEMS IN GRIEVING

If we accept that some people will struggle to heal through grieving, being able to ascertain who may be at risk for problems in grieving is valuable to counsellors. Many explanations for problems in grieving will be offered through the theories of grieving that we shall discuss later in this chapter. Some studies though have determined various risk factors through statistical means in exploring outcomes among grieving people.

Many studies have considered risks associated with problem grieving. We see risk associated with three broad categories: the person of the griever him or herself, circumstances surrounding the loss; and the context of the loss. In reviewing empirical studies of complicated grief, Lobb et al. (2010) found risks within the person included previous loss, previous mental health, attachment style as well as cognitive appraisals and high distress at the time of the death. Factors associated with the loss itself included death involving violence and other trauma, the quality of the caregiving or dying experience, close kinship relationship to the deceased, marital closeness and dependency, and lack of preparation for the death. In terms of the context of the loss, perceived social support played a key role.

It is difficult to easily separate these risk factors as their interactions may be more important than their singular effects. The risk factors may also influence grieving in discrepant ways in different populations. For example, there is risk of being a young widow; yet there is also noted risk in losing a lifelong partner in older people. Hence rather than simply assuming risk based on noted characteristics, we need to hear the story of the client in depth for possible risks, and the priority of those risks or their interaction in terms of disruption to the normal process of healing through grieving.

Understanding how risks work against healing occurring through grieving is through recognition of the loss and grief theories that suggest how the grieving process progresses and how it may be compromised for some people. So let us consider very briefly the major theories concerning this process of grieving.

MAJOR THEORIES

Counsellors have often become wedded to a single theory or school of thought and view all people experiencing a condition only through the lens of this favoured theory. With such a limited view, we risk missing the true story a person tells in all its complexity. We hear only the part of the story that 'fits' our theoretical view of the world. Loss and grief is one of the best examples of a concept or condition that refuses to be boxed into a single theory. There is no 'one size fits all' definitive theory of grief. Rather what we have is an amazing picture of a deeply complex human experience for which each theory offers us part of the picture. Just like the story of a person's grief, the story of the theories of grief is complex and much more interesting than a singular view of grief offered by only one theory.

Theories around grief and loss are largely considered WHY models (why grief occurs) and/or HOW models (how the process of grieving proceeds). To suggest that theories of grieving began in the 20th century is naïve. Philosophy, religions and stories from every culture have sought to understand grief, loss and suffering and comfort it. We should never discount the innate and cultural understandings of grief that a person brings. They form an integral part of the story they will tell and so form the basis of understanding how we best care for grief.

From a more formal psychological perspective, we can follow a story of the theories of grief and loss. However, we need to recognise that the theories mainly discuss loss through death. Moving to non-death losses will require us to go even beyond this theoretical story.

Early theories came from the psychodynamic work of Sigmund Freud in Mourning and Melancholia (1917). He largely argued that as people became attached to love objects, they attached psychic energy (libidinal bonds) to these things, a process known as cathexis. While these love objects remained, the internal energy remained in equilibrium and the mind remained stable. Any disequilibrium, and hence mental instability caused by loss of these love objects was seen in the intense grief reactions. The key to successful grieving was the removal of this psychic energy from the lost love object, a process of decathexis, and its placement in new available objects. This required an exchange process whereby the griever undertook 'grief work'. By repeatedly

re-examining aspects of the relationship with the lost object, the griever can relinquish the libidinal bonds that bound him or her to the lost object. A failure in this exchange process through unresolved ambivalence would then result in problems in grieving.

While also a psychodynamist, John Bowlby (1970, 1973) in his attachment theory, enhanced the understandings of grieving. Bowlby argued the need to consider the interpersonal perspective of grief with emphasis on the early experiences and attachment patterns developed between the griever and the deceased. He argued that yearning and searching for the lost loved one was normal. Therefore, the intense feelings and behaviours of grief were not indicative of pathology but were aimed to try to restore the lost love object to the griever. It was Bowlby who suggested that problematic attachment patterns may lead to problems in grieving. These theories were later expanded (Fraley and Shaver, 1999; Stroebe, 2002). This idea of an ongoing relationship with the deceased was expanded to the concept of continuing bonds by Klass, Silverman and Nickman (1996).

Bowlby (1980) was also the first to suggest that the process of grieving seemed to follow a pattern of stages and/or phases: Shock and numbness, Searching and yearning, Disorganisation, Reorganisation. These Stages/Phasic theories were also advocated by others (Parkes, 1972; Raphael, 1984; Hardt, 1978-79). The most popularised stages model was offered by Kübler Ross in her book *On death and dying* (1969). However, her stages were concerned with the process of dying and not on the situation of bereavement itself. Stages theories often spoke of the symptoms most noted in each stage rather than the part of the grieving process that was occurring that underpinned these symptoms. A number of theorists (Worden, 1991, 2009; Rando, 1993) tried to bring together the idea of grief work and stages in the Task Based models, which described the work the griever may be doing in each stage. Worden spoke of four tasks, being: to accept the reality of the loss; processing the pain of grief; to adjust to a world (both external and internal) where the deceased is no longer; and finding an enduring connection with the deceased within a new life. Anything that prevents a person moving through the stages of healing by successfully undertaking the tasks required of that stage can lead to problems in grieving.

As social beings our grief is more socially than individually constructed. The Social Learning/Social Constructionist theories increase our understanding of grief by helping us understand: a) what our social context considers a loss, and so determines the 'right' to be grieved or not, b) the rituals around the grief, c) the adjustments that will be needed to deal with the loss, and d) the language and attitudes around grief itself (Glick et al., 1974). At times the loss is not given legitimacy by the surrounding social environment and the grief is disenfranchised by others leading to its lack of recognition by others and a 'loneliness' for the griever (Doka, 1989).

The Cognitive-Behavioural school of thought argues that rather than grieving being a process over which a person had little control, cognitions and behaviours could alter the experience. The cognitions that people hold concerning the lost object, the process of grieving itself, as well as understanding the use of problem-solving and planning to rebuild the world are all important aspects of grieving. Irrational thought patterns, problematic core beliefs and depressive/avoidant coping patterns are often viewed as at the root of problems in grieving (Boelen et al., 2006).

Personal Construct Theory (Kelly, 1955) is a humanistic theoretical approach that argued that each of us constructs our individual reality based on patterns or 'templates' that we create. The theory recognises that an important question we then need to consider in loss is: What is the meaning of the loss to the person? From a constructivist perspective, problems in grieving occur when the person is unable to construct or re-construct a meaningful personal reality following the loss (Neimeyer et al., 2002).

These theories noted above are the main schools of thought that guide our thinking about loss and grief, and collectively offer a much better representation of the lived experience of grieving. A number of theoretical models have been developed that bring together aspects from several theories of grief. Bonanno and Kaltmann (1999) offered a Four Component model, while Rubin (1999) offered a Two Track model of bereavement. Maccallum & Bryant (2013) offered a cognitive attachment model that distinguishes both adaptive and prolonged grief by integrating aspects of attachment, memory, and identity. The most influential integrative model is the Dual Process model (Stroebe and Schut, 1999). It argues there are two forms of stressors related to grieving: loss oriented stressors and restoration oriented stressors. Throughout grieving

people oscillate between reacting to these two stressors. Initially people spend more time with loss oriented stressors and as healing occurs, move to spend more time working with restoration oriented stressors. However, it is the oscillation between the two forms of stressors that assists with grieving.

Neurobiology offers us new insights. However, rather than a new theory, neurobiology offers us a greater understanding of the mechanisms of grieving and explanations as to why good theory has persisted and been validated within people's experiences of grief. When we look at the grieving brain we see areas in the brain that are associated with processing of emotions, understanding the mental states of others, retrieval of emotion-laden episodic memories, processing of familiar faces, visual images, unconscious automatic motor responses, autonomic regulation and modulation, and coordination of a combination of functions (Freed et al., 2009; O'Connor, 2005). Neurobiology shows us how important it is for a grieving person to deal with the oscillation between approaching and avoiding the memories and finding a sense of accommodation of both (Freed & Mann, 2007). Hence a counsellor needs to have comfort in sitting with the person's often changing state of 'moving toward' and 'running from' their confusion and pain by 'sitting in the rubble' with people. Neurobiology also points to potential mechanisms of problem grieving finding the *nucleus accumbens*, the centre of the brain that determines if something is worth doing over and over again, working hard in those reporting complicated grief (O'Connor et al.,2008).

NON-DEATH LOSS

These many theories offer us a fuller understanding of grieving associated with death rather than any other loss. If we look at the definition of loss more broadly, we see that loss and resultant grief occurs following many non-death situations. Grief symptoms have been found among people experiencing situations as diverse as brain injury (Carroll & Coetzer, 2015), parenting children with mental disorders (Schofield et al. 2010), migration (Gitterman & Knight, 2019), unemployment (Archer & Rhodes, 1987), foster care (Mitchell, 2018), and nursing home placement (Van Humbeeck et al., 2016). However, often these symptoms of distress have not been interpreted as grief reactions but designated as adjustment disorders or their sadness interpreted as depression or anxiety. In trying to categorise the many non-death losses, Sofka (1999) suggests: a) obvious losses such as relationship breakdown, b) not so obvious losses such as loss of a dream, c) developmental losses across the life span, d) temporary losses and mini-losses such as small changes in life and; e) limbo losses associated with an uncertainty or a tenuous situation.

Boss (1999) offered the term ambiguous loss to describe a situation of loss in which a person is unsure if a loss really has occurred or not. For example, the loss surrounding the situation of a missing person or a threatened miscarriage or the diagnosis of a life-threatening but potentially curable condition may all involve ambiguous loss. This contrasts with what are termed non-finite losses that occur over a long period of time where an endpoint may not be clear (Bruce & Schultz, 2001). These non-finite losses are associated with a different grieving to that of the grieving of a death. This grieving is often termed chronic sorrow (Teel, 1991). Chronic sorrow is long-term sadness that accompanies ongoing loss and that sometimes comes to the fore, and sometimes sits uncomfortably on the periphery of the consciousness (Olshansky, 1962). The grief associated with death tends to display an intensity of distress that, while it may fluctuate to some extent short term, generally lessens over time. Chronic sorrow may be episodic in nature, but the intensity of distress in difficult times remains consistent over the long-term.

Counsellor Reflections

> In working in grief and loss there is one word that always remains foremost for me: respect. Deep and genuine respect is the absolute key to this work – respect for the lived experience of those who grieve, respect for those around them, respect for what was lost, respect for what people can and cannot tell you, respect for the natural process of healing and respect for the challenge of hearing their story as it is meant to be heard. More than any other area, loss and grief brings us to the core of who we all are as human beings. We can never truly understand the loss experience of another; but knowing how

> lonely loss can be often makes us as counsellors deeply committed to trying to know their story as they live it and helping them to tell it. There is no greater joy for me as a counsellor than to hear a person say that they have finally 'found a place' for their loss.

COUNSELLING WITH GRIEF AND LOSS

ASSESSMENT

Rather than conjuring a picture of the 'expert' counsellor deciding what part of a person's grief will be heard and explained and evaluated, I prefer to consider assessment as hearing the most complete story that may help the counsellor to generate in collaboration with the grieving person some hypotheses as to what may be causing their pain. A vitally important aspect of counselling with grief is the undertaking of a holistic assessment of the person's experience. The primary aim in caring for the grieving person and being able to gain a useful and focussed assessment is ensuring the person feels safe within the therapeutic relationship.

It is important to hear about the circumstances of the loss and its repercussions in the life of the person and also to understand the world 'that was', the one lost to the person. We need to understand how the world they now inhabit (the world 'that is') most differs from the one they knew before the loss and in which they felt some sense of safety. In understanding the often complex story of grief there are key questions we can consider. These questions should not simply be asked as in a structured clinical interview. Rather the questions allow us to sort the story we are able to bring out using our interpersonal skills according to what we know about grief and loss. Murray (2016) offers ten questions of loss based on the various theories and studies of grief. These offer a means of ensuring a fuller assessment of a person's grief.

1. *What has been lost?* Identify the many death and non-death losses that can be involved in a loss experience as well as seek those causing the most distress, the primary losses.
2. *What was the position/role/ importance of that loss in the life of the person?* Consider the centrality and the meaning of the loss to the person and hence the likely disruption to other areas of the person's life.
3. *What are the major symptoms of grief that this person is experiencing? Are there any causing particular distress?* Consider the physical, emotional and social manifestations of grief and potentially problematic symptoms such as suicide ideation or trauma responses.
4. *How far along the journey of mourning has the person progressed?* Consistent with phasic and task models, this allows us to consider the progress of grieving.
5. *What is the world of the person like?* Consider how different is the world of the person now (the world 'that is') and hence what makes their current situation feel safe or unsafe.
6. *How is the person trying to deal with the transition from the world 'that was' to the world 'that is'?* Consider the current coping mechanisms being used and so recognise both adaptive and maladaptive forms of coping.
7. *What strengths does the person bring to his or her loss?* This forms the basis of a strengths-based approach encouraging us to identify the resources both within and around people to stabilise their world.
8. *What hindrances are there to the progress of mourning?* Consider the risk factors present that may compromise the healing process.
9. *Is there any indication that mourning has become complicated?* Signs of problems in grieving suggest a need for more targeted interventions to occur that can 'unblock' the normal healing process of

grieving.

10. *Are there particular characteristics of the person that are going to challenge my care of him or her?* Consider issues that may challenge care, such as culture, sensory or cognitive impairment or existing disorders.

GRIEF COUNSELLING AND GRIEF THERAPY

Grief following a loss is normal. Distress in itself is not indicative of pathology and hence does not necessarily require therapy. What is required is support for the healing process of grieving. Basic supportive counselling is a vital area of prevention and early intervention. Loss threatens a person's sense of safety, mastery and control. The basic aim of all grief counselling for normal grief is the stabilisation of the griever and the returning of some sense of safety. It will be the grieving person who determines how best to return to a sense of safety as they will tell you what aspects of the loss are making them feel most 'unsafe'. They will also tell you what makes them feel 'safe' as paradoxically loss can increase safety in some areas. For example, a relationship breakdown may cause grief, but if that relationship was emotionally taxing or harmful to the person, there may be a sense of increased safety in some aspects of this loss. Safety will always be defined by the griever and needs to be respected and understood by the counsellor.

Safety can be felt internally, interactionally or organisationally. Internal safety comprises the thoughts, memories, feelings or sensations, making the person feel most safe or unsafe. Interactional safety may be enhanced through helping the person to improve communication with health professionals, or partners or family and friends. It may also be enhanced through community education to reduce stigma or ignorance about grief. Supporting organisational safety requires interaction with systems that may cause concern, such as hospitals or coroners or mental health services.

GENERAL PRINCIPLES OF GRIEF COUNSELLING

Several writers (Humphrey & Zimpfer, 1996; Worden, 1991) have offered general principles of care. In situations of loss, basic processes of support and symptom modulation will be needed initially to build trust, stabilize the person and allow the experience to be put into words. Once this personal sense of greater equilibrium has been supported in the griever, other important issues can be dealt with utilising the most appropriate therapeutic approaches.

Currier, Holland & Neimeyer (2008) surveyed 119 practitioners concerning their approaches to grief counselling and found three overarching categories. The first category is the importance of the presence of the helping professional. The study found the need for cultivating a safe and supportive environment, providing deep and empathic listening, and assuming a respectful and non-judgemental stance. The second category concerned the elements of the process of therapy and included: storytelling; facilitating integration or finding meaning; expressing and processing emotions; facilitation of continuing bonds; psychoeducation; focussing on the good, and exploring of spirituality and existential concerns; drawing and expanding upon existing resources and re-orienting toward future and hope. In terms of facilitating these processes, all psychological techniques may be potentially valuable for caring for someone affected by the loss. More than one approach is required over time to assist a person in grief. A continual process of 'assessment' and 'intervention' and 'reassessment' is needed.

COUNSELLING TO THERAPY

As we discussed, it is often difficult to determine when normal grief that simply requires support for the natural healing process becomes problematic and in need of more in-depth support or therapy. Bonanno (2004) found that resilience, characterised as a pattern of high initial distress for a few weeks, followed by quite low levels

of distress, is common among between 30%-60% of grieving people. Resilience is different from recovery, and chronic or delayed grief and can still be exhibited in traumatic losses and alongside PTSD.

Even for those who display symptoms of problematic grieving that fits a diagnosable category, there is no one definitive evidence-based method of intervention that fits all grieving people. As much as we would like to have an easy definitive 'treatment' for problem grieving, this is not the reality. Rather, a holistic thorough assessment for what may be causing problems in healing for one griever may not be applicable for another. For example, for one person, the problem may be due to an inability to process grief because of the avoidance of the memories due to trauma; while for another, the grieving difficulties occur due to a problematic attachment pattern that existed between the griever and the deceased.

Different theories and the techniques of care associated with such theories may then be required to assist the grieving person. For the first person, trauma techniques such as prolonged exposure or EMDR may be a first step necessary, while for the second person, attachment or psychodynamic work or Interpersonal Therapy (IPT) may be the most valuable approach. As such, an integrative, person-centred approach is vital in caring for problems in grieving.

A COUNSELLING MODEL EXAMPLE BUILT FROM THEORY

According to the Dual Process Model (DPM) of grief, problem grieving occurs when a person becomes 'stuck' in dealing with one category of stressors, most commonly the loss oriented stressors. According to the DPM, the healing of grieving requires an ability to accommodate the oscillations between loss-oriented and restoration-oriented stressors. As they are restored, grieving people find the ability to live with their experiences of the loss within their new world where the lost object is no longer present. When oscillation is reduced, and the griever remains 'stuck' in one group of stressors, healing does not occur. Such problems may be manifested in the symptoms of Prolonged Grief Disorder.

According to the model then, intervention needs to restore this oscillation between the stressors, so the normal process of grieving is then restored. Complicated Grief Treatment (Shear,2010) is a manualised bereavement-focused individual therapy. It is grounded in the DPM, Attachment Theory and with techniques modelled from both Interpersonal Therapy and Cognitive Behavioral Therapy. It also includes elements of Compassion-focused Therapy (Gilbert,2014) and self-determination theory (Ryan & Deci, 2000).

Case Study: Assessment and Intervention

If we return to the case of Mr K whose son suicided we can see how a holistic assessment of the whole story helps top guide effective care:

Assessment of Mr K

From a perspective of the *Ten Questions of Loss* (Murray, 2016) we could organise much of what Mr K reported, as well as generate and test several hypotheses as to what may be causing his difficulties.

What has been lost? Mr K reported many losses that all required their own grieving: loss of his son as a person, loss of his sense of being a 'good' father or 'boss', loss of trust in his son and their relationship, loss of meaning in his work, loss of his sense of self, loss of closeness to his wife and daughter, loss of financial security etc. The primary loss was the loss of his sense of being a good father and husband.

What was the role and the importance of the loss in his life? Mr K's family has been the prime motivating force in his adult life and the reason he worked so hard. He believed he had shown he could be a better father than his own father, and the suicide had destroyed this belief.

What were the main symptoms he was experiencing? Mr K reported great distress in his re-experiencing of finding the body. He also reported waves of uncontrollable anger mixed with an intense desire to be alone. He reported that he was using alcohol and doing 'inane' risky things with his mates to help him forget.

How far along the journey of healing had he progressed? While it had been 15 months since the death, Mr K reported little healing with vivid grief symptoms that preoccupied him.

What is the world of the person like now? Mr K described his whole world as being 'destroyed'. He no longer trusted himself or others. He expected his family would leave him, a belief that was in part becoming a reality in his marriage. His work no longer mattered to him.

How was he dealing with the transition from the world 'that was' to the world 'that is'? He reported 'not coping'. He slept only erratically, drank 'more than he should', was angry and controlling. He refused to talk about his son as it was 'too painful' and 'what was the use anyway?'

What strengths did he have? Mr K obviously still loved his wife and daughter. He was able to be honest and open. Most importantly, he wanted to 'get better' and would 'do anything' to 'fix things'.

What hindrances were there to his mourning? For Mr K re-experiencing of memories made it difficult to discuss his son. He also has no role model for being a 'good father' and had some very high expectations of what that should be.

Was there any indication the grief has become complicated? Mr K's reporting suggested problems in his grieving. He agreed to the administration of the Inventory of Complicated Grief (Prigerson & Maciejewski et al., 1995). Mr K was found to be experiencing complicated grief. Besides a score, in discussing the items of the measure, Mr K was able talk about the sensations he was experiencing and offered some useful symptoms specific to his experience that we could use to monitor his progress over time.

Were there characteristics that were going to make it difficult to care for him? There were no issues of concern here.

Intervention with Mr K

The most important aspect of caring for Mr K was the building of a safe and trusting therapeutic relationship. He found it difficult to use emotional language especially when memories of his son arose. Besides talking we used pictotherapy (i.e. the projective use of picture and metaphor to expand the story) to give him another way to put words on his experience.

Psychoeducation about grief was used to enhance the ongoing process as required. Being able to remember his son was important to Mr K, but was avoided due to the distressing memories. He wanted very much to remember his son without the distress. We began slowly to achieve this for him by encouraging him to help me to 'get to know his son'. Slowly we were able to bring him toward the difficult memories of his son's death, and using trauma-focused techniques, he was able to re-imagine the last moments in a manner that moved from a distress to a 'heavy but close sadness' as Mr K described it.

We also looked at how he felt he had failed as a father and, in so doing, explored his own childhood. His strong desire to be a 'good deserving father' was explored and meaning found for him in the father he had been and wanted to be. Mr K was able to speak about the loneliness of his childhood and the great fear that his son may have been 'lonely' and suicided because of it. Mr K was committed to his daughter but feared that as he was not 'good enough' as a father, she too may suicide. Even though he was able to acknowledge that this was not a rational thought, this was the thought that was at the basis of Mr K disconnecting from his daughter. His fear of abandonment was also on the basis of his reactions to his wife. We worked with these fears as the biggest problems to his re-establishing his life in the present.

The outcome

Like all problematic grieving, healing for Mr K did not come easily or quickly. Over time Mr K was able to hold his good memories of his son and felt more in control of his distressing memories. His relationship with his wife and daughter improved, and he reported much less anger. About a year later, Mr K became involved with a group working with adolescent boys who were considered as 'at risk' of entering the juvenile justice system. This became his positive way of 'honouring' his son.

CONCLUSION

Loss, and grief that may result from it, is universal to us all and so integral to the work of counsellors. This chapter has considered the many theories that, when taken together, offer us a clearer picture of this complex human experience. It has also highlighted that loss and grief may be implicit in many of the presenting

problems we see with clients that are not specifically labelled as grief. We have seen how theory can also guide our assessment and care of people who are grieving in such a way that we can offer respectful person-centred care across the many diverse loss experiences we may encounter among clients.

RECOMMENDED RESOURCES

Books

Harris, D. L. & Gorman, E. (Eds.) (2011). *Counting our losses: Reflecting on change, loss and transition in everyday life*. Routledge.

Murray, J. A. (2016) *Understanding loss: a guide for caring for those facing adversity*. Routledge.

Neimeyer, R.A. (Ed.) (2012). *Techniques of grief therapy: creative practices for counseling the bereaved*. Routledge.

Stroebe M. S., Hansson, R. O., Stroebe, W., & Schut. H. (Eds.). (2001). *Handbook of bereavement research: Consequences, coping and care*. American Psychological Association.

Websites

Australian Centre for Grief and Bereavement

Australian Child and Adolescent Trauma Loss and Grief Network

Good Grief (Includes Seasons for Growth Program):

Learning activities

1. Define loss, grief and grieving.
2. What are the main theories that help us understand grieving?
3. Ms H is telling her counsellor about her grief after the death of her mother. In listening to Ms H her counsellor becomes concerned about her long-term healing. What types of information may have led to such concerns for the counsellor?

GLOSSARY OF TERMS

Ambiguous loss: Loss associated with a situation of loss in which a person is unsure if a loss really has occurred or not.

Chronic sorrow: Long-term sadness that accompanies ongoing loss and that sometimes comes to the fore, and sometimes sits uncomfortably on the periphery of the consciousness (Olshansky, 1962).

Complicated grief: A pattern of symptoms associated with problems in adjustment to the loss and so is noted in grief that does not heal or is delayed in healing. Has been termed Prolonged Grief Disorder and Persistent Complex Bereavement-Related Disorder in classificatory systems.

Grief: The reaction to loss, whatever that reaction may be.

Loss: Loss is produced by an event which is perceived to be negative by the individuals involved and results in long term changes to one's social situations, relationships or cognitions (Miller and Omarzu, 1998, p. 12).

Mourning/grieving: The process that occurs internally as people try to deal with loss.

Non-finite loss: Loss that occur over a long period of time where an endpoint may not be clear and chronic sorrow occurs.

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Relationship Difficulties

TRISH PURNELL-WEBB AND JOHN FLANAGAN

ABSTRACT

Research into the impact of marriage and family breakdown abounds. Adverse effects on adults, children and communities range from increased mental health concerns, increased use of opioids, impoverishment, poorer outcomes for future relationships, to decreases in education and increased employment difficulties.

Most clinicians consider couple therapy to be amongst the most difficult therapeutic areas to work. It is fraught with high emotion and complicated by individual personality and cultural differences, mental health co-morbidities, and the subjectivity of personal experience that can cloud an individual's ability to accept their partner's own internal experience. Evidenced-based approaches to couple therapy, such as Gottman method couples therapy (GMCT) and emotion focused couples therapy for couples (EFT-C), provide therapists with frameworks, interventions, strategies, and skills to assist in the management of complex presentations. These include co-morbidities such as infidelity, addiction, and other mental health conditions.

Learning Objectives

- Identify current evidenced-based approaches to couple therapy.
- Explore two of the most commonly utilised approaches in Australia.
- Identify common interventions utilised with couples.
- Explore a typical case example to deepen understanding of the flow and process of couple's therapy.

INTRODUCTION

According to the Australian Bureau of Statistics (ABS, 2016), of the six million families living in Australia, almost five million consisted of couples living together with or without children. Intimate relationships are a vital aspect of human wellbeing. A longitudinal study by Harvard University concluded that happy relationships were the best predictor of improved health in older age. People in close relationships were also found to be more satisfied, have fewer physical and mental health concerns, and lived longer than those who were not in the long term, close relationships (Mineo, 2017).

In Australia, the divorce rate was 1.9 divorces per 1,000 people which, in 2020, represented 49,510 divorces (ABS, 2021). The divorce rate does not take into account the many de facto relationships that may also breakdown. Decades of research have established the long-term negative impact of family breakdown on children and community (e.g., Cherlin & Furstenberg, 1994; Doherty, 1997). The Australian Government Department of Families, Housing, Community Services and Indigenous Affairs Social Policy Research Paper No 42 (Rodgers et al., 2011) reinforced findings from previous international studies that family conflict contributed

the most to the differences between those children from divorced and intact families for depression, suicidal ideation, and opioid use. They also found that adults from divorced families of origin were more likely to report a wide range of adverse outcomes compared to their peers from intact families of origin and that those from divorced families were more likely to transition earlier to adult roles such as engaging in sexual intercourse before the age of 16, leaving the parental home before the age of 17, entering live-in relationships before the age of 20, and entering parenthood as a teenager. The odds for these outcomes were more than double for those from divorced families compared to those from intact families.

Studies looking at the impact of relationship breakdown on communities routinely identify that this leads to the growth of more impoverished communities with the natural flow on to higher rates of crime, poorer educational outcomes, and higher use of drugs and alcohol (Hogendoorn et al., 2019). Therefore, assisting couples in understanding how to create healthy, connected, close, and long-lasting relationships can have a substantial positive impact not only on the welfare of individuals, couples, and children, but can also have important positive effects on community and society in general.

Services for couples in contemporary Australia are widely available and highly sought after. Organisations such as Relationships Australia, Anglicare, Catholic Care, etc. offer a range of low-cost, government-funded services to couples and families. In addition, psychologists, social workers, counsellors, and psychotherapists in private practice also routinely provide couple therapy as part of their services to their communities. Many of these practitioners will have completed extensive post-graduate training in evidence-based approaches to couple therapy.

Case study: The story

Charlie and Blair have been in a committed relationship for 12 years. They have recently had their second daughter. Charlie has taken parental leave this time because Blair did that with their first baby three years ago. Charlie is becoming more and more depressed and complains that Blair works late too often, is withdrawn and unavailable on weekends and is not doing enough around the house or with the children.

Blair reports that Charlie only gives orders and acts like a drill sergeant, that they barely talk to each other, except when they are screaming abuse. Blair is unsure about staying in the relationship but does not want to move out because of the children. Charlie desperately wants the relationship but feels too disconnected from and angry with Blair to feel any positive feelings.

They both report their sex life has been non-existent since they had their first daughter, they barely touch each other, never hang out or go on dates, and that they spend long periods of time not talking to each other except about logistics, sometimes as long as a month to six weeks, before they escalate into very nasty fights and their cycle begins again.

MAJOR THEORIES ABOUT THE TOPIC

These days there is a substantial volume of books on how to have a successful relationship. In contrast, the amount of that literature based on empirical research is significantly less. Prior to the 1900s, help for couples was generally provided by older family members, religious, or community leaders. The advice provided was strongly linked to cultural mores and religious dogma without regard to the lived experience of the partners in the relationship.

It was not until the 1950's that psychiatrists and psychoanalysts began working with couples in conjoint sessions on relationship issues. At that time, there were no theories, models, interventions, or techniques for providing couple therapy, so clinicians based their work on their own experience of relationships and their own ideas about what makes for functional couples (Gurman, 2015).

During the 1960s Systems Theory became the predominant approach based mostly on the theories of Virginia Satir (1916-1988), Don Jackson (1920-1968), and Murray Bowen (1913-1990). This approach focuses on what Satir articulated as "the self in the system" (Nichols, 1987), but while Satir argued for the importance

of affect and attachment (Satir, 1988), sadly her views were mostly marginalised at the time by more "male" therapeutic values such as rationality as opposed to emotionality and power as opposed to equality in relationships (Gurman, 2015).

Bowen family systems theory arose as the primary approach in Australia to couple and family distress throughout the late 1960s and 1970s. According to Brown (1999), Bowen theory primarily focuses on patterns that develop in families to defuse anxiety which arises due to perceptions of either too much closeness or too much distance in a relationship. Stress is impacted by levels of external pressure and intergenerational familial sensitivities.

According to The Bowen Center, the main goal of Bowenian therapy is to reduce chronic anxiety within the system by increasing awareness of how the system functions; and by improving levels of differentiation with a focus on changing self as opposed to trying to change others. Bowen's theory consists of eight interlocking concepts where change may need to occur:

1. emotional fusion and differentiation of self
2. triangles
3. nuclear family emotional systems and couple conflict which includes symptoms in a spouse as well as symptoms in a child
4. family projection process
5. emotional cut-off
6. multi-generational transmission process
7. sibling positions
8. societal emotional process.

Bowen made important contributions to the field of couple and family therapy, especially with the introduction of the importance of the legacy of emotional processes across generations and on an individual's differentiation with the systemic context providing therapists with a multi-level view of the development and perpetuation of interactional patterns within the system (Brown, 1999).

Bowen's concept of a multi-level family system describes how patterns, themes, and positions (roles) are passed down from generation to generation through the projection from parent to child. The impact will be different for each child depending on a number of variables such as position in the family, their specific relationship with each parent (triangling), temperament, personality, and environmental factors. Bowen recommended a focus on at least three generations of a family when dealing with a presenting symptom. The attention to family patterns over time is seen as an intervention that helps family members see how they might change their own part in the transmission of anxiety over the generations, as well as an assessment tool for the therapist (Bowen, 1978).

Major criticisms of Bowen therapy include: the lack of randomised clinical trials to assess the impact on couple and individual functioning (Baker, 2015); its attention on the mother's contribution to symptom development without reference to the role of father, and the labelling of women as 'over concerned', and their relational roles as 'fused' and 'undifferentiated' (Luepnitz, 1988). Carter et al. (1988), argued Bowen's model pressures women to 'back-off' while placating and supporting the notion of the distant male. Luepnitz (1988) also criticised Bowen for his focus on being rational and objective in relation to emotional processes which relegates low priority to the expression of emotion in therapy.

By the late 1970's behavioural therapists such as Weiss (1975), Stuart (1969), and Jacobson and Margolin (1979) began extending their work to couple contexts with a focus on skills development primarily in the area of communication, problem-solving and behavioural change. The role of the therapist was primarily psycho-educational and directive. By 1995, Christensen et al. (1995) had developed Integrative behavioral couple therapy which was the first approach developed through clinical observation and empirical research.

In Australia, research on this approach has been spearheaded by Professor Kim Halford, resulting in his development of "CoupleCare" (Halford et al., 2006), a home study program for couples. This program was

designed for couples to use in their own homes with the use of DVD instruction and telephone or video call assistance from a counsellor. In the program, the couple learn arrange of behavioural strategies and practical skills such as arousal regulation, active listening, empathy training, etc., to enhance their relationship.

During the 1980s and 1990s while studies continued into the mechanisms for change using behavioural approaches to couple therapy, a more emotionally based approach to couple therapy became the focus of several researchers, most notably Drs John Gottman and Sue Johnson. While Gottman conducted extensive observational studies to understand what made relationships fail and what made them successful, Johnson focused on a move away from behavioural therapeutic approaches to an emotionally based approach for therapists to use with couples. Their research has resulted in the development of two highly effective, evidence-based approaches to couple therapy – Gottman method couples therapy (GMCT) and emotionally focused therapy for couples (EFT-C).

Gottman focused on conducting longitudinal observational studies to identify what couple dynamics and interaction patterns either destroyed relationships or strengthened them. He established what became known as the 'Love Lab', firstly at the University of Washington, and more recently at the Gottman Institute in Seattle, USA.

GMCT is an integrative approach based on analytic, behavioural, existential, emotionally focused, narrative, and systems theory. It includes three broad phases. The first phase, assessment, begins with a thorough clinical assessment after which the therapist provides the couple with feedback about their assessment using the framework of Gottman's sound relationship house, and together the therapist and couple formulate treatment goals.

The second phase is the active therapeutic phase during which the therapist uses structured interventions to assist the couple to:

- down-regulate negativity during conflict
- increase positivity during conflict
- build more positivity during non-conflict interactions
- increase understanding meta-emotion discrepancies between partners
- create and deepen a shared meaning system.

The third phase targets relapse prevention during which the therapist is slowly phased out toward the end of therapy with follow-up sessions for up to two years post the active therapeutic phase. GMCT is not a time-limited program of treatment. For most distressed couples, 15-20 sessions would be normal while couples with serious co-morbidities or recent infidelity, might require 25-50 sessions (Gurman et al., 2015).

EFT-C was initially an integration of experiential/gestalt approaches with interactional/family systems theory and was later heavily influenced by attachment theory. EFT-C consists of three tasks for the therapist and three stages of therapy. According to Johnson (2004), the three tasks are:

1. to create a safe, collaborative alliance
2. to access, reformulate, and expand the emotional responses that guide the couple's interactions
3. to restructure interactions in the direction of accessibility and responsiveness that build secure and lasting bonds.

Its three stages are:

1. de-escalation
2. changing Interactional position
3. consolidation and Integration of new constructive interaction patterns.

EFT-C is a short-term approach to couple therapy and may take 8-20 sessions on average, more distressed,

complex couples may require 20–40 sessions. GMCT and EFT-C are currently the two most prevalent approaches to couple therapy utilised in Australia mostly because comprehensive training in both approaches is now readily available around the country.

Counsellor reflections

Having undertaken training in both GMCT and EFT-C, I find an integration of both approaches is highly successful in working with couples regardless of presentation. GMCT provides easily accessible, structured interventions that make sense to couples and can be successfully replicated by the couple outside the therapy room. In contrast, EFT-C provides me, the therapist, with the skills to safely and successfully process deep emotion with the couple experientially during the structured interventions.

Working with couples would be one of the most rewarding experiences for a therapist. Bearing witness to the emotional vulnerability and courage couples demonstrate while often repairing broken relationships is one of the most touching and fulfilling professional opportunities a therapist can experience. I feel highly privileged daily that couples trust me and my therapeutic approach enough to allow me to be part of their recovery.

For more information on my experiences as a couples therapist, go to The Gottman Method and couples therapy with Clinical Psychologist Trish Purnell-Webb.

GOTTMAN METHOD COUPLES THERAPY (GMCT)

Assessment

Many clinicians doing couples therapy do not use formal assessment. When presented with a couple in high levels of distress and pain, clinicians are often motivated to immediately attempt to help the distressed couple by moving straight into therapy. GMCT strongly recommends the opposite. It is essential to understand the couple's presenting issues as seen through their eyes; to know their relationship history, individual histories, co-morbidities, and any contra indicators to couple therapy before engaging in therapy. GMCT argues the importance of a comprehensive assessment to ensure the clinician understands the couple's strengths and areas of concern before beginning treatment. GMCT methods also include a feedback session with the couple to both explore with them the assessment findings and also to work collaboratively with the couple to develop clear and shared treatment goals.

The following is a brief description of the assessment phase and will assist clinicians in organising this phase and, importantly, communicating the plan of assessment and the treatment plan.

The assessment is completed in four sessions—an initial co-joint session, an individual session for each partner and finally the co-joint feedback session. Early in the assessment phase a range of assessment questionnaires completed by the couple provide significant individual and relationship data that assists with the formulation of a treatment plan.

Furthermore, in this phase, the clinician needs to decide when couple therapy is contraindicated. Contra-indicators involve the following:

- Ongoing affairs, secret or reveals: the interviews and questionnaires attempt to collect this data.
- Ongoing characterological domestic violence. GMCT categorises two types of domestic violence – situational and characterological. Situational violence is defined as an argument that escalates out of control where low level violence occurs. It is symmetrical and does not cause physical injuries or generate fear and intimidation. Characterological violence is defined as extreme violence, both emotional and physical. There is a clear perpetrator and clear target, and the aim is to create fear and intimidation. Within couple therapy, situational violence can be treated; characterological violence cannot (Jacobson & Gottman, 1994).

- Significant mental health condition/s that may need to be treated prior to couple therapy if the symptoms are florid.

Initial conjoint session

Following the completion of the client information form and disclosure statements and explanation of the assessment and therapy stages, the initial co-joint session incorporates three distinct components.

1. Couples' narrative: In this component, the clinician asks a series of questions to understand the presenting issues as seen by the couple. Questions such as:

a. What brings you to therapy now?
b. What are your main concerns and issues in the relationship?
c. What your hopes and concerns about attending couple therapy?
d. Have you attended couple therapy prior to now and what was that experience like?

It is essential the clinician exhibits understanding and empathy and maintains a balance between each partner. The narrative generally takes 15 minutes of a 60-minute session. The clinician then moves the conversation to the oral history interview.

2. Oral history Interview: This component is a semi-structured interviewed aimed at gaining the couple's relationship history including, if appropriate, their first meeting, dating, commitment engagement, marriage, transition to parenthood, children, ups and downs, hard times and changes over time in the relationship. This interview provides data concerning the friendship, conflict and meaning systems in the relationship.
3. Events of the week and conflict interaction discussions: GMCT works from the premise that it is critical to understanding how conflict occurs in the couple's relationship through direct observation of their interaction. In this component two, ten-minute conversations (i.e., events of the week conversation and a conflict conversation) are set up and recorded. Physiological information is also measured—heart rate and oxygen uptake. The clinician does not intervene but observes the interaction looking for key relationship patterns and conflict indicators such as the ability to empathise, use of the four horseman, repair attempts, pursuer-distancer pattern, emotional distance, acceptance of influence, humour, affection, gentle start-ups, and validation. At the completion of the observation, each partner is asked to review the recording and use a distress rating dial to rate how positive or negative they were feeling during the conversations.

Online Gottman relationship check up (GRCU)

This clinical tool consists of 480 questions about friendship, intimacy, management of emotions and conflict and insight into shared values and goals. There are additional questions about parenting, housework, finances, trust, and individual areas of concern. The questionnaire is completely confidential, fully HIPAA compliant and a detailed report is sent only to the clinician. It is essential the GRCU is completed before the individual sessions are conducted to ensure information concerning co-morbidities and contra-indications to therapy are revealed In October 2020, the Gottman Institute released their Gottman Connect website and accompanying APP. It includes a new enhanced relationship check up and a range of resources for the couple called The Relationship Builder which includes educational resources, couple activities and video demonstrations.

Individual sessions

Following the initial co-joint session, the clinician conducts an individual session with each partner. This session is used to build trust with each individual and learn more about each partner's perspective, family of origin, history, possible co-morbidities, hopes, expectations, and commitment to the relationship. The individual

session provides a discreet opportunity to explore potential contra indicators such as domestic violence and ongoing affairs.

Feedback session

This session provides the opportunity to share your formulation with the couple from the information collected in the GRCU, the initial conjoint and individual sessions. The feedback session is structured using the Sound Relationship House with the clinician explaining each level of the house to the couple whilst giving feedback on their strengths and areas requiring development in each area. It is through these conversations that treatment goals are discussed and agreed upon.

Second phase therapeutic interventions

GMCT typically begins with the down-regulation negativity in a couple's conflict and ways to increase positivity during conflict moving towards building positivity during conflict and building positive affect during non-conflict, bridging emotional disconnections, and creating shared meaning in the relationship.

It is useful to view the therapeutic intervention in two ways. Some interventions are *Set Up* interventions. These are structures used to assist the couple in moving into a more in-depth dialogue on an issue. Gottman interventions such as the Gottman Rapoport intervention and Dreams Within Conflict intervention are key examples of *set up* interventions (defined later in this chapter). The other form of interventions is *step in* interventions which occur whilst the couple are in dialogue, aimed at either reducing escalation or promoting a deeper understanding of different perspectives. Four horseman intervention and flooding intervention are key examples of *step in* interventions (defined later in this chapter). Many other interventions are used regularly within GMCT however, only the four mentioned above will be detailed in this chapter.

The following is a detailed description of four interventions commonly used to de-escalate couple conflict.

Set up interventions

Gottman Rapoport intervention is a structured conversation where each partner takes a turn in being the speaker and the listener, providing the opportunity for each other's positions, feelings and positive needs to be heard, understood, and validated. Anatol Rapoport was a mathematician and social psychologist who worked extensively in international conflict (Gottman & Gottman, 2016).

John Gottman has used some of Rapoport's assumptions in this intervention. An important assumption of this intervention is the concept of two valid subjective realities, not just one; that both positions are valid, that there is no absolute right and wrong, simply each person has a different perceptive on the same issue. This allows the couple to focus not on facts but on perceptions. This intervention is about slowing down a conversation, reducing physiological arousal levels and ensuring the listener is able to reflect understanding and validate at least part of their partner's perspective. In this intervention problem-solving is suspended until both partners understand each other's perspective and each other's positive needs on the issue are fully understood. The speaker, with the assistance of the clinician, speaks directly to their partner using gentle start-up such as an 'I-statements', expressing emotions and avoiding blame and criticism, exploring their perspective with the articulation of a positive need on this issue. The listener is encouraged to take brief notes about what the speaker is saying, assisting in promoting listening and reducing the tendency to form rebuttals in their mind that interrupt listening capacity. Once the speaker is finished, the listener reflects back and validates what the speaker said, including the speaker's affect. The Gottman Rapoport intervention enables the couple to gain a deeper understanding and appreciation of each other's perspective and an opportunity to feel more understood and validated by one another thereby creating a corrective emotional experience that enables flexibility and possible compromise on the topic of conversation.

Dreams within conflict

This intervention is specifically designed for couples to explore gridlock conflict on perpetual issues in their relationship. Couples have issues that they continually fight about without resolution, from serious conflicts (e.g., should we have children or not, to small issues such as how one should fold the towels). Over time these conflicts can become stuck, gridlocked, where neither feels heard, understood, or validated. Indeed, perpetual gridlock conflict can create a feeling of vilification, distance, and emotional disconnection. Gridlock is an indication that the dreams embedded in the issue are not being understood or honoured. Dreams are defined as hopes, aspirations, and wishes that are part of one's identity, personality, and give purpose and meaning to one's life.

The purpose of this intervention is to move gridlock to dialogue; not to solve the problem but for the couple to engage in constructive ongoing conversation without escalation or vilification. The structure of the intervention again includes a speaker and a listener role, where the listener's role is to create a climate of safety, allowing the speaker to talk deeply about the meaning for them of the issue, exploring their underlying values, dreams, and fears on the topic. To assist the speaker in deepening the conversation, the listener asks a series of questions like an interview such as:

- What are your core beliefs, ethics and values that are part of your position on this issue?
- Is there a story behind this for you, or does this relate to your background or childhood story in some way?
- Tell me why this is so important to you.
- What feeling do you have about this issue?
- What would be your ideal dream here?
- Is there a deeper purpose or goal in this for you?
- What do you need?
- Is there a fear or disaster scenario in not having this dream honoured?

To move out of gridlock, both need to feel understood and that the deep purpose and dream that exists in their position on the issues is validated and honoured. Acknowledging and respecting each person's deepest, most personal hopes and dreams is the key to a strong and connected relationship.

Four horsemen

John Gottman's research identified four highly destructive interaction patterns that he named the four horsemen of the relationship apocalypse. These are criticism, defensiveness, contempt, and stonewalling. Consistent use of the four horsemen moves relationship interactions onto a battleground where the conversation quickly ceases being about the initial issue raised and moves to every complaint, they have about how they feel their partner is treating them. Criticism and contempt are personalised attacks on the partner's personality, communicating that something fundamental is not okay with them. Contempt can be condescending, speaking down at their partner, communicating that they think they are better than them. John Gottman was able to predict with 94% accuracy those relationships that will end in separation and divorce based on existing contempt in conflict conversations.

Using a gentler beginning when raising a complaint, with the speaker talking more about what they feel and what they need rather than negatively describing their partner allows the issue to be understood by their partner, providing a real opportunity for that person's concerns to be heard. Defensiveness and stonewalling are behaviours that redirect the complaint or criticism away, where feedback is received, and the person does not allow themselves to be influenced by the other. Interestingly, when someone is stonewalling, they are experiencing stress and shutting down to stop or avoid the conflict from getting worse. Unfortunately,

the opposite is true; defensiveness and stonewalling tend to escalate negative interactions. The capacity of a couple to accept some responsibility for their partner's concerns and to self soothe when feeling stressed and wanting to shut down, assists in reducing the cascade into negative interactions and the escalation of conflict.

When a couple in therapy uses the four horsemen, the clinician intervenes by stopping the interaction, identifies the horsemen that was used and explains the antidote for the client to use. The clinician then assists the client in using the antidote. The goal is for the couple to experience a different type of conversation, one that doesn't feel like a personal attack or a rejection of their perspective and that does not build negativity.

Horseman antidote

Criticism: Use a gentle start up.

Defensiveness: Take responsibility.

Contempt: Describe your feelings and needs; don't describe your partner.

Stonewalling: Do physiological self-soothing.

Flooding

John Gottman noticed in his research that when a couple's conflict escalated, it was not only their words, tone and volume that escalated, it was also their heart rates and the amount of stress hormones being secreted. This is called flooding or diffuse physiological arousal. The research findings were compelling**:** the more aroused couples were in conflict, the faster their hearts beat, the faster their blood flows, the more they sweat, the more stress hormones they release, the more their relationships deteriorated in the next three years. What we know is that it is the escalation of the conflict that builds negativity, and it is this build-up of negativity that predicts relationship demise. Flooding in conflict increases negativity in a relationship.

The term flooding refers to a flood of stress hormones (such as adrenalin and cortisol) to the nervous system that generates what is commonly known as the 'fight or flight' response.

What happens in your body when flooded?

- A cascade of physiological events takes place in the brain and the autonomic nervous system. Individuals are not in control of this cascade.
- Heart rate increases to 100 beats per minute or above.
- Blood is drawn in from the periphery and into the trunk to minimise haemorrhage.
- The frontal lobe of the brain is deactivated, and the amygdala is activated.
- Blood flow is redirected to vascular beds necessary for fighting or fleeing.
- Non-essential services like digestion are shut down.
- Glycogen in the liver is converted to glucose.
- Blood volume is increased through the renin-angiotensin system; there are considerable increases in myocardial contractility.
- Blood pressure increases.
- Breath becomes faster and shallower.

What happens in interaction with a partner when flooded?

- When people are physiologically flooded, they have trouble processing incoming information, meaning their capacity to listen and understand their partner is significantly impeded.

- In flooding, people cannot remember what they like about their partner, and it is hard for them to either give or receive affection.
- People do not want to be touched, and in many cases, it is even impossible to be polite and gentle with their partner.
- Tunnel vision occurs, and perception becomes distorted so that everything seems dangerous, the partner becomes the enemy, everything said by one's partner seems like an attack.
- Alternative solutions and creative problem solving becomes difficult, and people can move into what we call 'repeat yourself syndrome' where they repeat the same point over and over again with increasing tone and volume in a misguided belief their partner will somehow see the merits of the argument and without equivocation, totally agree with everything being said, Of course, this does not occur.

GMCT includes over 50 couple interventions that therapists can use with couples to not only assist them in better managing conflict but also to deepen friendship and intimacy, create shared meaning, and strengthen trust and commitment in their relationship. Outcome studies and individual case study follow up (derived from authors' private practice outcome data) routinely indicate that couples who complete a course of GMCT experience ongoing improvements in relationship satisfaction, conflict management and relationship commitment for years afterwards (Babcock et al., 2013).

EMOTIONALLY FOCUSED THERAPY WITH COUPLES (EFT-C)

EFT-C is a non-pathologising experiential, systemic and attachment-based therapy, focused on couple interaction in the present moment, facilitating awareness of emotion within the couple's interaction to promote positive interaction changes in the here and now.

The clinician observes the dynamics between clients in the therapy setting, ties this behaviour to the dynamics in their home lives, and helps direct new conversations and interactions based on more honest feelings. To accomplish this, the clinician encourages the couple to explore their current issues and assists in the discovery of deeper feelings and emotions that exist. The couple may access deeper past feelings and vulnerabilities that are blocked by the more immediate emotions displayed in their current relationship. They may learn to express these emotions in a way that will help one another connect, rather than disconnect and distance one another. The therapeutic goal is for the couple to learn new ways to listen and stay attuned to the other's emotions and discover more productive ways to respond to emotional situations.

EFT-C identifies three stages in the therapeutic process, and within the three stages, there are nine steps of the therapeutic process.

1. The first stage is to de-escalate the couple's negative cycle of interaction and to assist the couple in gaining insight and understanding of the deeper processes of each other's interactions in their relationship. The clinician assists the couple to see and understand what is underlying the current negative interactions in their relationship. The couple begin to see more substantive emotions and needs that exist with the negative interaction patterns that are commonly masked through the escalation of negativity and the distancing and pursuer patterns.
2. The next stage is to restructure interactions, where the clinician assists the couple to engage in dialogue about their fears in the relationship in a way that can be heard by the other and thereby increase, not decrease, connection. Couples learn to turn toward each other and express their needs and hopes in a way that creates openness and responsiveness.
3. Consolidation is the third stage of EFT-C, where the clinician assists the couple see how they got into negative patterns and points out how they were able to change those patterns and how they can continue these types of conversations in the future.

Limits of therapy

EFT-C identifies three fundamental limits to therapy:

- The clinician does not decide if the couple should end or continue the relationship; the decision is only for the couple.
- Information in the individual sessions is confidential unless it seems crucial for the therapy to move forwards. The clinician will advise that partner to disclose relevant information with their spouse.
- The clinician cannot change the relationship, only the couple can. The couple is responsible for their relationship between therapeutic sessions.

Contra-indications for EFT-C

The critical question with contra-indicators is: can the clinician create safety in therapy? Two major considerations for making this decision are the following:

1. ongoing domestic violence
2. competing attachments (ongoing affairs or serious addiction).

Stage 1: Assessment and de-escalation (includes the first four of the nine steps)

Assessment is carried out in the first stage of the therapy with the clinician using conjoint and individual sessions to create a therapeutic alliance, formulate couple issues and concerns, and gain individual and relationship histories.

Individual assessment sessions are completed after one or two initial couple sessions. These sessions aim to develop rapport with the couples and to understand their perspective on the relationship, negative interaction patterns and attachment issues. Further, the individual session covers the following areas:

- commitment or ambivalence to the relationship
- previous attachment trauma
- previous relationships
- childhood and family background
- affairs
- domestic violence
- mental health issues
- drug and alcohol use
- medical conditions
- chronic pain
- sexual difficulties.

The individual session provides a discreet opportunity to explore possible contra indicators such as domestic violence and ongoing affairs.

Throughout the first phase of counselling, the clinician relies on the use of EFT-C micro-skills such as empathic listening, normalising, mirroring, or reflecting, reframing individual stories and perspectives. Importantly, the clinician tracks and articulates the negative interaction pattern and reflects back the problem cycles. These processes assist the client in becoming more aware of their emotions and how their emotions can affect themselves and others. It helps the client become more confident in the changes that are occurring.

Step 1: Identify the relational conflict issues

The clinician assists the couple to identify the presenting issues within the relationship and assess the effects on the relationship.

Step 2: Identify the negative interaction pattern in which the conflict is expressed

The clinician and couple explore the interaction pattern at the heart of the problem. This occurs through identifying positions of withdrawal and pursuit within the interaction and tracking the steps in the reactive cycle. Tracking the negative interaction cycle is identifying how the couple interacts in relation to each other's feelings, thinking and behaviour, and how attachment needs are met or not.

Step 3: Access unacknowledged emotions underlying the interactional position

Through discussion, the clinician assists the couple to explore each partner's feelings in relation to the conflict cycle, with a focus on emotions that had not previously been expressed—accessing the underlying and often hidden attachment fears that perpetuate the negative interaction cycle.

Step 4: Reframe the problem in terms of the negative interaction cycle

The clinician begins to reframe the issues of the relationship away from deficits in either individual into seeing the problem within the negative interaction cycle. Reframing assists in the de-escalation of conflict and help the couple move towards validating each other's different perspectives on the same issue. This step is to help the client view the problem from their partner's point of view, helping each partner to understand the other's emotions and needs.

Stage 1 is complete when the couple gains awareness that the core issue in the relationship is the negative interaction loop creating their distress, hurt and pain. This negative, self-reinforcing cycle is nicknamed the demon dialogue in *Hold me tight* (Johnson, 2008). At the end of stage 1, the couple is able to take ownership of their part in the negative interaction cycle and understand what draws them back into it. They recognise how each other's attachment fears are triggered and how this continues the negative cycle.

Stage 2: De-escalation (includes the steps five through to seven)

In Stage 2, the clinician facilitates deepening the expression of primary attachment emotions to generate new pathways of connection and interaction, rebuilding secure and safe attachment bonds. Each partner expresses their deeper unmet attachment needs that have been hidden in the negative interaction pattern. Each partner takes a risk, to allow vulnerability, to turn towards each other and ask that these previously hidden attachment needs be met. These acts are intentionally structured interventions known as "enactments".

The clinician uses a range of micro-skills and techniques such as:

validation—expressing the legitimacy of the person's emotion

empathic reflection—highlighting and commenting on emerging emotions, noticing verbal and micro-expressions of the client

heightening of emotions—validating the emotion of the client whilst emphasising and evocating a stronger connection for the client with that emotion. Heightening enhances vulnerable emotions that can lead to a high arousal state that moves the client towards a greater understanding of themselves and others. The use of metaphor or imagery assists heightening.

empathic conjecture—the clinician works on the edge of a client's experience to move the client forward in his/her experience such that new meaning can emerge. Often these conjectures address the attachment fears related to self and others.

restructuring interactions—the clinician offers a new suggestion for the couple, which in turn builds on a

new emotional experience that seeks a different response to one's partner. This challenges the couple's old relationship interaction patterns and creates the possibility of something new.

tracking the cycle—the clinician names the steps in the negative interaction pattern between the couple from the material they bring into the session. The clinician, step by step, talks through the feelings, thoughts, and behaviour of the couple in interaction, touching on deeper emotions and attachment fears and needs.

reframe—the clinician draws out the attachment needs through reframing the negative interaction of the withdrawer and pursuer.

enactments—the clinician sets up small experiences/experiments for the couple to express primary emotions to one another (e.g., Can you turn to your partner and tell them how lonely you are feeling right now?)

RISSC—to enable the client to contact and engage with difficult emotions, the following RISSSC acronym is useful.

- Repeat: the key words and phrases repeated several times.
- Image: images capture and hold emotion in a way that abstract words cannot.
- Simple: keep words and phrases simple and concise.
- Slow: a slow pace enables emotions to unfold this process.
- Soft: a soft voice soothes and encourages deeper experiencing and risk-taking.
- Client's words: the clinician uses the client's words and phrases in a collaborative and validating way.

These skills and techniques ensure the therapist is attuned to the couple allowing the couple to feel heard, understood, and safe.

Step 5: Promote the identification of disowned needs

The clinician assists the couple to express and understand each other's needs, wants and desires. This step places significant emphasis on the importance of understanding the other's needs and wants fully through dialogue, and once achieved, to move towards meeting those expressed needs and wants.

Step 6: Promote partner acceptance

The clinician encourages each partner to accept the other's emotional experience and acknowledge their changing experiences.

Step 7: Facilitate expression of needs and wants to restructure the interaction based on the new understandings and create bonding events

The clinician will guide each partner in learning how to interact more positively. A bonding exercise may accompany this step to help the couple promote a healthy new connection. The couple can risk the direct expression of their needs and wants to one another and have the capacity to create a new positive interaction that is responsive to unmet attachment needs.

Stage 3: Consolidation and integration: (includes steps eight and nine)

Stage 3 involves consolidating the learning and experience of the EFT-C therapeutic experience by integrating and consolidating the changes made during therapy and creating a plan for continued success outside of therapy. The clinician uses encouragement and support and aftercare teaching to promote relapse prevention.

Step 8: New solutions

The clinician supports the couple to collaborate in solving pragmatic problems. Now that differences are no longer triggers of attachment threats, and new solutions are more readily forthcoming. With the new, more positive foundation in place, solving these problems become much easier than it seemed in step one.

Step 9. Consolidation

In consolidation, the couple will take new skills and interaction patterns into their lives to continue developing effective ways to interact and new, more adaptive behaviours.

As with all humanistic therapies, the task of building and maintaining an alliance with each partner remains critical thought the three stages and nine steps of the EFT-C process. The other two key tasks are reprocessing emotional experience and restructuring new interactions between partners; creating corrective emotional experiences for the couple, reconfiguring their interaction patterns from negative escalated interactions to conscious attuned interactions that build connection and attachment.

Case study: Intervention

Treatment Summary—Charlie and Blair—using GMCT

Assessment phase

Charlie and Blair were assessed using standard GMCT protocols. They attended an initial conjoint session where a relationship history was taken, presenting issues identified and they engaged in two 15-minute video-taped conversations (an event of the week conversation and a conflict conversation) during which their physiological arousal was monitored using pulse oximeters. They each attended an individual session where an individual clinical history was taken, and they used the Gottman Love Lab rating dial to assess their level of distress while watching back the two video-taped conversations mentioned above. They both completed the online Gottman Relationship Check Up Questionnaire.

From this data, the therapist prepared a case formulation, treatment plan and feedback report for the couple. A conjoint session in which feedback and psychoeducation related to the assessment data was provided and the following treatment goals were collaboratively established:

- manage DPA
- eradicate the four horsemen
- learn conflict management skills—listening for meaning, reflection, attuning, repairing
- develop strategies and skills for deepening friendship and intimacy
- create a system of rituals of connection and shared meaning.

Brief formulation—Charlie and Blair presented with high levels of negative sentiment override driven by lack of emotional and physical intimacy, familial and financial stress. Within this, perceptions of workload fairness have resulted in hurtful and bitter arguments. The assessment indicates that while both partners experience diffuse physiological arousal (DPA), Charlie tends to become louder and more aggressive while Blair becomes overwhelmed, shuts down and attempts to withdraw which in turn escalates Charlie more – a common pursuer/withdrawer negative interaction pattern.

Charlie grew up in an intact household as the oldest of two children. Charlie's father was a military officer who, despite being frequently absent, was the primary disciplinarian and used yelling, physical intimidation, and low-level corporal punishment (smacks, holding, dragging) to manage misbehaviour. Charlie describes him as "scary but fair". Charlie reported a mostly happy childhood free from major trauma except for witnessing his beloved family dog being fatally hit by a car at the age of 12. Charlie denied any bullying or problems at school and graduated to a university to study law. After graduation, Charlie obtained a position with a large law firm and has steadily advanced with that

company over the last eight years until taking recent parental leave. Charlie has some concerns that decision may have an impact on future advancement but feels it "was the right thing to do at the time".

Blair is three years older than Charlie and grew up as the middle child in a family of five. Blair's parents separated and subsequently divorced while Blair was in primary school. Blair continued to live with two younger siblings in the home with their mother, visiting their father and older siblings on alternate weekends. Blair describes this time as "confusing, unstable and unsettling". Blair's mother remarried within three years of the separation, and Blair reports her new partner was "aloof and dismissing". Blair reports feeling "different and always on the outer" at school and identifies as being "a loner". Blair was academic and did well in school, gaining entry to a medical degree and now works as a medical researcher and academic.

Blair and Charlie met at university when Blair was 24 years old, and Charlie was 21. Neither report any significant prior romantic relationships.

Therapeutic phase

Consistent with GMCT Blair and Charlie were scheduled for four 2-hour consultations to assist them in learning skills to better manage conflict and to process and repair old hurts. Each consultation began with the question "what would be useful to talk about in today's session?" They were also reminded that they had agreed for the therapist to interrupt their conversation if DPA or use of the four horsemen occurred. Blair and Charlie agreed the initial topic they wanted to discuss was "My thoughts on workload distribution in our relationship". The therapist introduced and explained the Gottman Rapoport Intervention. Blair chose to be the speaker first. During this conversation, Blair used two of the four horsemen (criticism and contempt) a few times.

The therapist intervened each time and assisted Blair to restate using the appropriate antidote. This allowed Charlie to stay in listening mode for the most part. However, Charlie did become flooded (BPM 102) once, and the therapist led both partners through a self-regulation breathing exercise which allowed them to de-escalate and continue their conversation. Charlie was able to accurately reflect back Blair's position and to both validate and empathise with Blair's feelings of hurt, disrespect and loneliness. Charlie then took the speaker's role, and the process was repeated. Charlie demonstrated some distress while disclosing shame and fear in not being able to manage in the parenting role as well as Blair had. The therapist assisted Charlie to draw a link between these feelings and his experiences in his childhood (internal working model intervention) that have led to behaviours that included being short, harsh, and demanding. Blair demonstrated deep empathy and disclosed "it all makes so much more sense now". The couple were assisted to engage in a compromise intervention to establish some processes to better support each other in the parenting role. Both partners were gentle and affectionate with each other at the end of the session.

The following session, Charlie and Blair reported that they had experienced great benefit from their previous session and had been feeling closer and "more of a team". They decided they wanted to work on deepening their understanding of each other's emotional needs. The therapist introduced the dreams within conflict intervention and framed the discussion as "What I need to feel loved and supported in our relationship". Blair and Charlie took turns to respond to their partner's questions on this topic. With the assistance of the therapist, Blair learnt that Charlie has carried a story from childhood about perfectionism and that when Blair gives appreciation and praise this helps Charlie to feel valued and worthwhile even when things aren't perfect. Charlie learnt that Blair has always felt unacceptable, different, and alone and that messages of approval and acceptance help Blair feel connected and wanted.

In treatment session three, Charlie and Blair identified that they both still had hurt feelings relating to a very escalated argument they had had three years earlier. The therapist introduced the aftermath of a fight intervention and assisted them to reprocess the fight, empathise with each other, apologise for their own part in the fight and create a constructive plan to assist each other in better managing, in future, the emotional triggers that had led to this fight.

During the subsequent six sessions attended over the following 14 weeks Charlie and Blair worked on issues related to increasing their friendship and intimacy through Gottman-Rapoport and dreams within conflict conversations around topics such as "my thoughts on how we can have more fun in our relationship"; "what a close, connected, intimate relationship means to me"; and "what I need to feel ready of sex". They also engaged in activities such as the 'I appreciate' intervention, love map cards, open ended question cards, salsa cards, and rituals of connection cards.

Charlie and Blair reported they were feeling more connected, experiencing less conflict, and when conflict arose, they were able to manage it by using a Gottman-Rapoport conversation. They reported using this process, and the skills they had learnt during couple therapy sessions had resulted in a complete reduction of the use of the four horsemen and physiological flooding.

Follow-up and relapse prevention stage

Charlie and Blair attended five follow up consultations over the next six months during which they were introduced to GMCT interventions such as stress reducing conversation, the state of the union conversation, and expressing needs cards. They consistently reported their relationship was feeling more satisfying and happier.

Twelve months post their initial presentation Charlie and Blair again completed the Gottman Relationship Check Up questionnaire which demonstrated marked decrease in their initial challenging areas related to conflict management, emotional disengagement, and loneliness in the relationship along with a marked increase in satisfaction, commitment, emotional connection, romance and quality and frequency of sex. A second post-treatment Relationship Check Up Questionnaire was administered nine months later, which indicated the positive trend on all measures had continued. At this time Charlie and Blair were advised their case would be closed and that they were welcome to recontact should they need to in the future.

Charlie and Blair's complete course of treatment, including relapse prevention, consisted of a total of 24 hours of face-to-face contact with their therapist and three administrations of the online Relationship Check Up Questionnaire.

CONCLUSION

Couples therapy requires a thorough assessment, formulation, and treatment plan due to the complexity of individual needs and couple interaction patterns/dynamics. The therapist needs a deep understanding of relationship theory, a well-developed, evidence-based framework and therapeutic process to competently manage the emotional and frequently escalated issues that couples present with, and a well thought out and executed follow up and relapse prevention plan. Pre and post assessment is highly recommended as part of this process.

Engaging in specific couple therapy training in an evidenced-based approach such as GMCT and/or EFT-C for couples provides therapists with the specialised knowledge, framework, interventions, and skills to ensure their couple clients are provided with best practice treatment and outcomes.

RECOMMENDED RESOURCES

Information for post-graduate training in Gottman Method Couples Therapy can be found at:

Professional Training Workshops including certified Gottman Method Couples Therapy
The Gottman Institute, upcoming events

Information for post-graduate training in EFT-C for couples can be found at:

EFT Training & Certification Overview

Helpful YouTube channels:

The Gottman Institute
Dr. Sue Johnson

Great reading:

Dr John Gottman has published over 200 journal articles and authored or co-authored over 40 books, below are a few of his most recent books. A list of journal articles, some with dynamic links, can be found on this John Gottman webpage.

Gottman, J., & Gottman, J. (2018). *Eight dates: Essential conversations for a lifetime of love.* Workman Publishing Company.

Gottman, J., & Gottman, J. (2018). *The science of couple and family therapy.* W. W. Norton and Company.

Gottman, J, & Silver, N. (2013). *What makes love last: how to build trust and avoid betrayal.* Simon and Shuster.

Gottman, J, and Silver, N. (2015). *The seven principles for making marriage work.* Random House.

Greenberg, L., & Goldman, R. (2008). *Emotion-focused couples therapy: The dynamics of Emotion, Love and Power.* American Psychological Association.

Johnson, S. (2008). *Hold me tight.* Little and Brown Company.

Johnson, S. (2013). *Love Sense.* Little, Brown Spark.

Johnson, S. (2018). *Attachment theory in practice.* Guilford Press.

Learning activities

For more information about GMCT, watch these four short YouTube videos:

- Making relationships work—Part 1
- Making relationships work—Part 2
- Making relationships work—Part 3
- Making relationships work—Part 4

A brief demonstration of EFT-C in action.

A brief summary of EFT-C.

GLOSSARY OF TERMS

acceptance of influence (Gottman method couples therapy)—taking your partner's opinion into account, and being open to using their contribution to make shared decisions

Bowen theory—a theory of human behaviour describing a family system where each family member has an assigned role with the expectation to respond to each other per their assigned role. The family is considered an emotional unit by applying systems thinking processes to describe the unit's complex interactions. The aim is to maintain patterns of behaviour within a system that can be beneficial or dysfunctional to its members.

conjoint sessions—clients from a couple are seen together in a therapy session by one clinician

contempt (Gottman method couples therapy)—is the third horseman of the apocalypse. Contempt is communicating to your partner an attitude of superiority, that you look down at them, implying your partner is inferior, less than or worthless. Contempt is used to create a position of moral superiority.

consolidation and integration (emotionally focused therapy with couples)—third task of EFT-C where the couple continue to reorganise their cycle of interaction by finding new solutions to their relationship problems and sharing their changed emotional experiences. With the clinician providing feedback to the couple on their accomplishments.

contraindicated (Gottman method couples therapy and emotionally focused therapy with couples)—defines the limits of not proceeding with therapy for a couple, citing the possible risk of harm that it may cause to either client within the couple. For both approaches, therapy is contraindicated when there is an ongoing affair or the presence of domestic violence within the relationship.

criticism (Gottman method couples therapy)—is the first horsemen of the apocalypse. Criticism is an attack on your partner's character, focusing on your partner's defects rather than the actual issue or complaint.

de-escalation—the clinician facilitates a reduction in harmful interactions between the couple through identifying patterns of interactions, emotions, behaviour, and unmet attachment needs, creating emotional safety for the clients

defensiveness (Gottman method couples therapy)—is the second horsemen of the apocalypse and is an automatic batting away of their partner's issue or complaint. Often defensiveness is a response to criticism. Defensiveness is a lack of taking responsibility and accountability for one's own actions including an inability to listen and validate your partner's perspective.

demon dialogue (emotionally focused therapy with couples)—rigid and negative patterns of conflict communication that prevent safe communication by the confusion of emotional signals, preventing safe connection between partners. Dr. Johnson describes three demon dialogues as being: find the bad guy AKA mutual attack, the protest polka AKA demand and withdraw, and flight and freeze AKA tension and avoidance.

disowned needs (emotionally focused therapy with couples)—the clinician helps the couple to understand the needs and wants of each individual. Then how to convey these needs. The premise is to be able to meet your partner's needs, firstly you must understand them.

differentiation of self (Bowen theory)—the ability to be socially connected to others while remaining independent in one's emotional functioning

diffuse physiological arousal (DPA) (Gottman method couples therapy)—an internal alarm system that sets off a chain reaction from the brain to the body in response to a threat (perceived or real) alerting danger. Priming the body for the fight or flight response; heart rate increases, blood flow to the gut and kidneys slows down and stress hormones such as cortisol, adrenalin, and catecholamine are released. Another term for DPA is flooding.

down-regulation negativity (Gottman method couples therapy)—the use of positive emotions to facilitate the body's return to homeostasis caused by the physiological arousal of negative emotions

dreams within conflict intervention (Gottman method couples therapy)—this intervention is specifically designed for couples to explore gridlock conflict on perpetual issues in their relationship. The purpose of this intervention is to move gridlock to dialogue; not to solve the problem but for the couple to engage in constructive ongoing conversation without escalation or vilification.

emotional cut-off (Bowen theory)—driven by high levels of anxiety in self and within the relationship, describes the pattern of extreme emotional distancing to address unresolved attachment needs

emotional distance—a symptom of an unhealthy relationship dynamic that obstructs the development of intimacy

emotional fusion (Bowen theory)—the formation of intense relationships where individual choice is minimised to maintain harmony within the relationship

enactments (emotionally focused therapy with couples)—the clinician nurtures a new interaction experience, with the couple experiencing each other as being available and responsive. Designed to reduce relationship distress and enable change by highlighting and heightening brief snippets of attachment related relationship dynamics.

family projection process (Bowen theory)—the process of parents transferring their emotional problems to their children. Describes the primary way parents transfer their emotional problems to their children.

flooding Intervention (Gottman method couples therapy)—intervention used to reduce physiological arousal with one or both partner in couple therapy. The intervention including identifying when one or both partners are flooded, moving them into a relaxation exercise until their heart rates have reduced from above 100 beats a minute to nearer to rest. Once this is completed the therapist encourages the couple to re-engage in the dyadic conversation.

four horsemen of the apocalypse (Gottman method couples therapy)—a metaphor to describe the counterproductive communication and behaviours that can predict relationship failure if left unchanged. These being **criticism, defensiveness, contempt, and stonewalling.** Each horseman corrodes away at the level of trust and commitment within the relationship.

four horseman intervention (Gottman method couples therapy)—intervention used to stop the four

horsemen through the identification of their use and rephrasing the conservation using each associated antidote. To foster healthy, productive communication habits.

gentle start-ups (Gottman method couples therapy)—crucial in resolving relationship conflicts that protect both people from feeling either attacked or defensive. A gentle start up is the antidote to the horseman of criticism and involves a partner saying what they feel about a situation and what they need rather than describing negative attributes of their partner.

Gottman Rapoport intervention (Gottman method couples therapy)—Gottman Rapoport intervention is a structured conversation where each partner takes a turn in being the speaker and the listener, providing the opportunity for each other's positions, feelings and positive needs to be heard, understood, and validated

gridlock conflict (Gottman method couples therapy)—couples have issues that they continually fight about without resolution, from serious conflicts (e.g., should we have children or not, to small issues such as how one should fold the towels). Over time these conflicts can become stuck, gridlocked, where neither feels heard, understood, or validated. Indeed, perpetual gridlock conflict can create a feeling of vilification, distance, and emotional disconnection.

multi-generational transmission process (Bowen theory)—a family's level of functioning is influenced by the instability or functioning of previous generations

negative cycle of interaction (emotionally focused therapy with couples)—describes the repeating interaction between each partner's surface emotions and negative behaviours, thoughts, and feelings that cause relationship distress. Driving the cycle is the maladaptive attempts at intimacy or closeness within the relationship.

perpetual issues (Gottman method couples therapy)—John Gottman's research identified that 69% of conflict in a relationship was perpetual in nature, meaning that most conflict is not solvable and is based on individually held values, family backgrounds, experiences, and personality

primary attachment emotion (emotionally focused therapy with couples)—repressed primary emotions drive the negative interaction cycle between a couple. Emotional attachment is rebuilt through honest emotional expression.

pursuer-distancer pattern (Gottman method couples therapy and emotionally focused therapy with couples)—a relationship pattern that describes attempts to relieve relationship anxiety and stress. Through attempts of turning towards (pursue) or turning away (distance) from their partner.

repair attempts (Gottman method couples therapy)—any preventative statement or action that averts escalation between partners. A repair attempt strategy is unique to each couple, designed to amend rather than fix what is broken.

shared meaning system (Gottman method couples therapy)—is the attic level of the sound relationship house that consist of rituals, goals, roles, and values. That encompasses the legacy of a relationship to reflect a life together that is full of meaning. It is the creation of culture, beliefs, and stories that form the shared meaning.

sibling positions (Bowen theory)—people who grow up in the same sibling position, having the same functional characteristics of personality

societal emotional process (Bowen theory)—describes how the emotional system influences behaviour on a societal level, promoting both progressive and regressive periods in a society

set up intervention (Gottman method couples therapy)—these interventions are structures used to assist the couple in moving into more in-depth dialogue on an issue or past regrettable incident. Examples include the Gottman Rapoport intervention and the dreams within conflict intervention.

step in interventions (Gottman method couples therapy)—these interventions occur whilst the couple are in a set up intervention, aimed at either reducing escalation or promoting a deeper understanding of different perspectives

stonewalling (Gottman method couples therapy)—the fourth horseman of the apocalypse is stonewalling and is a form of defensiveness. Stonewalling is when one shuts down interaction and stops responding to their partner. Internally the person stonewalling is experiencing heightened levels of stress and physiological arousal.

the sound relationship house (Gottman method couples therapy)—is the relationship theory for

relationships by John and Julie Gottman. It is divided into three interrelated components of friendship, conflict, and meaning systems. The sound relationship house has 7 floors and 2 walls of trust and commitment.

systems theory (family systems)—a philosophy that focuses on the interdependence of individuals within a group to understand and improve relationships

triangles or triangulation (Bowen theory)—the recruitment of a third person into a conflict between two people to reduce relationship tension.

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Trish is certified to present all three levels of the Gottman Method training sequence, as well as the Art & Science of Love couple workshop. Trish frequently presents Gottman Method trainings for clinicians throughout Australia, New Zealand, Asia, and the USA. Trish has also undertaken training in Emotionally Focused Therapy for Couples having completed an externship, and all Core Skills training offered by the International Centre for Excellence in Emotionally Focused Therapy and integrates this into her work with couples.

Because of Trish's training and experience in couples therapy and clinical mental health disorders especially Post Traumatic Stress Disorder and Mood Disorders, Trish has been involved in the development and delivery of a number of couple programs and clinical treatment programs for the Department of Veteran's Affairs, The Australian Defence Force and Open Arms (Formerly known as Australian Veterans and Veteran's Families Counselling Service).

Trish is also trained in:

- Cognitive Process Therapy (CPT)
- Schema Therapy
- Cognitive Behavioural Therapy (CBT)
- Acceptance and Commitment Therapy (ACT)
- Motivational Interviewing

Trish has been in private practice on the Gold Coast in Queensland, Australia since 1997 and provides a range of services to members of the general public including couples therapy, intensive marathon couples therapy, couple workshops and is an active educator and speaker to many community and professional organisations.

Trish has recently co-authored a book called 365 Simple Ideas to Improve Your Relationship with her business partner John Flanagan. This book provides a unique daily guide for couples and contains a daily tip and a task designed to help them make positive change in their relationship.

To learn more about Trish, listen to this We All Wear it Differently podcast where Trish is interviewed about her journey into and through Psychology and Couple Therapy.

John Flanagan has, since completing his Bachelor of Social Work in 1988 and later a Masters in Gestalt Therapy, had an extensive history in direct service delivery with couples, families, and young people.

John was the first Social Worker in Australia to become a Certified Gottman Therapist, Master Trainer, and Consultant. This means that John has completed all levels of training and mentoring available through the Gottman Institute in Seattle, USA and can now provide training to other therapists in this modality as well as provide couples with world-class couple workshop experiences. He is one of only 26 therapists in the world to hold this standing. John is a certified presenter for all levels of Gottman therapist training and the Art and Science of Love Couples Workshop. He has completed his Certificate IV in Workplace Training and Assessment and has delivered a broad range of training both accredited and non-accredited.

John is trained to provide therapy to individuals, couples, and groups in a range of therapeutic approaches including:

- Gottman marital therapy
- Emotionally focussed therapy for couples
- Cognitive Processing Therapy
- Motivational Interviewing
- Gestalt Therapy
- Cognitive Behavioural Therapy

Over the last 20 years, John has provided a range of psycho-educational group programs to Australian veterans and their families in areas such as trauma, post-traumatic stress disorder, depression, anxiety, and resilience. He has provided training to therapists and human service organisations in Australia, New Zealand, Hong Kong, Malaysia, the USA.

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Trauma in Adults

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ABSTRACT

Clients with trauma-related presentations seeking counselling are a unique sub-population with specific needs and challenges. The nature of this work can be both challenging and rewarding and have significant potential to affect the individual's life trajectory in positive ways. Counselling can provide a forum to assist with support, validation, meaning-making and processing of trauma to assist people to live to their potential. Therefore, this chapter will provide an overview of types of trauma and the psychological effects of trauma. It will identify relevant screening and distress assessment tools relevant to trauma, as well as an overview of possible evidence-based interventions. The chapter then discusses considerations for counsellors when working with trauma-affected clients.

Learning Objectives

- Describe the nature and types of trauma and possible psychological effects.
- Identify screening tools relevant to trauma across the lifespan.
- Understand risk and protective factors among individuals and priority groups.
- Increase awareness of post-traumatic growth and resiliency.
- Consider relevant professional issues when working with trauma-affected clients.
- Gain awareness of possible interventions.

INTRODUCTION

The term 'trauma' represents an aggregate grouping of salient, negative life events and their associated psychological sequelae. This chapter is intended to provide a broad overview of the nature and types of trauma, and the ways in which counsellors can assist individuals and groups to recognise trauma, provide support/psychoeducation, and refer/support clients with assessment and therapeutic interventions. This chapter is not intended to provide an exhaustive account of all traumas nor intended to be a compendium for the treatment of severe/chronic/pervasive/complex trauma. This is highly specialised area requiring further training and under ongoing clinical supervision to ensure safety, wellbeing, and duty of care for both the client and practitioner. Counsellors may work with clients with trauma in a range of trauma-specific settings (e.g., domestic and family violence), however given the high rates of lifetime prevalence (estimated at 71.1% and 80.7% for lifetime prevalence for any potential trauma) Knipscheer et al. (2020) and de Vries and Olff (2009)

argue that trauma is likely to be a common feature of client presentations and history within any counselling setting/context.

A trauma response is something that one experiences that is typically out of the ordinary and may initially be life 'shattering'. Some traumatic events may be anticipated (e.g., knowing that a flood may occur at some time in a specific region, but not knowing exactly when this may occur; or the death of a loved one after a long and arduous battle with cancer). A traumatic event, however, is often unexpected, whereby the individual experiences a range of predictable and typical reactions to something highly atypical and potentially life threatening. Traumatic events can be 'one off', acute isolated events (e.g., earthquake, sexual assault, house fire, accident) or experienced as ongoing (e.g., repeated childhood sexual abuse, torture/trauma due to political circumstances); likewise, they may have been recent or historical, including from childhood (Bromfield et al., 2007; Higgins & McCabe, 2000; Finkelhor et al., 2005; Price-Robertson et al., 2013).

People may also experience a range of distinct traumatic events throughout their lifetime, which may result in cumulative and confounding trauma reactions/effects and potentially poorer prognoses. Trauma reactions are most commonly experienced by those directly exposed to the incident/s; however, vicarious trauma can also occur as a result of being exposed to other people's traumatic stories/experiences (e.g., as counsellors) or based on the viewing of repetitive media images (such as after 9/11 occurred in the USA) (Lowell et al., 2018). Other examples of traumatic events include: climactic (e.g., cyclone, floods), domestic and family violence, political (e.g., terrorism), and trauma associated with hate crimes (e.g., discrimination, assault or persecution based on gender, sexuality, or ethnicity). People may experience trauma in relation to distressing birth events or a diagnosis of a chronic health condition (e.g., fear of cancer recurrence or stigma associated with HIV) (Mullens et al., 2004; Mullens et al., 2018; Strodl et al., 2015). Trauma may also coincide with public health emergencies (e.g., COVID-19 pandemic) and disaster responses (e.g., bushfires), both directly and vicariously and with cumulative effects due to repeated exposure, other predisposing factors and/or salience of the trauma. Mental Health First Aid may be provided to assist with psychosocial support after such events (Jacobs & Meyer, 2005). The wide range of examples provided here regarding trauma is intended to demonstrate the heterogeneity of trauma and those associated with individual experiences and help you to build a context and terminology regarding trauma when working with future clients. Within an Australian context it is estimated a lifetime prevalence of 57–75% of a potentially traumatic event (Mills et al., 2011; Rosenman, 2002). Further, the majority of Australians will experience at least one traumatic event during their lifespan, however, individual reactions and adjustment processes vary tremendously. Australian research suggests that the most common traumatic events experienced by Australians are: experiencing an unexpected death of a close loved one; witnessing a person critically injured or killed, or finding a body; and being in a life-threatening car accident (Phoenix Australia (PA), 2019).

Like the wide range of trauma examples, the individual effects and trajectories post-trauma can vary significantly—even if two or more people have experienced the same event at the same time. Reactions and adjustment to trauma can also be heavily influenced by how a trauma was 'dealt with' at the time and the extent to which the individual felt sufficiently supported, as well as pre-morbid psychological factors (de Munter et al., 2020). For example, if an adolescent has been sexually assaulted and then attempts to seek support from their parents and is not believed, and/or experiences a negative interaction with police when trying to make an official report, these subsequent experiences will likely have further compounding cognitions (e.g., sense of injustice, vulnerability) and negative self-evaluation (e.g., defectiveness, helplessness) associated with the incident/s—as compared to if the individual had felt well supported after the incident (see Lorenz et al., 2019). Seeking support and not receiving it can result in further trauma or secondary victimisation.

PREVALENCE OF TRAUMATIC LIFE EVENTS IN ADULTS

Most people will encounter a traumatic life-event at some point. Exposure to a potentially traumatic event (PTE) is a common experience, with large community surveys in Australia and internationally revealing that 50–75% of people report at least one traumatic event in their lives (Benjet et al., 2016). PTEs include any threat,

actual or perceived, to the life or physical safety of a person, their loved ones or those around them. While PTEs are not uncommon experiences, only a small number of people who encounter trauma will go on to develop post-traumatic stress disorder (PTSD) (Shalev et al., 2017). Overall, the prevalence rate of PTSD in the general population ranges from 1.3% to 12.2% (Shalev et al., 2017). Some groups may be predisposed to PTSD, as relevant to social determinants of health and minority stress theory, and these predispositions may include childhood environment, prior exposure to trauma, pre-trauma psychopathology, and pre-trauma life stress (Carlson et al., 2016). Additionally, demographic variables like gender, race, and socioeconomic status can be risk factors for developing PTSD following a PTE (Carlson et al., 2016) and intersectionalities. Further, people who experience discrimination and marginalisation (e.g., migrants, members of sexually and gender diverse commuities) may be less likely to engage with formal help-seeking due to past negative experiences or fear of future mistreatment and may require more innovative health promotion approaches (see Mullens et al., 2020) and staff training (see Mullens et al., 2017) to more appropriately meet the needs of these at risk, priority communities.

While there is a chance that the majority of people will encounter a PTE in their lifetimes, there are some jobs that pose increased risk. Emergency service professionals (ESPs), such as police, firefighters, paramedics, emergency nurses and doctors, defence force personnel, and State Emergency Services, are frequently exposed to PTEs as part of their everyday work that may be considered traumatic. In unique and challenging work environments, ESPs are often required to provide immediate and urgent interventions in crisis situations and operate under conditions that may present some personal danger. Consequently, the prevalence of PTSD is higher among ESPs than the general population, ranging from 16.5% to 20.9% (Dobson et al., 2012; Forbes et al., 2016; Marmar et al., 2015; O'Toole et al., 1996; Shalev et al., 2017).

COURSE OF TRAUMA REACTIONS, DIFFERENTIAL DIAGNOSES, AND CASCADE OF COMORBIDITY IN ADULTS

Trauma, as described above, is a psychological and emotional response to a distressing event or experience, such as an accident, an assault, or a natural disaster (American Psychological Association, 2021). Such traumas may be singular or multiple in nature, and the research suggests that repeated and chronic trauma is more common through multitype maltreatment, poly-victimisation, and re-victimisation (Higgins & McCabe, 2000; Finkelhor al., 2005). Multi-type maltreatment has been proposed as a theoretical framework for understanding the interrelatedness of the five childhood abuse types (i.e. sexual, physical, emotional, neglect, witnessing domestic and family violence), however poly-victimisation is a model which focuses on traumatisation in childhood in the broader sense, taking into account other forms of victimisation, including but not limited to, bullying, neighbourhood conflict and crime which might co-occur in childhood (Price-Robertson et al., 2013). Re-victimisation is also a broader model, exploring the same adversities as poly-victimisation, although from a 'whole of lifespan' perspective (Bryce, 2018). To acknowledge the multiplicity of trauma, the term complex trauma is used to conceptualise the complexity of traumatic outcomes for survivors of repeated traumas across the lifespan. Two diagnosable conditions are recognised as possible outcomes of trauma and complex trauma, acute stress disorder (ASD) and post traumatic stress disorder. It is important to acknowledge that all presentations of ASD and PTSD are caused by trauma or complex trauma, but not all trauma results in these diagnosable conditions. This highlights that these two terms speak to the heterogeneity of traumatic outcomes—multifinality and equifinality. In the case of multifinality, similar initial conditions may lead to dissimilar outcomes, depending on the mix of ecological risk and protective factors. Equifinality holds that multiple causal pathways can result in the same outcome, in this case maltreatment.

In the acute phases after a traumatic event, it is expected and typical for individuals to experience a wide and variable range of anxiety (e.g., hypervigilance), stress, and depressive (e.g., low mood) symptoms (American Psychiatric Association, 2022). This can initially manifest as an acute stress reaction or an adjustment disorder (as per the DSM-5-TR), which over time and after a longer duration of course may be better accounted for by a diagnosis of PTSD. Beyond the symptoms of PTSD, those with PTSD are 80% more likely to have another mental health condition, in comparison with those without PTSD (O'Donnell et al., 2004; Rytwinski et al., 2013).

The most common include mood and anxiety conditions, such as major depressive disorder, which has a co-morbidity with PTSD of 50% (Rytwinski et al., 2013). Further, among people within inpatient substance abuse treatment centres, it is estimated that approximately 50% meet criteria for PTSD (Souza & Spates, 2008). In an attempt to self-manage symptoms, individuals exposed to trauma may also develop substance-related conditions associated with hazardous/harmful use or substance dependence (van Dam et al., 2012). This indicates that a serious disorder such as PTSD can have a significant flow-on effect, which may adversely impact many aspects of a person's life.

TRAUMA SYMPTOMS AND DIAGNOSTIC CRITERIA IN ADULTHOOD

Diagnosis, whilst not typically in the scope of a counsellor's role, is critical knowledge which informs practice and assists the practitioner to engage with multidisciplinary professionals to holistically support the client. There are two main models of post-traumatic stress disorder (PTSD) in the mental health diagnostic sphere of understanding: the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5-TR) model (American Psychiatric Association, 2022) and the World Health Organization's International Classification of Diseases (ICD-11) model (WHO, 2022). Both models require an individual to have encountered a PTE, however, there are some differences in symptomology between these models. A comparison of the diagnostic criteria in each model is presented below in Table 1.

The DSM-5-TR diagnostic criteria of PTSD list 20 symptoms separated into four factors or symptom clusters (American Psychiatric Association, 2022). The first factor, 'intrusion' (Criterion B), focuses on five symptoms of intrusion (memories and flashbacks), including the distress the intrusive thoughts can cause. The second factor, 'avoidance' (Criterion C), represents two symptoms that relate to the active avoidance of reminders of the traumatic event, both internal (memories) and external (places, people, or situations). The third factor, 'negative alterations in cognitions and mood' (Criterion D), is comprised of seven symptoms that relate to poor mood and negative beliefs and feelings. The fourth factor, 'alterations in arousal and reactivity' (Criterion E), is comprised of six symptoms that relate to poor functioning (e.g., sleep issues, concentration problems, aggressive behaviour).

The ICD-11 model has six symptoms across three symptom clusters (WHO, 2022). The first factor, 're-experiencing', focuses on two symptoms that relate to re-experiencing the traumatic event (i.e., upsetting dreams and flashbacks). The second factor, like the DSM-5-TR model, is 'avoidance', and relates to two symptoms: avoidance of reminders of the traumatic event including internal (memories) and external (places, people, or situations) aspects. The third factor, 'sense of 'threat', is focused on feelings and perceptions of threats that are disproportionate to the actual stimuli (i.e., hypervigilance to threats and perceived threats). The ICD-11 has classified an additional model of PTSD—complex PTSD. This model of PTSD has the symptoms previously mentioned, and includes additional symptoms of disorganised self organisation across three symptom clusters. These clusters include affective dysregulation (i.e., emotional reactivity/numbing), negative self-concept (i.e., feelings of worthlessness/failure), and disturbances in relationships (i.e., feeling disconnected from others).

Table 1: PTSD symptom mappings for the DSM-5-TR, ICD-11, and ICD-11 (Complex PTSD) diagnostic criteria

DSM-5-TR symptoms	ICD-11 symptoms (PTSD)	ICD-11 symptoms (Complex PTSD)
A. Exposure to trauma	Exposure to Trauma	Exposure to Trauma
Intrusion	Re-experiencing	
B1. Distressing memories	1. Upsetting Dreams	
B2. Distressing dreams	2. Flashbacks	
B3. Flashbacks	Avoidance traumatic reminders	
B4. Psychological distress	3. Avoidance of internal reminders (memories)	3. Avoidance of internal reminders (memories)
B5. Physical reactivity	4. Avoidance of physical reminders	4. Avoidance of physical reminders
Avoidance	Sense of threat	
C1. Avoidance of internal reminders (distressing memories, thoughts, feelings)	5. Hypervigilance	5. Hypervigilance
C2. Avoidance of external reminders (people, places, conversations, activities, objects, situations)	6. Hyperarousal	6. Hyperarousal
Negative alterations in cognitions and mood		Affective dysregulation
D1. Inability to recall key features		7. Emotional Reactivity
D2. Exaggerated negative thoughts		8. Emotional Numbing
D3. Distorted cognitions leading to blame		Negative self-concept
D4. Negative emotional state		9. Failure
D5. Diminished interest in significant activities		10. Worthless
D6. Feelings of detachment or estrangement		Disturbances in relationships
D7. Inability to experience positive affect		11. Cut-off from people
Alterations in arousal and reactivity		12. Hard to stay close to people
E1. Irritability or angry outbursts		
E2. Risky or self-destructive behaviour		
E3. Hypervigilance		
E4. Exaggerated startle reaction		
E5. Problems with concentration		
E6. Sleep disturbance		

SCREENING AND ASSESSMENT TOOLS FOR ADULTS FOR TRAUMA INDICATORS AND COMORBID CONDITIONS

Counsellors can work within a vast range of government and community-based organisations and settings (e.g., child safety, substance use, domestic and family violence), where they may be required to administer standardised measures to determine eligibility for engagement with services, assess severity of symptoms, and measure changes in distress and coping over time. Such measures may also be required to meet the organisation's funding or clinical governance requirements or as part of the organisation's 'minimum data set' regarding clients and service engagement. Examples of brief screening and assessment tools are available within the public domain and can assist with screening for symptoms of trauma and PTSD include: Patient Check List-5: Civilian Version (PCL-5; Weathers et al., 2014) and the Impact of Events Scale-Revised (IES-R; Weiss & Marmar, 1997). Further, other psychometrically validated scales can be used by mental health practitioners to screen for frequently occurring co-morbidities post trauma, including for: alcohol and other substance use (e.g., Alcohol Use Disorders Identification Test (AUDIT); Drug Use Disorders Identification Test (DUDIT), Severity of Dependence Scale (SDS) and the Depression, Anxiety and Stress Scale-21 (DASS-21; Lovibond & Lovibond, 1995). Diagnostic clarification can be further provided by a qualified mental health professional, psychologist, doctor, or psychiatrist. Counsellors (as with all professionals/clinicians) must check whether or not measures

are freely available within the 'public domain' or require prior permission or purchase for use, and must confirm prior whether they meet the requirements for administration of measures based on training and qualifications.

INTERVENTIONS FOR TRAUMA WITH ADULTS: AN OVERVIEW

The following section will provide a brief overview for counsellors regarding commonly utilised evidence-based interventions for trauma, which are typically provided by psychologists, psychiatrists, and counsellors with specific training in trauma. It is not intended to provide a comprehensive treatment guide, but rather to provide readers with a working knowledge of approaches to interventions their clients may be exposed to. The following useful summary from Phoenix Australia (PA), a research centre in Melbourne, provides a useful summary of information they have developed in relation to the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder (2017).

The first-line evidence-based interventions for trauma are psychological in nature and includes:

- trauma-focussed cognitive behavioural therapy (TF-CBT)
- eye movement desensitization & reprocessing (EMDR)
- cognitive processing therapy (CPT)
- structured writing therapy (SWT).

These therapies include common elements:

1. narrative exposure (e.g., writing about the trauma and its symptoms) and/or gradual exposure to reminders of the trauma
2. unlearning the fearful responses to distressing reminders
3. changing how a person thinks about themselves, the future, or the world around them. This is particularly important for people who blame themselves or others for their trauma.
4. relaxation techniques, including breathing activities, to help manage the distress caused by memories or flashbacks
5. psychoeducation that helps to explain to a client how and why they are experiencing these symptoms. This helps them to take control of their own recovery.

The second-line or adjunct interventions include medication—selective serotonin reuptake inhibitors (SSRIs, i.e., antidepressants). These are normally only used to stabilise a person enough so that therapy can begin to be effective and are prescribed by a psychiatrist or other qualified physician.

TRAUMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY (TF-CBT)

TF-CBT is the gold-standard intervention for PTSD. Normal CBT focuses on challenging negative cognitions and emotions, and changing behaviours (de Arellano et al., 2014). In this case, TF-CBT is similar, but with a focus on the trauma-based thoughts, feeling and behaviours (de Arellano et al., 2014). Many individuals who have experienced trauma hold unhelpful beliefs about their trauma (e.g., they are responsible for their trauma), and this can result in destructive behaviours (e.g., anger or numbing). TF-CBT aims to reframe these negative self-beliefs, and identify behavioural coping mechanism and goals (de Arellano et al., 2014). From an evidence perspective, it has relatively strong post-intervention outcomes for PTSD. This is supported by, for example, 29 studies that compared TF-CBT to waitlist or control conditions and a further 38 studies that compared TF-CBT to 'treatment as usual' or another intervention (PA, 2019).

EYE MOVEMENT DESENSITIZATION AND REPROCESSING (EMDR)

EMDR is a therapy that focuses on using eye movements and other types of stimuli, like hand tapping, to unblock the mental processes associated with memory (Shapiro & Solomon, 2010). A client focuses on a traumatic memory, and the therapist evaluates the client's eye movements to see how the rapid eye movements are intensified by traumatic memories. These traumatic memories are often avoided by the client and remain unprocessed. Once a memory is found that is significantly distressing, the therapist will explore the memory in more detail and provide coping mechanisms (Shapiro & Solomon, 2010). Six studies compared EMDR to waitlist, and a further 9 studies compared EMDR to 'treatment as usual' or another intervention (PA, 2019), showing EMDR to be efficacious.

COGNITIVE PROCESSING THERAPY (CPT)

CPT is another type of therapy that assists a person to identify unhelpful thoughts & beliefs '('stuck 'points'), challenge them and replace with rational alternatives. CPT typically includes psychoeducation about trauma and mental health and will focus on allowing the client to reframe the traumatic event (PA, 2019). The reframing process begins with the client writing a narrative about the trauma, and then the therapist assists in challenge unhelpful beliefs, like self-blame (Resick et al., 2016). This type of therapy can also include artificially creating exposure to distressing circumstances. CPT is a relatively young therapy, but it has been shown to be highly effective in Australian veterans (Resick et al., 2016).

STRUCTURED WRITING THERAPY (SWT)

SWT utilises the act of writing about a client's memories of trauma, as well as the thoughts and feelings that the trauma invokes, to process the trauma itself (Schoutrop et al., 2002; Smyth & Pennebaker, 1999). By writing about a traumatic event, the client is processing the negative feelings associated with the trauma, and these negative feelings will begin to ease. It has been found that SWT can be beneficial for both the mental and physical health of a client (Schoutrop et al., 2002; Smyth & Pennebaker, 1999). This therapy can be delivered in online, distance, or in-person, making it an effective form of therapy for clients who wish to remain anonymous or live some distance from a mental health clinic.

SOCIAL AND FAMILIAL SUPPORTS

One of the major things that can help a person recover more effectively and completely is support from friends and family. A person cannot undertake the PTSD recovery process solo—both professional and personal support are typically needed. It is often families/partners/children that witness the full spectrum of symptoms before the recovery process, so encouraging family to be involved in the recovery process and their own self care is vital. Social support is crucial for persons with PTSD, as it reduces the feelings of isolation, and increases life satisfaction (Taylor, 2011). Additionally, education and support from both professionals and the community are very helpful. Education for understanding PTSD, how to take care of themselves, and how to get both practical and emotional support for the whole family can often make a huge difference for effectiveness of interventions (PA, 2019). Psychoeducation also provides family members with greater understanding and compassion for the person experiencing PTSD. Additionally, incorporating aspects of the recovery model into therapeutic interventions can promote healing by supporting the individuals to regain a sense of meaning, support, and normalisation (e.g., Sarkadi et al., 2018), as well as supporting them through processing associated grief and existential issues. Sufficient investment in building rapport and therapeutic alliance is also vital in relation to creating a sense of safety for your client and are relevant to outcomes of intervention.

RISK FACTORS FOR TRAUMA AMONG ADULTS

There is strong evidence to suggest that a person's genetics play a role in the development of PTSD, with approximately 30% of the variance within PTSD diagnosis being accounted for by genetic factors (Skelton et al., 2012; True et al., 1993). Studies into twins exposed to combat in the Vietnam War found that monozygotic twins (identical twins) were more likely to both have developed PTSD than dizygotic twins (non-identical twins) (Skelton et al., 2012; True et al., 1993). It has been found that genetic predisposition to other mental health concerns, such as anxiety or panic disorders, can also predict genetic predisposition to developing PTSD (Skelton et al., 2012). Further, we know that environmental stress can permanently influence genes that can contribute to trauma-related vulnerabilities and resilience via epigenetic factors. This supports the notion of the interaction between environment and biology via the diathesis-stress model—that biology can influence environment, and conversely, environment can also influence biology.

Protective factors for trauma among adults

There are several factors that can be protective for developing PTSD following exposure to a PTE:

- resilience: people who have high levels of psychological resilience report lower levels of PTSD symptomology following a PTE
- social support: high levels of support from friends/family is a strong protective factor against developing PTSD/symptomology
- disclosure following trauma: individuals who 'open up' about their traumatic event are less likely to develop PTSD
- self-efficacy: the belief in one's abilities to take control of their engagement with therapeutic intervention and recovery
- health coping mechanisms: people who have healthier ways of coping with mental health concerns (e.g., seeking help) and who avoid unhelpful coping mechanisms (e.g., excessive alcohol/drug use) have a greater chance of not developing PTSD or recovering once being diagnosed
- general healthy lifestyle choices: exercise and a good diet are further protective measures against PTSD (Carlson et al., 2016; Weisaeth, 1998).

Individuals' who possess strong self-belief or resilience are less likely to develop PTSD, or experience lower levels of distress following a PTE (Bonanno & Mancini, 2012). This is likely related to the adaptability associated with resilience. Additionally, individuals with strong and diverse social support networks are more buffered from the negative effects of PTEs than individuals with lower levels of social support, following self-disclosure of thoughts and feelings around the event to trusted friends and family (Campbell & Renshaw, 2013; Tsai et al., 2012). The support provided by an individual's social network, as well as the feeling of being heard with regards to the PTE can be a buffer between the stress of the event and mental health. Individuals' who experience high levels of self-efficacy and translate this self-efficacy into healthy coping and help-seeking behaviours are also less likely to develop PTSD following a PTE (Adams et al., 2020; Greenberg et al., 2009). This is due to the belief that one can overcome a traumatic event, as well as the belief that one can get help and succeed in maintaining healthy functioning and behaviours. It is also worth noting that exercise and healthy diet has also been shown to buffer and individual from the stress of PTEs and the effects this can have on health (Adams et al., 2020). As trauma can have a negative effect on physical health, it is important that individuals who experience trauma maintain a healthy lifestyle (Ryder et al., 2018).

SUMMARY

There are a wide range of trauma experiences that can result in subsequent significant and varied symptomatology associated with distress and/or impaired functioning for an individual. Comorbidities may also be common, including hazardous and harmful substance use. The symptomatology, course, prognosis,

and process of recovery can vary considerably from person to person; and is influenced by a wide range of biopsychosocial factors. The role of the mental health professional can help to provide psychosocial support, psychoeducation, and counselling to assist the individual to more effectively cope with their traumatic experiences and develop adaptive coping strategies.

POST-TRAUMATIC GROWTH AND RESILIENCY

While the development of PTSD significantly impacts a person's life in many negative ways, a number of people who encounter trauma can experience positive psychological changes. These changes, known as posttraumatic growth (PTG), come from the successful processing and navigation of adverse life events (see Calhoun & Tedeschi, 2013). This PTG has been supported by recent epigenetic studies (Mehta et al., 2020). Following a traumatic event, a person can experience intrusive thoughts and feelings about the event, which can be distressing. However, it has been found that deliberately ruminating on the traumatic event, and seeking to understand and process the feelings around the event, can lead to PTG (Henson et al., 2021). If an individual reframes their personal narrative to see the PTE as a potential catalyst for positive changes in their life, this can result in improved mental and physical health outcomes. This can lead to greater resilience when encountering future stressful or difficult life events. PTG can also result in positive spiritual or personal growth, improved relationships with loved ones, improved life directions, stronger self-belief, and a greater appreciation for life (see Brown, 2017). Other factors that have been associated with greater PTG among those who have experienced a traumatic event include sharing negative emotions, positive coping strategies (e.g., positive reappraisal), and personality traits (e.g., agreeableness) (Henson et al., 2021).

CONSIDERATIONS FOR COUNSELLORS WHEN WORKING WITH TRAUMA-AFFECTED INDIVIDUALS

Given the prevalence of counsellors entering the helping profession with a personal history of trauma, as well as the nature of the work itself, it is critical for counselling practitioners to maintain their own well-being when working with people affected by trauma. Vicarious trauma is defined as the permanent transformation in the inner experience of the clinician that comes about as a result of empathic engagement with clients' trauma material (Didham et al., 2011) and secondary traumatisation refers to the experience of trauma-related symptoms from learning others' stories (Davidson 2017).

Chenoweth and McAuliffe (2015) identify that it is often those who do this work well who are the most vulnerable to what is known as secondary traumatic stress, vicarious trauma, or compassion fatigue. Counsellors are exposed to traumatic stories and want to assist their clients. This exposure and desire to assist lead to a specific form of stress that creates compassion fatigue (Figley, 1995). Given the nature of the work of counsellors, with the risk of vicarious trauma or secondary traumatic stress high, the need for proactive self-care is imperative.

Self-care is a strategy that has been found to reduce vicarious trauma and burnout while promoting compassion satisfaction (Radey & Figley, 2007; Ruysschaert, 2009). Self-care is often difficult for counsellors to prioritise but it is vital to mitigating the risk of vicarious trauma, and thereby sustaining the capacity to continue helping. It is necessary that when counsellors are suffering and may sense they need to take action; seek counselling, support, or therapeutic intervention.

A counsellor's motivation to enter the helping professions to heal their own wounds, may diminish their capacity for effectiveness with clients (Ford, 1963). Briere (1992) hypothesised that issues related to child abuse, including counter transference, may adversely affect the competency of helping professionals. Some researchers have argued that experiencing an accumulation of childhood maltreatments, especially emotional abuse and neglect, can increase the risk of helping professionals experiencing secondary traumatic stress (Figley, 1995; Nelson-Gardell & Harris, 2003). This is also reflected in literature which asserts poor mental

health contributes significantly to a lack of career success, including acquiring and maintaining employment (McIlveen, 2014; Olesen et al., 2013).

Whilst a counsellor's own experience of adverse experiences in childhood may increase the risk of bias or counter transference and impair or diminish objectivity, a personal history of trauma can also provide strengths that may support an individual's professional capacity (Calhoun & Tedeschi, 2006). This reflects post traumatic growth and trauma-sensitive resiliency. If counsellors are resilient and remain positively connected to their work there is potential for growth, also known as compassion satisfaction (Figley, 1995; Ruysschaert, 2009).

Clinical supervision is an important strategy for mitigating the impact of working with clients who have experienced trauma. Supervision forms a central tenet of ethical and effective professional practice, invaluable in assisting helping professionals to acquire the knowledge and skills necessary to achieve a high standard of professional performance (Joubert et al., 2013; Kadushin & Harkness, 2002; Shulman, 2010). Supervision offers practitioners the opportunity to debrief and challenge assumptions and biases, explore alternative perspectives, and make informed decisions (Joubert et al., 2013).

Legal issues may emerge during engagement with intervention related to the client's experiences of trauma. A client, for instance, could seek to prosecute a perpetrator of trauma (e.g., for domestic violence) or to sue for damages sustained in an accident or natural disaster. The counsellor's role is not to provide legal advice, but to offer support during the process and, if needed, refer the client to appropriate legal help. Legal matters may permeate the counselling experience and a client's progress may be intimately associated with the trajectory and resolution of a legal matter. The impact of the legal context is an important consideration in working with trauma survivors.

Given the relational origins and complications of trauma one of the most important considerations in working with trauma-affected individuals is the therapeutic alliance and the building of rapport. Successful intervention with traumatised individuals is significantly influenced by a strong therapeutic relationship (Eltz et al., 1995; Kearney et al., 2010; Lawson, 2009). The therapeutic alliance, commonly defined as agreement on goals, task collaboration, and an emotional bond (Bordin, 1979), has been shown to be linked with outcome in individual child, adolescent, and adult therapy (Horvath et al., 2011; Ormhaug et al., 2014; Shirk et al., 2011). It is recommended the counsellors develop and hone their skills in rapport and the therapeutic relationship to maximise engagement and outcomes of intervention.

Given the nature of the counselling role, the prevalence of trauma-affected individuals entering the helping professions, and the emotional toll counselling can take on the practitioner, important considerations must be acknowledged to ensure a safe and effective therapeutic experience for client and counsellor. To prevent burnout, secondary trauma or retraumatisation, self-care, supervision and self-awareness form imperative considerations for counsellors and support the development of a safe and positive therapeutic relationship.

CONCLUSION

In summary, there are a range of experiences that can result in post-traumatic stress reactions for individuals. However, the likelihood of developing clinically significant trauma responses varies significantly from person to person, and may manifest somewhat differently for affected individuals—with DSM-5-TR and ICD-11 providing a useful framework for substantiating diagnostic threshold. This chapter has presented a range of evidence-based interventions, along with risk and protective factors. Further it is well documented that post-traumatic growth can occur concurrently with trauma responses. Finally, it is important to maintain optimal self-care and supervision to promote well-being and longevity in the profession when counselling those who have experienced traumas.

LEARNING ACTIVITIES

Learning Activity 1

Please take 5 to 10 minutes to sit in a quiet space and reflect on your memories and experiences regarding 9/11 in the USA or a similar event. What do you recall about this event? Where were you at the time that you heard about this event? What images did you see on TV? What sorts of psychological impacts did these events have on those who were directly involved and the broader community (including internationally)? What were your thoughts/feelings/reactions at the time? What are your own thoughts/feelings/reactions now?

Learning Activity 2

Consider the following case study:

Your client, James, has sought therapy for issues with alcohol abuse over the last 12 months. After a number of sessions, James discloses to you that he was the victim of a violent robbery 5 years ago. He describes being unable to watch television that portrays criminal acts, has memories surface from that event at seemingly random times, and has mood issues that he needs to numb.

Is it possible that James' issues with alcohol are related to this trauma? Clients will often take time to build a therapeutic relationship before disclosing trauma.

Reflect on how clients can present with an immediate issue, like alcohol abuse, but may have trauma in their past that could be related.

Learning Activity 3

Please watch the following recording regarding nature and impacts of trauma among first responders [11:47]:

One or more interactive elements has been excluded from this version of the text. You can view them online here:
https://usq.pressbooks.pub/counselling/?p=71#oembed-1

Reflect on the following questions:

- What are some reported challenges of working as a first responder?
- How do individuals attempt to cope who work in this field?
- What are some of the unique stressors associated with these roles?
- How can the nature of this work impact upon vicarious trauma, cumulative trauma, and susceptibility to poorer/better coping with trauma?

Learning Activity 4

Please read this article on growth after trauma:

- How does your personal values, beliefs and experiences influence your thoughts and feelings about posttraumatic growth?
- Do you believe that negative, traumatic experiences can be beneficial to a person?
- When does posttraumatic stress move into growth?
- Can the two happen at the same time?

Learning Activity 5

Please watch the following recording regarding self-care for counsellors and mental health professionals [5:51]:

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://usq.pressbooks.pub/counselling/?p=71#oembed-2

- What are some ways in which you can nurture your own wellbeing on a regular basis, now and throughout your work and career in mental health?
- What are the elements of your daily, weekly, and monthly 'self-care' plan?

RECOMMENDED RESOURCES

- Psychological first aid
- Mental health resources: COVID-19
- Negative experiences with the justice system post-sexual assault
- The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder

ADDITIONAL SUGGESTED READINGS

Calhoun, L. G., & Tedeschi, R. G. (Eds.). (2006). *Handbook of posttraumatic growth: Research & practice.* Lawrence Erlbaum Associates Publishers.

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GLOSSARY OF TERMS

CPT—cognitive processing therapy (for veterans), a recent therapy found to be effect in veterans

DSM-5-TR—the American Psychiatric Association's Diagnostic and statistical manual of mental disorders: Text revised version (DSM-5-TR)

EMDR—eye movement desensitization and reprocessing, a front-line therapy for PTSD

ESP—emergency service professionals (e.g., police, fire fighters, paramedics)

High risk professions—employment in which encountering potentially traumatic events are to be expected as a part of the job

ICD-11—the World Health Organisation's international classification of diseases (ICD-11)

PTEs—potentially traumatic event, an event in which the individual feels that they or someone else is at risk (e.g., assault or car accident)

PTG—posttraumatic growth, or positive psychological changes that can come from processing traumatic events

PTSD—posttraumatic stress disorder

SSRI—selective serotonin reuptake inhibitors (i.e., antidepressants)

TF-CBT—trauma-focussed cognitive behavioural therapy, the gold standard of PTSD interventions

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Trauma in Children and Adolescence

GOVIND KRISHNAMOORTHY AND AMY B. MULLENS

ABSTRACT

Children and adolescents with trauma-related presentations represent an important priority group for counsellors. Effective engagement and helpful interventions during this critical developmental phase have the potential to result in better coping trajectories throughout the life course. This chapter will provide an overview of trauma indicators in youth populations as well as associated changes young clients may experience as a result of trauma. This chapter is not intended to provide an exhaustive summary or all areas of youth trauma nor intended to be a compendium for use of interventions within these populations.

Learning Objectives

- Describe trauma symptoms in childhood and adolescence.
- Describe changes in emotions, behaviours, and thoughts.
- Describe changes in attachment and relationships.

INTRODUCTION

Research has shown that the psychological impact of traumatic events can be different for children and adolescents, compared to adults exposed to such events (Lanktree & Briere, 2015). Some examples of traumatic experiences in childhood include, but are not limited to: physical, emotional, or sexual abuse or neglect; witnessing or being the direct victim of domestic, community, or school violence; severe motor vehicle and/or other accidents; natural and human-made disasters; violent or accidental death of a parent, sibling, or other important attachment figure; exposure to war, terrorism, or refugee conditions; and multiple traumatic events. It is important to first acknowledge that it is normal for children and adolescents to experience emotional distress and other reactions following traumatic events. Some emotional reactions have been found to be adaptive, and many children and adolescents find a way to cope and recover fairly quickly, but not all do. Some will present with symptoms that are consistent with a diagnosis—one of which may be PTSD. A meta-analysis on the incidence of PTSD based on 43 independent samples of trauma-exposed children and adolescents that were assessed with diagnostic interviews revealed an overall prevalence of 15% (Alisic et al., 2014).

TRAUMA SYMPTOMS IN CHILDHOOD AND ADOLESCENCE

Several factors, including developmental level, inherent or learned resiliency, and sources of social support, may influence which children or adolescents develop difficulties. Research has shown that the level of exposure (i.e., proximity to the event, level of involvement) to a traumatic event, combined with a perception of a threat to life (or threat to the life of a loved one), are most consistently associated with problems related to PTSD (Pine & Cohen, 2002). Children and adolescents have unique ways of understanding traumatic events: they can differ in how they make meaning of such events in relation to themselves, how they access familial and other forms of support, and how they integrate these events into their identity and sense of self (Van Horn & Lieberman, 2009). Early intervention appears crucial for children and adolescents experiencing PTSD symptoms, to mitigate the risks for mental health concerns into the future. For example, a 33-year follow-up of the children who survived the Aberfan landslide disaster found that 29% of those traced and interviewed still met criteria for PTSD (Morgan et al., 2003). In other words, in the absence of effective therapy, the long-term effects of traumatic events in childhood can be adverse.

Children and adolescents are often brought to counselling because of behavioural or emotional dysregulation rather than because of their exposure to traumatic events. Since parents, caregivers, and other adults may not understand that these problems are related to these traumatic experiences, it is critical to recognise, identify, and make connections between trauma reminders and the child or adolescent's presenting concerns. Doing so helps the family better understand the problems as trauma responses, allowing them to embrace the need for interventions that are informed by the impact of these traumatic experiences. The remainder of this section will summarise some key developmental considerations across various domains, when identifying and understanding trauma in children and adolescents.

CHANGES IN EMOTIONS AND AFFECT

Fear is both an instinctual and learned reaction to frightening situations. Children and adolescents instinctively experience fear in situations that they perceive as being life-threatening situations. It is important here to recognise that a child's or adolescent's perceptions of such situations may be different to those of the caregivers and adults—who may otherwise view such situations as relatively benign. For example, a child who was in a serious car accident may become very frightened whenever they ride past the location of the accident. This fear response can then become generalised so that people, places, or objects that are objectively innocuous but remind the child of the traumatic event will cause the same level of fear as the original trauma (Scheeringa et al., 2003). For instance, the child exposed to the car accident in the aforementioned example, might experience intense fear when riding in a car—irrespective of where the car was being driven to.

In addition to specific fears, more diffuse anxiety may develop due to the sudden, unpredictable nature of the traumatic experiences. This anxious state may leave children and adolescents feeling generally unsafe and hypervigilant, on guard to protect themselves from being taken by surprise the next time. This sense of impending danger can impinge on a child's ability to engage in developmentally appropriate tasks (Perry & Szalavitz, 2017). Such feelings of insecurity can lead to a range of maladaptive behaviours, including disengaging from school, disengaging from appropriate peers, or even becoming proactively aggressive in the belief that this is the only way to survive and not once again be the victim in traumatic circumstances. In this way, constant vigilance for possible omens of future threats and other anxiety-driven behaviours begins to interfere with healthy adjustment and development (Hambrick et al., 2019).

Children and adolescents may develop sad or depressive feelings along with PTSD symptoms. Specifically, traumatic grief after a death or traumatic separation that might occur suddenly, perhaps due to parental incarceration or placement in foster care (Cohen et al., 2016). Natural disasters may result in children r adolescent's loss of personal belongings, their homes, or even the lives of loved ones. In the face of these real losses, children and adolescents often develop maladaptive beliefs or cognitions (described later in this section), which significantly contribute to depressive and other negative emotional states. Children's

developmentally appropriate egocentric view of the world may lead to self-blame for the traumatic event, which in turn may lead to depressive symptoms that include guilt, shame, diminished self-esteem, feelings of worthlessness, and even a longing to die (Cohen et al., 2016). Grief reactions can manifest themselves in the form of persistent thoughts of suicide and may represent an adolescent's attempts at reuniting with a deceased parent or attachment figure.

Anger may result from the awareness that the traumatic event was unfair in the sense that the child or adolescent did not do anything to 'deserve' the trauma. Other children and adolescents, particularly those experiencing physical abuse or bullying, may develop anger as they observe the behaviour of caretakers or others who cope inappropriately with difficulties or frustrations (Becker-Weidman, 2006). Anger in traumatised children and adolescents may take the form of noncompliant behaviour, unpredictable rages or tantrums, or physical aggression toward property or other people. While it is important to clarify myths about all children and adolescents exposed to traumatic events becoming sexual predators or criminals. Careful assessment is required to clarify concerns about bullying, sexual aggression, and other possible coercive forms of antisocial behaviour (Yoder et al., 2019).

Chronically traumatised children and adolescents may become highly sensitive and over-reactive to perceived rejection because parental or other rejection in their past experience was associated with, and served as an early warning signal for, abusive or other traumatic acts. For example, one study indicated that children who have been physically abused perceive angry faces (a trauma reminder for such children) more readily than non-physically abused children (Pine et al., 2005). These children often display emotional dysregulation—sudden changes in mood or affect accompanied by difficulties in modulating their emotions and regaining calm (Teicher et al., 2019). Severe emotional dysregulation occurs more commonly in children and adolescents who are impacted by the cumulative harm of multiple traumatic experiences (e.g., child abuse or domestic violence), than in children who have experienced a single, nonintentional traumatic event. These children and adolescents often lack a nurturing, supportive, and well-modulated coping response from parents and caregivers after traumatic events. Such supportive responses model to children and adolescents the skills required in managing emotions, while demonstrating to them the value of seeking support from a safe and benevolent adult (Hughes et al., 2019).

Children and adolescents who live in a household where they are exposed to domestic violence are at higher risk of being exposed to interactions with adults where their feelings are invalidated and disregarded. In fact, some children and adolescents are even punished by their caregivers for displaying feelings of fear, sadness, or anger. Thus, while traumatised children and adolescents may certainly benefit from learning skills to modulate their emotions, the cumulative harm of multiple past or current experiences of threat and maltreatment may interfere with a child's capacity to use and benefit from counselling. Children and adolescents who are currently experiencing interpersonal trauma of this nature should be considered at risk and steps should be taken to ascertain whether a mandatory report is required to protect the child or adolescent from further victimisation[1]. Helping a child or adolescent regulate their emotions by developing a sense of safety in the counselling environment may be the first task of counselling. While this may take longer for some children and adolescents who have experienced trauma compared to others, a child or adolescent's ability to see counselling as a safe and supportive process is often a therapeutic intervention in itself and may be aided through use of creative approaches such as art or puppets (Desmond et al., 2015).

CHANGES IN BEHAVIOUR

In order to escape overwhelming negative feelings, children and adolescents may try to avoid thoughts,

1. Mandatory reporting of child maltreatment is a requirement of the Codes of Ethics of the accreditation bodies of counselling in Australia—Psychotherapy and Counselling Federation of Australia (PACFA) (see Code of Ethics, Section 4: Ethical Standards of Clinical Practice) and Australian Counselling Association (see Code of Ethics, Section: Exceptional Circumstances). In Queensland, Commencing July 5th, 2021, a new section, 229BC was inserted into the 'Queensland Criminal Code Act 1899' making it a crime, punishable by up to 3 years imprisonment, for all adults who, without reasonable excuse, fail to report child sexual abuse to police.

people, places, or situations that trigger recollection of their traumatic experiences. Unfortunately, such avoidance is seen to be linked to the generalisation of triggers—where previously benign and safe situations begin to be associated with previous traumatic experiences, based on their resemblance to these circumstances (Cohen et al., 2016). It is difficult, if not impossible, for children and adolescents to avoid all trauma reminders. For a child or adolescent who has witnessed ongoing domestic violence, both parents may be trauma reminders. For a child or adolescent experiencing pervasive, ongoing community violence, their whole neighbourhood may become a trauma trigger. Among children and adolescents who are easily triggered and experience pervasive reminders of past traumas, avoidance is not a viable nor effective long-term management strategy. When avoidance is unsuccessful in protecting children and adolescents from overwhelming negative emotions, they may develop emotional numbing, or in more severe cases, dissociation. Trauma-related behaviours may also develop in response to modelling or traumatic bonding (Bancroft & Silverman, 2002). Modelling occurs when children who grow up in abusive or violent homes and communities have many opportunities to observe and learn maladaptive behaviours and coping strategies. They may also see those behaviours being repeatedly rewarded—in the form of the perpetrator continuing to be in a position of power (Foa et al., 2008).

Aggression and persistent anti-social behaviour have been linked to a phenomenon referred to as traumatic bonding. Traumatic bonding involves both modelling of inappropriate behaviours and maladaptive attachment dynamics (Dutton & Painter, 1993). It also involves the acceptance of inaccurate explanations for inappropriate behaviours. In such situations, children and adolescents both fear and love the abusive parent. Such children and adolescents may bond with the violent parent out of self-preservation. To manage the guilt and cognitive dissonance associated with turning against the victimised parent, these children and adolescents may adopt the violent parent's views, attitudes, and behaviours toward the victimised parent and become abusive or violent themselves (Bancroft & Silverman, 2002).

Other trauma-related behaviours may emerge in children and adolescents including the avoidance of healthy age-appropriate peer interactions, with these children and adolescents preferring to associate with children and adolescents who share similar emotional and behavioural difficulties. Their choice of friends likely relates to the negative self-image that many traumatised children and adolescents develop. These children and adolescents have been found to fear rejection by "normal" peers and find that associating with children and adolescents experiencing similar situations, such as those with ongoing maltreatment, feels more familiar or comfortable. The anger that many traumatised children and adolescents develop is typically manifested through oppositional, aggressive, and/or destructive behaviours (Koffman et al., 2009). Children and adolescents who have experienced trauma are also at greater risk for substance abuse (Barrett et al., 2019), which may be used as a strategy for avoiding trauma reminders, a way of coping with negative self-image, or may arise as a result of associating with other children and adolescents engaging in antisocial behaviour.

Other trauma-related risk-taking behaviours may include: engaging in high-risk sexual behaviours; driving under the influence of drugs or alcohol; using guns, knives, or other weapons without considering the consequences (Thompson et al., 2017). Risk-taking behaviours place the youth in circumstances in which there is a high likelihood of experiencing and/or causing serious injury or death. The serious risks of some youth behaviours warrant starting with interventions that reduce the risk of them engaging in these behaviours and enhancing their safety. Self-injury, such as cutting or burning, as well as suicidal behaviours, are also associated with childhood trauma. Adolescents who engage in self-injury describe these as methods for reversing the numbness that they feel. Others may be seeking connection and a sense of belonging that they feel unable to gain in more adaptive ways. Some youth describe cutting behaviour as a means of managing anxiety (Thompson et al., 2017).

Sometimes children and adolescents are entrusted with the caretaking tasks for younger children and/or for an impaired parent. Over time, the family often comes to expect one child or adolescent to take on caretaking tasks and they come to believe that this is their indispensable family role, both of which contribute to maintaining the child or adolescent's over-functioning (Tedgard et al., 2019). Also referred to as parentification, such over-functioning persists even if the child or adolescent is removed from the family home and placed

in alternate or foster care (Tedgard et al., 2019). Helping such children and adolescents learn appropriate developmental functioning (i.e., to 'just be a child') is often an important goal in counselling.

CHANGES IN THINKING AND BELIEFS

The intrusion of fearful thoughts and memories is characteristic of PTSD in children and adolescents —manifesting itself in the form of intrusive, frightening thoughts during the day or scary dreams at night. In younger children, the content of these frightening dreams may not be related to the traumatic event in an obvious way, but may instead depict other frightening things and the development of new fears, with no apparent relationship to the trauma other than temporal proximity (Scheeringa et al., 2003). Following a traumatic event, children and adolescents typically search for an explanation for why something so terrible has happened to them or their loved ones. If no rational explanation is found, children may develop inaccurate or irrational beliefs about causation in order to gain some sense of control or predictability.

A common irrational belief involves children and adolescents blaming themselves, either by taking responsibility for the event itself (e.g., I was sexually abused because I wore a provocative dress) or for not foreseeing and avoiding the event (e.g., I should have known the flood was coming —why didn't I warn mum and dad that the water was coming?). Alternatively, although not blaming themselves directly for the traumatic event, children and adolescents may come to believe that they are bad, shameful, or otherwise lacking in some way that justifies bad things happening to them (e.g., I must be stupid for this to have happened to me) (Cohen et al., 2016). In this manner the world remains fair, predictable, and makes sense; it is only they who are deserving of bad fortune. Developing realistic cognitions of responsibility (i.e., blaming the perpetrator) is often more difficult and painful for children and adolescents than blaming themselves.

Children and adolescents may generalise their experience of betrayal by one person to mean that no one is trustworthy. This belief can lead to difficulties in peer relationships or in the child or adolescent's attachment to the non-offending parent and other adults, which may further contribute to the child or adolescent's impaired self-image (i.e., the child undermines these relationships, then attributes the disappointment to their own personal failings). Children and adolescents may respond to a betrayal of trust by repeatedly trying to correct their experience by seeking out inappropriately close relationships with peers or adults who may or may not be safe. Underlying these behaviours are often long-standing beliefs about what it means to be involved in a loving relationship (e.g., It's normal to have some violence in every relationship) (Cohen et al., 2016). Adjusting these beliefs is a critical component for successfully treating these youth (Cohen et al., 2016).

Unhelpful thoughts can also contribute to negative affective states and behaviours because they are not contextualised to accurately reflect reality, or they focus only on the negative aspects of situations. For example, the cognition 'anybody could sexually abuse you' might be true in a given environment, but equally true is the alternative cognition, 'most men do not sexually abuse children'. It is clear that the first thought is likely to promote fear and avoidance, whereas the second, equally accurate thought is more reassuring and hopeful (Cohen et al., 2016). Traumatised children and adolescents often experience inaccurate and/or unhelpful cognitions that reinforce their negative expectations of others and their destructive self-views.

CHANGES IN ATTACHMENT AND RELATIONSHIPS

As with all aspects of early childhood development, it is important to understand the impact of such traumatic events in the context of their significant relationships, namely the parent-child relationship (Hughes et al., 2019). For example, a post-natural disaster home environment may mean that some parents and other caregivers are unable to provide basic needs such as food, clothing, or shelter. For families severely affected by natural disasters, disorganisation and unstable living arrangements are common. For children, this may mean moving to a new home, a new school, and a general lack of familiarity with their new surroundings. Coping with such changes and transitions can be difficult, and sometimes distressing, for young children (Cobham et al., 2016).

Parents who perpetrate ongoing interpersonal traumas (e.g., child abuse or neglect; domestic violence) also disrupt the primary child–parent attachment relationship upon which children learn and model future trusting interpersonal relationships (Hughes et al., 2019). The result of such disruption is typically profound: these children experience ongoing challenges when attempting to establish new relationships since the possibility of any trusting relationship itself serves as a trauma reminder of the caretakers who perpetrated the initial maltreatment.

Children and adolescents who experience trauma may withdraw from peers or have difficulty enjoying social activities. Children and adolescents who feel shame or stigma related to their trauma experiences may not share these even with very close friends, leading to a change in the tenor of such friendships at times when children and adolescents are in even greater need of close friends (Perry et al., 2018). As noted above, after trauma experiences, some youth feel that their usual peers will not understand their experiences, and they begin to affiliate with deviant peers based on the assumption that only these youth can relate to their feelings of being different and 'on the outside'. Such affiliation can place the youth at heightened risk for additional trauma exposure and the development of more severe trauma responses.

CONCLUSION

In summary, although some children and adolescents who experience traumatic events are able to cope and recover, many others develop symptoms related to trauma. These symptoms can have a profound and long-lasting negative impact on their development, health, and safety. The impact of traumatic event/s may manifest uniquely in children and adolescents and can be observed across multiple domains of functioning—emotions, relationships, cognition, and behaviour. While early referral and intervention are crucial (such as seeking additional support, helping to establish/maintain a regular routine, and allowing the child or adolescent to share their concerns), it is important for counsellors to be informed of how such traumatic experiences may impact on the child or adolescent's presenting concerns and how trauma can influence the child, adolescent, and their family. The establishment of a safe, calm, and predictable counselling environment, and therapeutic relationships, are the foundations of supporting a child or adolescent's recovery from trauma. It is recommended that counsellors seek additional training and supervision in relation to providing more detailed therapeutic interventions for this population.

LEARNING ACTIVITIES

Learning Activity 1

Please read the following journal article on a case study of the application of trauma-focused cognitive behaviour therapy with a six-year-old boy:

- Jørgensen, I. M., Cantio, C., & Elklit, A. (2019). Trauma-focused cognitive behavioral therapy with a 6 year-old boy. *Clinical Case Studies*, 18(6), 480-495.

Questions:

- How do your personal values and beliefs influence your reactions to the case material?
- How do trauma symptoms manifest in Casper's difficulties?
- How might the 'complicating factors' and 'access and barriers to care' be overcome for children like Casper?

Learning Activity 2

What are your thoughts about how the intervention for Casper in Learning Activity 1 is similar or different to supporting an adult with concerns relating to post-traumatic stress?

Do you think you would feel more comfortable providing counselling with children/adolescents or adults? Why?

What could assist you to develop more experience or self-efficacy in providing support or counselling to those at different developmental stages?

RECOMMENDED READINGS

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GLOSSARY OF TERMS

parentification—when a child or adolescent is regularly expected to provide emotional or practical support for a parent or caregiver

traumatic bonding—involves both modelling of inappropriate behaviours, maladaptive attachment dynamics, and acceptance of inaccurate explanations for inappropriate behaviours

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