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CAJ

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Definitions of counselling: your thoughts

Eating disorders: workforce capacity building

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See page 54 for peer-reviewed article submission guidelines.

Editorial

Finding an escape network from self-doubt

Philip Armstrong
Editor

When I look back to my first counselling job, which was with the RSL, I realise just how far counselling and psychotherapy has advanced as a profession.

While I was a veteran and could connect with my clients, I was not prepared for my own feelings of isolation, the questions I had of my own skills, or to debrief appropriately from a day's work – like many counsellors.

I was managing in Logan, Queensland – a low socioeconomic area – with veteran clients who were often suffering multifaceted and chronic health issues, and clients with generational trauma, as well as dealing with language barriers.

Counsellors and mental health practitioners have a huge responsibility; good or poor mental healthcare impacts not just the individual but also their families, friends, workplace and community.

I was acutely aware of this, and I questioned everything. I also knew I needed to take the necessary personal accountability to be in touch with my own feelings – whether they be feelings of loneliness or that my skills weren't good enough.

Other compounding factors that most people in this role would be familiar with include, for example, limited access to your supervisor because of time or financial constraints, or trying hard not to take your professional burdens home to your own family environment.

It was many months into that first job before I realised I needed to develop networks. I started walking the pavement, finding local healthcare works and starting a networking group – a 'chapter' of sorts. I met other counsellors, which was a huge help and something I wish I had known the importance of before I started the job.

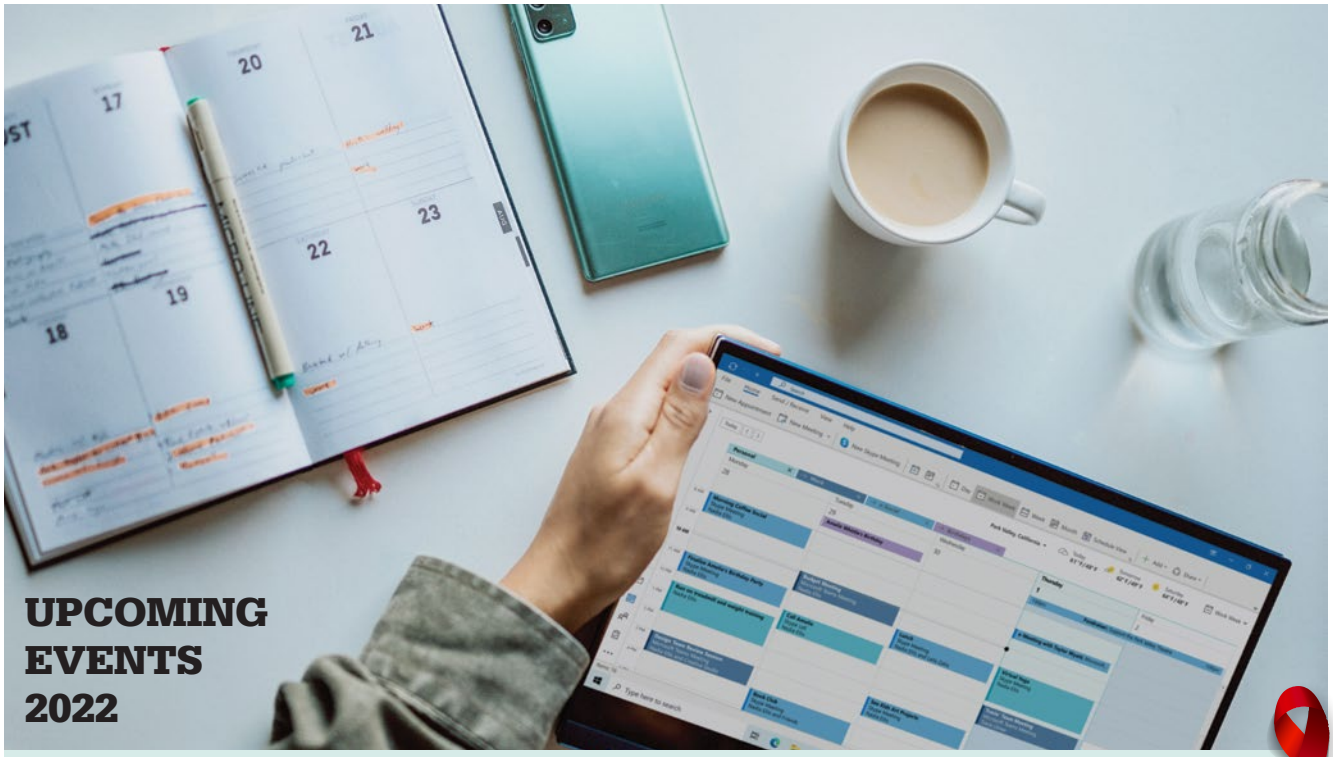
Counsellors and mental health practitioners have a huge responsibility; good or poor mental healthcare impacts not just the individual but also their families, friends, workplace and community.

The reality is you can't be everything all at once, especially in the early days of your career. Most counsellors work in isolation in private practice, and that is why learning from others and developing a strong network of peers becomes so crucial.

It's an important role played by this journal and why, in this Spring edition, we have invited members to share their tales of what they wish they knew when they were starting out. I hope you find some learning or inspiration in these stories.

This introspection also relates to what is – and is not – understood more widely about counselling and psychotherapy as a profession. In this edition we also provide a snapshot of the 800-plus definitions of counselling we collected from counsellors and psychotherapists. I encourage everyone to read these and share your thoughts among your own communities.

Be published
Share your research and articles with the editor of *Counselling Australia* by emailing to editor@theaca.net.au.
See page 54 for the submission guidelines.



UPCOMING EVENTS 2022

Breast Cancer Awareness Month

1 to 31 October

Australia's Breast Cancer Awareness Month provides people with the chance to focus on breast cancer and its impact. Host a breakfast, share stories, speak to family members and get important information out to family, friends and colleagues. fundraise.nbcf.org.au/event/pink-ribbon-breakfast

Ocsober

1 to 31 October

Ocsober is a fundraising initiative that encourages people to give up alcohol for the month of October.

Headspace Day

5 October

Headspace Day is about ensuring young people have access to mental health services no matter where they live in Australia. Get involved by sharing stories, using social channels and connecting with your local headspace centre. headspace.org.au/reconnect

World Mental Health Day

10 October

World Mental Health Day raises public awareness of mental health issues and promotes greater understanding of its effect on individuals and the wider community. who.int/campaigns/world-mental-health-day

World Sight Day

13 October

World Sight Day raises public awareness of blindness and low vision, providing an opportunity to educate people more about the causes of blindness and preventative measures. iapb.org/world-sight-day

Movember

1 to 30 November

Movember raises awareness of men's health issues and is a fun way to raise money for a good cause. au.movember.com

World AIDS Day

1 December

World AIDS Day is a globally recognised event that takes place on 1 December. The day raises awareness about the issues and concerns surrounding HIV and AIDS. It is also a day for people to show their support for people living with HIV and to remember those who have died.

Decembeard

1 to 31 December

Decembeard Australia encourages men to grow a beard in December to raise awareness for bowel cancer. Everyone, bearded or not, can join in. decembeard.co

International Day of Persons with Disabilities

3 December

The International Day of People with Disabilities is celebrated every year in Australia on 3 December to acknowledge the incredible contribution people of all abilities make to the community. idpwd.org

Technology Update

With **Dr Angela Lewis**

Photo: 123rf

Ever since the COVID-19 pandemic and the various restrictions and lockdowns experienced globally, we are relying on the virtual world far more than we could have ever expected – from ordering groceries to Zoom work meetings, to accessing mental healthcare to searching for a partner. This month, we take a look at virtual reality and the role it has to play in mental healthcare, as well as taking a quick peek at what's happening in the world of online dating.

Virtual reality and mental healthcare

While it may sound like it belongs in the world of gaming and sci-fi movies, virtual reality is already being used by therapists and psychologists globally to address various mental health issues such as phobias, post-traumatic stress disorder and anxiety disorders. Put simply, virtual reality (often simply referred to as VR) is the use of computer technology to create simulated environments. It offers myriad possible immersive experiences that the user can explore in 360 degrees from a first-person perspective. A simple example might be when an individual has a fear of flying – by using a headset and a flight simulator program, they can experience flight while safely sitting in a therapist's office.

There is a huge amount of research and literature available online (a simple Google search of 'VR and mental health' will yield a plethora of results) and, while it is not considered a replacement for therapy, it is believed to be an effective tool. The general consensus appears to be positive, as virtual reality simulations are able to provide individuals the opportunity to repeatedly experience problematic situations and, together with appropriate psychological treatments, learn how to overcome difficulties. A good article to follow up on is 'Three ways virtual reality could transform mental health treatment, (2021) by Poppy Brown, doctoral researcher in psychiatry, University of Oxford.

There are already a number of clinics around Australia offering VR therapy. Further investigation of their services may provide you with information and guidance, should you wish to experience VR to gauge its usefulness to your practice or whether it might be a resource you utilise in client referrals. Some existing clinics include:

- Melbourne Wellbeing Group (Camberwell, Victoria): melbournewellbeinggroup.com.au
- Sydney Phobia Clinic (Sydney, NSW): sydneyphobiaclinic.com.au
- ThinkWise Clinical Psychology (Cumberland Park, SA): thinkwise.net.au.

If you have an interest in VR for mental health treatment but are unsure where to start, there are free

Quickly reopen a tab in your Chrome browser

If you have accidentally closed a tab while using your Chrome browser, it is just as easy to reopen – with no need to retype the website address.

1. **Right-click** on an empty space of your Chrome tab strip (this is the very top strip of the browser where you can usually see all open tabs).
2. **Click Reopen closed tab.** Repeat this for however many tabs you need to reopen. (You can also use the keyboard shortcut Ctrl + Shift + T if you prefer.)

applications available online so you can personally gauge where the therapeutic potential lies. (I prefer not to recommend any as I have no experience with their use, so it is best to locate them yourself, particularly given they are free.) You will need to have access to a VR headset (prices vary from around $400 to $600), and these can be purchased at retailers such as Officeworks or JB Hi-Fi or online at Amazon or Catch.com. ■

Quick tip

If you are in Melbourne, there is a (non-clinical) VR studio in Flinders Lane, CBD, where you can experience a single session for $45. There are apparently a number of different scenarios to try, such as 'Walk the Plank' (virivr.com.au).

What's happening in online dating

The purpose behind online dating is (for most people) to find a person with whom they can ultimately enjoy a real-life relationship. As there can be many so-called 'time wasters' who have no intention of actually progressing to a relationship, or those with unclear agendas, the practice of 'hardballing' has evolved to become an accepted way of approaching the dating world. When hardballing, the person is very clear about their relationship expectations from the outset – whether this is a serious long-term partnership, children, marriage or simply a casual fling. If there is no match with the stated life plans, there is an instant goodbye and the search continues.

Almost the polar opposite of hardballing is a new trend (thanks to enforced lockdowns and quarantining) known as 'apocalypsing'. Initially identified by the dating service Plenty of Fish in a poll of more than 2000 singles, apocalypsing describes treating every relationship like it's your last. In this scenario, you meet someone you're infatuated with and very quickly become committed and firmly established in each other's COVID bubbles, ready to make sourdough starters and plan your life together. One-third of singles polled by Plenty of Fish said they know someone who has done this.

Then we have the 'thirst trap', where someone intentionally posts something provocative (a message, a sexy photo, a flirty social media comment) in order to get some type of response from a targeted person (or people) in order to 'trap' said person into admitting their 'thirst' (interest, attraction) in the poster.

Mates not dates

Foura, found at joinfoura.com, is a new web service designed for meeting others with a view to friendship (as opposed to dating). Recently launched in Sydney with plans to expand to other states down the track, it was created with the purpose of helping reduce social isolation and loneliness. A colleague of mine who moved interstate for her job has reported it as a fun, relaxed way to meet others without sitting in bars or joining multiple clubs or sporting organisations.

It works by linking like-minded people into pods of four, based on interests and activities they have in common, and then arranging a group meeting at a bar or café. Before meeting attendees are told names and given an overview of things they share, but relationship status, race, sexuality and religion are not revealed. The group meetings can be mixed or single-gender based on requirements.

As always, all website addresses and user instructions supplied were correct at the time of submission and neither the ACA nor Dr Angela Lewis receive any payment or gratuity for publication of any website addresses presented here.

Book reviews

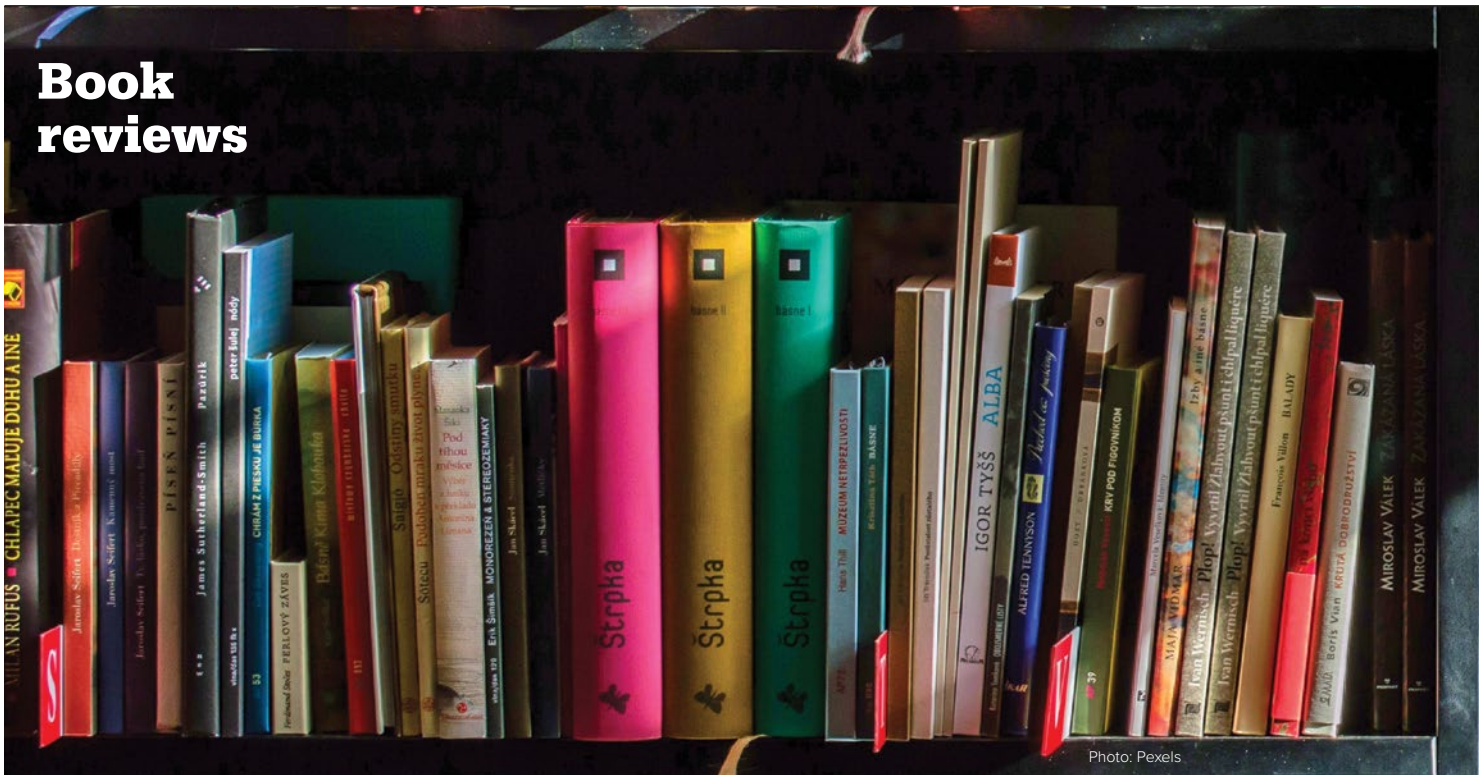
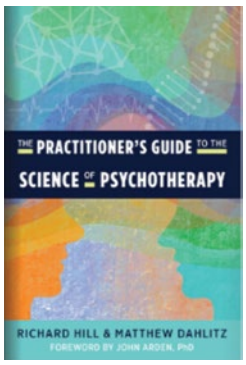


Photo: Pexels



The practitioner's guide to the science of psychotherapy
By Richard Hill and Matthew Dahlitz

Reviewer
Dr Philip Armstrong

Richard Hill and Matthew Dahlitz have produced a very dynamic text for us that references up-to-date, evidence-based research on psychotherapy.

What makes this text stand out from others is not just its coverage of therapy but also its well-laid-out explanations of how the brain works, with extensive coverage of the neuroscience of the brain.

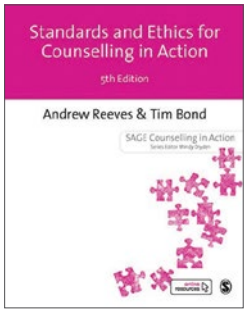
The text moves through issues in a logical sequence, starting with what mental health is before exploring the brain and then the body. The authors explain the complexities of how each of these relies on the other while remaining separate in their functions.

The authors dedicate a chapter to a subject rarely found in texts: the molecules. This chapter also includes material on epigenetics and brain dysfunctions.

The text then moves seamlessly through disorders such as personality, behavioural, affective and developmental disorders, followed by a chapter on what the experts do.

The text concludes with innovations for the twenty-first century therapist. Areas covered of most interest to me were the gut–brain axis, neurofeedback, skin, and trauma and the body. This text is a must for all counsellors and psychotherapists who want to have a broad and comprehensive knowledge of the latest techniques and science; it is also for those who wish to be better therapists.

About the reviewer
Dr Philip Armstrong is chief executive officer of the Australian Counselling Association.



Standards and ethics for counselling in action 5th Edition
By Andrew Reeves and Tim Bond

Reviewer
Jacqueline Mitchell, ACA Member Officer

Standards and ethics for counselling in action provides a solid foundation for both new and experienced counsellors in understanding the concepts of counselling in practice, in conjunction with ethical decision-making. This book is a must-have for the toolkit of any counsellor who wishes to keep up to date with counselling ethics across the areas of online counselling, record keeping and understanding the benefits and importance of ongoing professional supervision.

Authors Andrew Reeves and Tim Bond start with an overview of the definition of counselling in a cultural context, before moving on to the area of where our sources of ethics are derived. The importance of understanding that a code of ethics from a regulatory body is merely a tool that is used when processing ethical dilemmas is reinforced through their writing. They discuss an ethical problem-solving model as a way for counsellors who are confronted with a dilemma to systematically resolve that dilemma.

The text also provides a comparative analysis of what the codes of ethics across different jurisdictions have as common themes and provides an interesting insight into counselling in other parts of the world. It also outlines the importance of operating within a scope of practice to ensure that there is a solid framework for those who work in a voluntary registered or self-regulated industry.

The text tackles what I see as areas of counselling that draw the most consumer complaints including respect for client autonomy, confidentiality and avoiding exploitation of clients. The authors weave in examples of how these ethical dilemmas can arise and pose questions to the reader to elicit their understanding of ethical significance of these situations and how their own ethical decision-making processes may work.

The topic of counselling supervision is also extensively reviewed in this text, with the authors outlining the importance of supervision for counsellors – from understanding what supervision is and what to expect from your supervisor, to the importance of supervisors promoting and supporting ethical practice by their supervisees and ensuring the counsellor is engaging in self-care.

Additionally, the text covers general information about record keeping, ethics, values and other legal requirements (albeit UK-based) and is an essential tool for counsellors for practising in an ethical manner to ensure best practice.

The topics covered in the text are highly beneficial for understanding how clients can be better supported by ethical practice in line with a scope of practice and a code of ethics. The book's best piece of advice for my own role as a complaints officer with ACA is to ensure that counsellors are proactively aware of their regulating body's code of ethics, and that it shouldn't be used only reactively, once a complaint has been lodged.

Photo: Pexels

EATING DISORDERS: WORKFORCE CAPACITY BUILDING

A credentialing system for counsellors specialising in eating disorders is helping to improve patient support and treatment.

Treating eating disorders is recognised as complex. This complexity can contribute to variability in the quality of treatment available to people with eating disorders. Combined with increased prevalence of eating disorders, especially since the COVID-19 pandemic, greater need for the availability of safe, quality and effective eating disorder treatment is evident. To meet this need, workforce capacity building – enhancing both the quality of treatment provided and the number of health professionals who can provide this treatment – is necessary. Counsellors and psychotherapists can play an important role in contributing to this capacity building.

The Australia & New Zealand Academy for Eating Disorders (ANZAED), in partnership with the National Eating Disorder Collaboration (NEDC), have developed the ANZAED Eating Disorder Credential to help drive workforce development. The credential provides formal recognition of qualifications, knowledge, training and professional activities needed to meet minimum standards for delivery of safe and effective eating disorders treatment. In doing so, it endorses transparent standards for eating disorder treatment based on NEDC's core competencies and ANZAED's clinical practice standards, and it recognises the significant investment by health professionals in training and professional activities to meet these standards.

Who can become a credentialed eating disorder clinician?

The ANZAED Eating Disorder Credential is open to health

professionals delivering mental health and dietetic care for eating disorder patients within both public and private settings. This includes counsellors and psychotherapists, who can play a key role as part of the multidisciplinary team by providing psychological support and evidence-based psychological treatment for people with eating disorders. Clinicians applying for the credential need to demonstrate that they have the appropriate clinical experience, introductory and treatment provision training, and ongoing engagement in supervision and professional development activities. Detailed information about the pathway to become credentialed can be found at connected.anzaed.org.au/becomingcredentialed.

What are other benefits of credentialing?

Beyond building the eating disorders workforce, the credentialing system has an equally important purpose, which is to connect people seeking care with credentialed clinicians. People with eating disorders and their families and supports frequently report that finding a treatment provider with appropriate knowledge and understanding of eating disorders is fraught with difficulty. The path to suitable treatment can be rocky and problems finding the right provider at the right time can result in unwanted setbacks and prolonged illness. In credentialing clinicians who have demonstrated that they meet minimum standards for eating disorders treatment provision, people with eating disorders can have confidence that the credentialed clinicians are easily located via the connect.ed platform at connected.anzaed.org.au. Credentialed eating disorder clinicians can also be readily recognised by the use of the postnominal 'CEDC' and visually with the 'ANZAED Eating Disorder Credentialed Clinician' badge displayed on provider websites, business cards or social media.

The credentialing system built by ANZAED and NEDC also provides greater choice for those seeking treatment for an eating disorder as they can be more informed about the treatment modalities and ways of working with clients that health professionals offer. Through the searchable feature on the connect•ed platform, consumers or referrers can filter their search for important preferences such as location, delivery mode (for example, telehealth), language spoken, provider area of interest (such as LGBTIQ+ or client age bracket) and, importantly, consumers and referrers can limit their search to providers with currently available appointments. Clinicians can also provide information about their treatment philosophy or scope of practice in their clinician profile on connect.ed. This helps consumers and referrers to better understand the treatment approaches that are available from different mental health disciplines and meets consumer needs for greater choice in treatment.

These features of connect.ed, along with flow-on effects to build workforce capacity in eating disorder treatment across a range of health professions, help to connect people in need to the right provider at the right time, enhancing the potential for improved outcomes for people with eating disorders. ■

References

Heruc, G., Hurst, K., Casey, A., Fleming, K., Freeman, J., Fursland, A., Hart, S., Jeffrey, S., Knight, R., Roberton, M., Roberts, M., Shelton, B., Stiles, G., Sutherland, F., Thornton, C., Wallis, A., & Wade, T. (2020). ANZAED eating disorder treatment principles and general clinical practice and training standards. *Journal of Eating Disorders*, 8(1), 63. https://doi.org/10.1186/s40337-020-00341-0

Hurst, K., Heruc, G., Thornton, C., Freeman, J., Fursland, A., Knight, R., Roberts, M., Shelton, B., Wallis, A., & Wade, T. (2020). ANZAED practice and training standards for mental health professionals providing eating disorder treatment. *Journal of Eating Disorders*, 8(1), 58. https://doi.org/10.1186/s40337-020-00333-0

McLean, S. A., Hurst, K., Smith, H., Shelton, B., Freeman, J., Goldstein, M., Jeffrey, S., & Heruc, G. (2020). Credentialing for eating disorder clinicians: A pathway for implementation of clinical practice standards. *Journal of Eating Disorders*, 8(1), 62. https://doi.org/10.1186/s40337-020-00332-1

National Eating Disorder Collaboration (2018). Workforce core competencies for the safe and effective identification of and response to eating disorders. https://nedc.com.au/research-and-resources/show/workforcecore-competencies-a-competency-framework-for-eating-disorders-in-australia

ANZAED
AUSTRALIA & NEW ZEALAND ACADEMY FOR EATING DISORDERS

Treating eating disorders

What is the role of a counsellor or psychotherapist in supporting someone with an eating disorder? By **Dr Sarah Trobe**

Approximately one million Australians are living with an eating disorder in any given year – that is, four per cent of the population. Counsellors and psychotherapists can hold different roles in the area of eating disorders, depending on the setting in which they work, the training and experience they have, and the people that they might provide care for. Regardless of these factors, however, everyone does play an important role.

The National Eating Disorders Collaboration (NEDC) has developed a model called the Stepped System of Care for Eating Disorders, which describes the care and treatment services that people experiencing an eating disorder may require across the course of illness and recovery. This helps to identify the functional role that counsellors and psychotherapists can hold across the system of care. Importantly, clinicians may hold multiple roles across the system.

The pathway through the system of care will be different for each person, and the elements should be organised around the person and their family and supports, according to individual needs.

The functional roles for professionals identified within the system of care define the specific tasks clinicians will be involved in. These are outlined here:

a. **Prevention and advocacy:** Clinicians have an important role in reducing stigma and best practice communication about bodies and eating.
b. **Identifying and screening for the eating disorder:** These clinicians act as the first point of contact for a person experiencing an eating disorder, and their families and supports. Their role is to proactively engage people at risk, and to promote early help-seeking and early intervention.
c. **Completing an assessment for an eating disorder and facilitating a referral to a treatment provider:** These clinicians provide the first level of intervention, including completing an assessment as appropriate for their professional role, and referring to the most appropriate service/s.
d. **Providing treatment within a multidisciplinary care team approach:** Health professionals in this category provide treatment for the person experiencing an eating disorder. Treatment needs to address all aspects of the eating disorder including psychological, medical and nutritional.
e. **Supporting someone towards recovery:** This includes professionals providing support to those who are learning to self-manage their recovery from an eating disorder, and to families and supports.

Photo: Unsplash

Professional development pathways

To build a workforce of clinicians that can respond effectively to eating disorders, it is important to consider the professional development pathway a clinician needs to take to meet minimum standards for their role and that is aligned with their scope of practice. Training needs will vary depending on the functional role a clinician fills and the setting and context they work within. This may include providing information and educating groups about eating disorders, and/or identifying and assessing. For some professionals, such as mental health, dietetic and medical, this requires further training to provide evidence-based or evidence-informed eating disorder treatment.

Identification and response

Counsellors and psychotherapists have an important role in identifying, screening, assessing and referring a person who may be experiencing an eating disorder, filling the role of identification and response. Clinicians do not necessarily need to be able to provide treatment for the person, but they can engage, support and ensure that the person accesses the treatment they need when they need it. Early intervention is crucial to better outcomes and, with the right training, counsellors can confidently fill this important functional role in the system of care. Building on the knowledge and skill that has been developed through tertiary training and on-the-ground experience, accessing introductory eating disorder training can allow a knowledgeable and confident response to people experiencing eating disorders. For more information on how you can access this training, please see page 14.

Treatment

For some clinicians, providing treatment may be the functional role to be filled. This will depend on your practice setting and access to a multidisciplinary care team. These clinicians, in addition to having the foundational knowledge about eating disorders, also need to learn at least one evidence-based treatment approach. The specific model or approach that is learned will depend on the treatment setting as well as the diagnostic presentations that may be seen in that practice. Not

Photo: Unsplash

everyone will become a treatment provider, but it is essential that this can be accessed within the local system of care. In alignment with the ACA Scope of Practice guideline, clinicians need access to supervision and ongoing professional development to support ongoing knowledge and skill development, ensuring safe and effective care for people experiencing eating disorders.

If you are already providing treatment for people experiencing eating disorders, you may be interested in applying for the ANZAED Eating Disorder Credential. This will assist those seeking treatment to find you. Further information can be found at connected.anzaed.org.au.

How do I access the training that I need?

To support the quality of eating disorder training available within Australia, NEDC, in collaboration with state and national training providers, developed a training approvals process (nedc.com.au/credentialing/nedc-training-approvals), underpinned by the National Framework for Eating Disorders Training – A guide for training providers (nedc.com.au/assets/Credentialing/A-National-Framework-for-Eating-Disorders-Training-A-guide-for-training-providers.pdf). The purpose of this process is to align with national standards, ensuring consistency and quality across eating disorder training and contributing to building a skilled and competent workforce able to confidently identify, assess and refer and/or provide safe and effective treatment for people experiencing an eating disorder.

If you are interested in learning more, please follow the below professional development pathways as appropriate to your learning needs and clinical role.

I want to learn more about eating disorders

Having a strong understanding of eating disorders will provide a solid foundation for any practical role you may fill within the stepped system of care. Visit the sites below to find out more:

- **The facts about eating disorders** (nedc.com.au/eating-disorders/eating-disorders-explained/the-facts): What are eating disorders? Who is affected? It also covers types of eating disorders and eating disorders in Australia.
- **Introductory videos:** https://nedc.com.au/professional-development/webinars-and-videos/: These cover eating disorders, myths, screening and assessment, and multidisciplinary care.
- **Stepped system of care** (nedc.com.au/support-and-services/system-of-care): Learn more about the system of care for eating disorders and where your role or workplace setting fits.

I want to know how to screen and assess for eating disorders

You can access NEDC's Eating Disorder Core Skills: eLearning for Mental Health Professionals at nedc.com.au/professional-development/elearning/eating-disorder-core-skills-elearning-for-mental-health-professionals. This training will equip mental health professionals with the knowledge and skills needed to identify when a person is experiencing an eating disorder, complete a comprehensive eating disorder assessment, refer to appropriate services in the stepped system

of care, and understand the components of eating disorder treatment and recovery.

I want to be able to provide best practice treatment for people experiencing eating disorders

You can currently access free professional development in training and supervision through the **Credential Professional Development Packages** (connected.anzaed.org.au/pdpackages) – a program coordinated by NEDC with support from the Australian Government Department of Health. The packages are designed to support mental health professionals to upskill in this area and to meet the training and supervision requirements of the ANZAED Eating Disorder Credential.

Counsellors and psychotherapists are a crucial part of the mental health workforce, and this time-limited opportunity will provide you with the foundation to provide safe and effective treatment for people experiencing eating disorders. Clinicians can choose training in one of several different evidence-based treatment models depending on their workplace setting and context. All counsellors and psychotherapists are eligible for a PD Package regardless of where they work, where they live, and the population/s they work with, and we encourage you to apply. ■

Training

For further training opportunities, please see the NEDC professional development listings (nedc.com.au/professional-development/upcoming-training-and-events).

References

National Eating Disorder Collaboration. (2018). Workforce core competencies for the safe and effective identification of and response to eating disorders. https://nedc.com.au/research-and-resources/show/workforcecore-competencies-a-competency-framework-for-eating-disorders-in-australia

Heruc, G., Hurst, K., Casey, A., Fleming, K., Freeman, J., Fursland, A., Hart, S., Jeffrey, S., Knight, R., Roberton, M., Roberts, M., Shelton, B., Stiles, G., Sutherland, F., Thornton, C., Wade, T., Wallis, A. (2020). ANZAED eating disorder treatment principles and general clinical practice and training standards. Journal of Eating Disorders, 8, 63. https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-020-00341-0

Hurst, K., Heruc, G., Thornton, C., Freeman, J., Fursland, A., Knight, R., Roberts, M., Shelton, B., Wade, T., Wallis, A. (2020). ANZAED practice and training standards for mental health professionals providing eating disorder treatment. Journal of Eating Disorders, 8, 58. https://jeatdisord.biomedcentral.com/articles/10.1186/s40337-020-00333-0

JUST RELEASED

Emotion-Focused Work
A POCKETBOOK OF PROTOCOLS

Protocols can guide our clinical practice by providing a structure for sessions, from the initial re-engagement and information-gathering or intervening to finishing a session.

This handy little pocketbook summarises the elements in the protocols for Emotion-Focused counselling, psychotherapy and couple work. It can sit on your desk and be a reminder of the steps in information gathering and intervening.

The Annandale approach is primarily Emotion- Focused, an integrative approach that draws on humanistic psychology, family therapy, and psychodynamic therapy. It is mainly a verbal therapy that incorporates creative, experiential techniques. It is a relational approach that works with both the real and symbolic aspects of the therapeutic relationship.

Read more or purchase your copy at The Annandale Institute:
www.Annandale.net.au

SUICIDE PREVENTION IN AUSTRALIA

Photo: Unsplash

We can never underestimate the impact that every life lost to suicide has on family, friends, workplaces and the broader community. Over 10 million Australian adults are estimated to know someone who has died by suicide, and one in two young people is impacted by suicide by the time they turn 25. Sadly, over 3000 lives are lost to suicide each year and male suicides make up three-quarters of these deaths. Every life lost to suicide is heartbreaking. It's important to remember that every statistic represents a life lost and has a cascading impact across the community.

Suicide Prevention Australia is the peak national body for the suicide prevention sector, guided by people with lived experience of suicide. It is a member-based organisation, which includes large and small organisations, practitioners, researchers and community leaders.

"We find ourselves at a critical juncture for suicide prevention," a spokesperson for Suicide Prevention Australia says. "We know the risk of suicide rates are often highest two to three years after a crisis, pandemic or natural disaster. We know there's record levels of distress across our community. It's clear that sustained and systemic change is required."

Suicide Prevention Australia also manages the National Suicide Prevention Research Fund, which was established by the Australian Government to support research into suicide prevention and facilitate the translation of knowledge into more effective services for individuals, families and communities.

Final Advice

The Final Advice is a collection of resources from the National Suicide Prevention Adviser and Taskforce that outlines major and lasting reforms needed to deliver a 'connected and compassionate' suicide prevention system.

The document is a culmination of 18 months of engagement with government, community, researchers, the suicide prevention sector and, importantly, people with lived experience of suicide. This engagement focused on better understanding the needs of people who experience suicidal distress, as well as identifying how Australia's services, systems and government structures can change to meet their needs.

More than 3000 people who have been affected by suicide shared their insight and knowledge to inform the Final Advice, and helped to identify that, often, the barrier to accessing suicide prevention services was self-stigmatisation and/or traumatic experiences as they entered support services. It points to the need for more whole-of-community models of care – underpinned by

Workforces in suicide prevention need to be trauma-informed, which means being able to understand and be responsive to the deeply personal impact and ascribing to their experience of trauma – helping people who have been affected by it to feel physically and psychologically safe and empowering a sense of control.

trauma-informed approaches – and a workforce trained in suicide prevention to deliver these models with compassion.

To drive change, the Final Advice identified four key enablers:

- a whole-of-government approach;
- lived experience knowledge and insight;
- data and evidence to drive outcomes; and
- workforce and community capability.

Four further priority shifts were also recommended:

- responding earlier to distress;
- connecting people to compassionate services and supports;
- targeting groups disproportionately affected by suicide; and
- delivering policy responses that improve security and safety.

Suicide prevention workforce

It is important to recognise that the suicide prevention workforce is distinct to the mental health sector and requires tailored recruitment, retention and training strategies to build its capacity.

Counsellors are an important touchpoint in supporting people in distress and connecting them to the right services and programs. Research highlights that the first time someone shares their story of distress is a critical window for support. Given the workforce challenges across suicide prevention, it is important that all layers of the workforce are utilised to their potential.

Many people who experience distress or thoughts of suicide are known to have a personal history involving trauma. Workforces in suicide prevention need to be trauma-informed, which means being able to understand and be responsive to the deeply personal impact and ascribing to their experience of trauma – helping people who have been affected by it to feel physically and psychologically safe and empowering a sense of control.

Part of the workforce solution is a commitment to prioritising evidence-informed and compassion-focused workforce development. This will drive cultural change and improve the capacity and capability of all (formal and informal) workforces involved in suicide prevention.

Another part is the implementation of contemporary compassion-based training for frontline workers that will enable them to respond to distress. This is particularly relevant for those providing financial, employment and relationship support to people experiencing distress.

A 10-year National Mental Health Workforce Strategy has been funded to deliver a sustainable, skilled, supported and equitably distributed mental health workforce to meet Australia's current and future needs.

Upcoming changes

The Australian Government is working with states and territories to establish a national Distress Intervention Trial. An agreement has been reached with New South Wales, Victoria and Queensland to fund trials in each jurisdiction.

Suicide Prevention Australia anticipates the newly formed National Suicide Prevention Office (NSPO) will develop a National Suicide Prevention Workforce Strategy. It will include government departments, social services, educators, employer groups, miscellaneous service providers, community-based organisations and other settings where a risk of suicide may present for individuals.

Key investments in new services and supports will not succeed without commensurate investment in the suicide prevention workforce. Failure to progress workforce strategies risks undermining other important reforms. What good is a new service if there are no staff to deliver it? What benefit do we gain from people reaching out for help if

Photo: Pexels

help is not available or waitlists are too long?

A National Suicide Prevention Workforce Strategy needs to be fully funded and deliver both a long-term strategic vision for our workforce as well as clear, specific and implementable actions. This means concrete actions to recruit, skill, compensate, retain and sustain the suicide workforce. It needs to join up, in an integrated way, other workforce strategies in related sectors already under development.

Community

Beyond the workforce, everyone can play a role in suicide prevention. Of those who attempt suicide, only a minority (four in 10) will share their thoughts of suicide with a medical professional. Often the first conversation they have is with a member of the community.

Training for evidence-based suicide prevention capability should be as common in the community as CPR and first aid. The Final Advice recognises this for clinical and health staff and frontline workers who support people experiencing distress. While $18 million over three years in the National Suicide Prevention Leadership Support Program will provide some investment in this training, more is required, and additional resources are needed to build community capability.

Building competency

Suicide Prevention Australia, in collaboration with more than 50 organisation members and experts in workplace suicide prevention, developed Suicide Prevention: A Competency Framework, Australia's first national framework for suicide prevention in the workplace.

The framework is designed to help organisations find the gaps within their business when it comes to promoting a culture of wellbeing and recognising when people are in distress. Employers can take the framework, apply it to their business and specific roles, and then identify where improvements need to be made.

The framework is a starting point for employers and staff members to consider what they need to know to promote wellbeing and intervene effectively to reduce distress and suicidal behaviour in their workplace. There are suggestions on ways to adapt, tailor and apply the framework to different working environments and roles.

It promotes a compassionate and collaborative focus to

Photo: Pexels

reducing suicide risk in non-clinical workforces and the community. We are striving to ensure that every person who needs support can access a consistent, high-quality and safe standard of care.

An example of the framework in practice can been seen in our partnership with Universities Australia to create a suicide prevention competency framework for universities. Universities Australia represents 39 member universities that educate 1.5 million students every year and employ over 100,000 staff. This important partnership provides a structure that enables early intervention for staff experiencing suicidal behaviour, staff or students with a lived experience of suicidal behaviour, and people studying who may experience struggles or factors that cause significant distress.

Research

Suicide prevention policy in Australia has had an increasing focus on building the evidence base to address this major public health concern. In recent times, the Australian Government has increased its investment in suicide prevention research.

The Suicide Prevention Research Fund was established by the Australian Government to support research into suicide prevention, with the aim to support world-class Australian research and facilitate the rapid translation of knowledge into more effective services for individuals, families and communities.

On behalf of the Australian Government, Suicide Prevention Australia manages the fund with a focus on addressing gaps in suicide prevention research. This results in projects undertaken with collaboration between researchers, service providers and people with a lived and living experience of suicide.

Translational research is a priority in suicide prevention as it looks at ways to move research from the clinic to the community. It has the power to accelerate the flow of insights from researchers

Too often, new insights from suicide research are not translated into saving people's lives. Therefore, translation of research and clinical evidence remains one of the key challenges in suicide prevention.

and clinicians to the community, and vice versa. Too often, new insights from suicide research are not translated into saving people's lives. Therefore, translation of research and clinical evidence remains one of the key challenges in suicide prevention.

Fortunately, the situation is changing in Australia. The release of the full report from the Royal Commission into Mental Health Services in Victoria in 2021 emphasised the importance of facilitating translational research through the establishment of a dedicated Collaborative Centre for Mental Health and Wellbeing. This centre will have a specific remit to facilitate interdisciplinary research into new models of care that can inform service delivery, policymaking and lawmaking within the broader mental healthcare sector.

A better future

Any Australian experiencing or impacted by suicidal distress should have access to compassionate, quality and connected services when they need them. The suicide prevention sector, and specifically Suicide Prevention Australia, is focused on finding ways to deliver much-needed support to those at risk, those who have attempted suicide or those who are bereaved by suicide. ■

Clinical Supervision Services

'Critical reflection, continuous learning'

Clinical supervision is a collaborative process that supports the professional development of practitioners working in the helping professions; and promotes ethical practice to enhance client outcomes.

Charlene Pereira is an ACA registered supervisor and a member of the ACA Clinical Counsellors College. She has in excess of 15 years clinical experience. To learn more about her areas of specialisation see her ACA profile - https://www.theaca.net.au/counsellor/charlene-pereira

Where is Charlene located? Offices are in Warrandyte Road, Ringwood North and Collins Street, Melbourne.

What are my supervision options?

- individual
- group
- Skype/telephone
- onsite at your workplace

Want to find out more? The first session is complimentary.
Phone Charlene on 03 9999 7482 or email **charlene@superviseme.com.au**

MISCONCEPTIONS IN NARCISSISTIC ABUSE

By **Nicki Paull**

Working in the space of narcissistic abuse for the past near-decade, I've seen firsthand the confusion in victim-survivors who usually present to me after a period of obsessive online research. At the bottom of this confusion lie two enduring questions: Is my abuser a narcissist? Or is it me who is the narcissist – am I to blame?

The first question is possibly fuelled by a growing presence of social media influencers posting about their lived experience (some of whom may paradoxically be narcissistic themselves). The second question is often the result of the opinions of US psychologists who dominate the debate worldwide. The victim-blaming rhetoric is pervasive.

Gender dynamics play a huge part in the nature and extent of harm experienced by survivors, as does gender role socialisation. This is why a cultural context is important.

Traditional domestic violence models only go part way to explain the confusing matrix of abuse, which often has far-reaching impacts on survivors in every sphere of their lives – family, psychosocial, professional, financial, emotional and spiritual.

Narcissistic abuse, and the risk of post-traumatic stress disorder following a separation, require trauma-informed, narcissism-informed support. Worldwide, there is a paucity of accessible, qualified professionals with expertise in 'Dark Triad' personality traits (narcissism, psychopathy and Machiavellianism).

Grasping the model of mind of a narcissistic individual can be very difficult for a neurotypical practitioner or survivor. Recognising narcissistic behaviours from the clinical diagnostic criteria is also difficult. For example, the use of the word, 'grandiose' to describe a narcissist may not be immediately evident in a sophisticated covert presentation.

In my experience, well-researched victim-survivors know what they have endured and are frequently better-informed about narcissism than your average clinician. Little or no formal teaching on this subject is provided in doctoral programs training psychologists.

Narcissistic abuse can cause existential crisis and deep moral injury, whatever the cultural context. Survivors' behavioural dysregulation in the aftermath of narcissistic abuse can vary from uncomfortable and unfamiliar to unmanageable and terrifying. This can often lead to misdiagnosis, creating a further burden on the survivor and, worse, the wrong formulations and interventions by those very clinicians.

Without a shared vocabulary to describe the complex and confusing interpersonal manipulation used by narcissists, it can be impossible for victim-survivors to articulate their experience in a way that makes sense to your average therapist. It is the survivor who looks like the crazy one.

The internet provides jargon that will not be found in any academic text but has come to provide a lexicon by which victim-survivors can finally communicate their lived experience. ■

CARETAKER MODEL SAMPLE

A gentler model for narcisisstic abuse survivors than the common codependency model.

Source: *Stop caretaking the borderline or narcissist: how to end the drama and get on with life.*

Resources

Internet resources

DoctorRamani: youtube.com/c/DoctorRamani (US context)

Unfilteredd: unfilteredd.net – multiple qualified therapists and lived experience blogs (European context)

Narcissistic Sociopath: narcissisticsociopath.net (Australian context)

Literature

Arabi, S. (2020). *The highly sensitive person's guide to dealing with toxic people: how to reclaim your power from narcissists and other manipulators*. New Harbinger Publications, United States.

Fjelstad, M. (2014). *Stop caretaking the borderline or narcissist: how to end the drama and get on with life*. Rowman & Littlefield Publishers.

MacCallum, M. (2019). *Healing the trauma of psychological abuse: a lived experience roadmap to a mindful recovery*. Balboa Press.

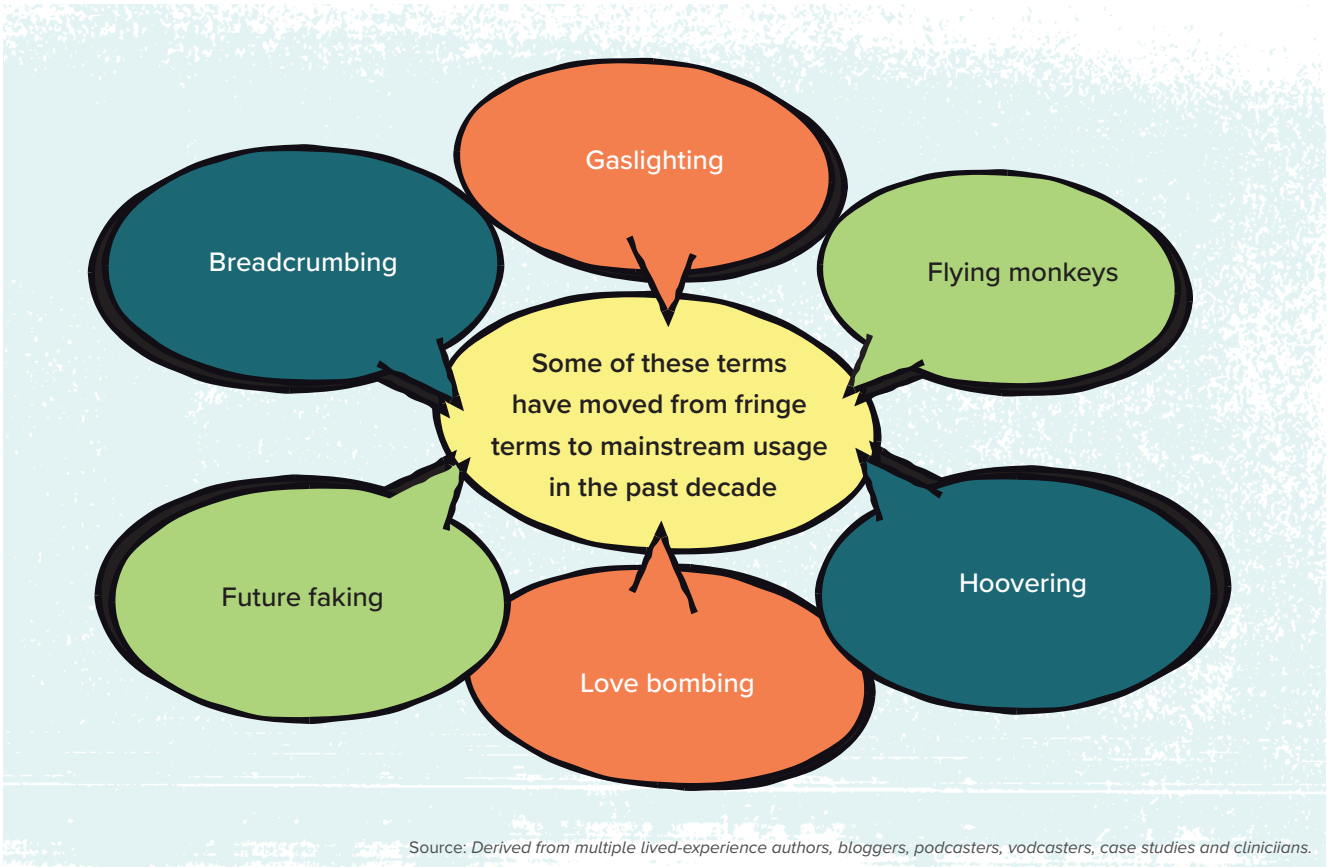
Thomas, S. (2016). *Healing from hidden abuse: a journey through the stages of recovery from psychological abuse*. Mast Publishing House.

Simon, G. (2019). *In sheep's clothing.'*. Parkhurst Brothers Publishers Inc.

About the author

Nicki Paull MACA, AABCAP has been an author, blogger and podcaster in the niche field of narcissistic abuse since 2016 (pseudonym Margot MacCallum). Her work is informed by lived experience of comprehensive narcissistic abuse, PTSD and remission via the mindfulness-based modalities. She is a long-term practitioner of yoga and Vipassana meditation, and she integrates Buddhist psychology into her practice.

NON-CLINICAL SHARED LEXICON FOR NARCISSISTIC ABUSE SURVIVORS



Source: *Derived from multiple lived-experience authors, bloggers, podcasters, vodcasters, case studies and cliniciians.*

In this new series, counsellors share with *CA* their professional journeys and the things they have learnt along the way. **Janina King**, counsellor, clinical transport officer and crisis support worker, tells *CA* what she wishes she knew in the prelude to her career.

So you want to be a counsellor ...

Tell us about your work. Do you love your work? Why? How do you describe the work that you do?

I have multiple roles across several platforms. They all are about uplifting others. I get a kick out of caring for, and supporting, people in crisis. I bring my healing presence to the situation, along with extensive life experience, and I listen and provide. I look at things from a broad perspective, knowing that by the time a crisis has arrived, there are many components at play that led a person to that point.

I am trauma-informed. Most people seeking support are traumatised somehow, and I believe in always 'being there' for a person. So many people have been left to feel abandoned and that no one is listening. Listening deeply is profoundly important and such a gift. Trauma training allows me to function as a catalyst to reduce another's distress. I aim to ensure every person feels I am 'there' for them and will not abandon them. This is more important than knowing things. I operate from the belief that all people have their own answers for themselves. I am simply the catalyst for exploration, discovery and change.

In my ambulance role, even though it is a 'physical' response to medical events, heart rates can lower with just comfort and care. I have seen cardiac arrests caused by a stressful, scary event. I believe that really caring about another can cause huge positive change. Humans can feel if you care. As I am trained in the medical sphere, as well as exercise physiology, I bring this knowledge into the space when I am counselling someone. It allows me to view a person's presentation from a holistic perspective.

So many people have been left to feel abandoned and that no one is listening. Listening deeply is profoundly important and such a gift.

I have ended up – purely by default – becoming something of a specialist in the WorkCover space. I have had to design my own processes for this, and to combine my counselling skills and my knowledge of the WorkCover system and health issues with an expert caring legal team for great outcomes for clients. I am still carving out my place in this space as it is unchartered territory.

Looking back to your final year as a student (before starting your counselling career), what are the top three pieces of advice you would give?

I would say: always keep learning, forever. Every person you will ever meet is an opportunity to learn about how people are unique, different and mysterious. Be kind, be gentle – including to yourself. Approach everyone with curiosity and interest. If you care, and engage authentically, you are off to a great start.

We may have an idea in our mind of where we are going, but life may offer you other opportunities of which you had never thought. It turns out I am effective in the medico-legal space, and that was never on my radar as something of interest.

Work on yourself always. Apply what you learn to yourself. See what you discover. Get to know yourself and keep growing. Find supports who believe in you.

Be curious, interested and always care for you first – you can't provide diligent care if you are not caring for you. Check in with yourself before and after work, every time.

Imagine yourself entering your first counselling session as a qualified counsellor. What is the knowledge or advice you wish you had had?

Have a basic structure of what you would like to explore. For example, in my couples counselling I follow the Gottman template for gathering a baseline of information to get an overview. In my individual counselling, I collect mental, physical, medical and social information to gain as complete a picture as I can to work from. Be curious, interested and always care for you first – you can't provide diligent care if you are not caring for you. Check in with yourself before and after work, every time.

Would you change your decision to become a counsellor or psychotherapist? Why?

I have taken many years and a journey to get to this point. For me, it's a natural progression to be here. I follow what I find intriguing and engaging, and I go where what I bring is wanted. There is endless scope in this field, so the sky is the limit.

What is your definition of counselling?

Well, I don't like to define things too definitively as I find it limiting. But, if I had to, I might say something like, it is about bringing oneself as a healing presence to a conversation with a person, caring about them, and exploring what's going on. It is about listening deeply, exploring difficulties and the human experience, and being a catalyst for peace and insight. Ultimately, we all want to feel good. ■

About the counsellor

Janina King
Master of Counselling; Bachelor of Education (Exercise Physiology); Diploma in Paramedicine, ambulance community officer/clinic transport officer/PEER Support; and crisis support worker.

Employed at: Janina King Counselling – registered counsellor (Bass Coast and South-East Melbourne); Ambulance Victoria – ambulance community officer, clinical transport officer, PEER Support (Victoria wide); Lifeline Australia – crisis support worker (Gippsland); Member ACA, ARCAP, Level 2.

So you want to be a counsellor ...

Marc de Bruin,
Counsellor and life coach

How do you describe the work that you do?

As an 'elevator pitch', I tell people that I assist businesses and individuals in working through and finding solutions for topics that affect people's mental health.

More to the point, I have been working as a life coach, counsellor and educator in private practice since 2005 (after first forging a career as barrister and solicitor in the Netherlands for nearly 10 years). To me, in contrast to practising law, counselling and mental health work only contains win-win scenarios. No-one ever 'loses' anything by talking to a counsellor (other than ineffective behavioural and thinking habits!). Most of my work on a day-to-day basis revolves around seeing clients (anywhere between 25 and 35 per week) in my office and via telephone or video sessions.

I also teach at the University of the Sunshine Coast and other vocational and tertiary education institutions. I have been running workshops and seminars, and I also write articles for online magazines and my blog. The clients I see have either sourced me privately or came to me via Employee Assistance Program (EAP) providers. I am registered with about eight of them and, between them and my private practice, they keep my calendar filled! Because I have been in the profession long enough, I now also practice as a counselling supervisor for registered counsellors and psychotherapists.

Do you love your work? Why?

I absolutely love what I do. It's an amazing ongoing realisation that I can work with fellow human beings and help them with their mental health questions so they can improve their situation. It is the most fulfilling work I have done so far in my career. I often say to clients – and I mean it – that is a great honour to have them share their personal stories with me and have them put their trust in our working relationship. It is also very humbling to hear people speak about their life, to ask me for help and assistance, and to realise that we all have a story to tell. Strangely enough, I often end my day feeling more energetic than when I started it in the morning. That to me means I must be doing something right. My simple life philosophy tells me, if the work I do gives me energy, I'm onto something good.

Looking back to your final year as a student (before starting your counselling career), what are the top three pieces of advice you would give?

Well, this depends on whether we take my law career or counselling career as a starting point. If we go with counselling, I would have to say:

1. Be proud to wear your 'counsellor' badge. No, we're not psychologists, and no, we're not social workers. We are counsellors, with a very specific skillset that is very much needed in our society. Counsellors are trained communicators and 'professional listeners', on top of being therapists – skills not everyone possesses.
2. Don't trip yourself up by thinking that there are no jobs for counsellors. This may have been the case many, many years ago (when psychologists

About the counsellor

Marc de Bruin
Master of Counselling; Graduate Diploma MiCBT (Mindfulness Institute); Diploma of Counselling; Diploma of Community Services; Master of Laws (Netherlands).

Counsellor, life coach, facilitator and tutor (sole trader). Sippy Downs, Sunshine Coast, Queensland.

and social workers were the preferred choice), but this has very much changed. Adequately trained counsellors are wanted more and more in the workforce because of their specific skillset. And my hunch is that this will only continue.

3. Be bold enough to profile yourself wherever you think a work opportunity exists, even if it initially seems beyond your reach or where a psychologist or social worker seems to be preferred. As a counselling supervisor, I always challenge my supervisees to keep knocking on the door. Many organisations are unaware of what counsellors can offer, and would happily hire one, if they were educated on this. There is a fair bit of ignorance in the field, still, and a good way to reduce that ignorance is to get out there and get noticed! As a Dutch saying goes: 'no' you have, 'yes' you can get (along the lines of: nothing ventured is nothing gained); the more you try, the more 'yeses' you will most likely attract. ■

If you're looking for a counselling job, I suggest doing the following:

- **Go for any 'counsellor' position you think would suit you.** Explain that you are a qualified professional, and that you are willing to learn and upskill on the job. Obviously, do this within reason; don't go for a role where a minimum of 10 years' experience is required, or a specific degree that you don't have. Many positions advertised as 'counsellor' require a psychology or social work degree and membership of the Australian Health Practitioner Regulation Agency or the Australian Association of Social Workers. On the other hand, I have applied for roles where initially psychologists were wanted, but – after some psycho-education from me – the employer was willing to hire a counsellor instead. I have never let a job description stop me from applying (unless it was totally out of my reach). You will get a few more 'no, sorry' replies if you work this way, but your chances of landing that first paid job go up quite dramatically.
- **Have a great resume and LinkedIn profile!** These are your business card to the potential employer. Maximise your transferrable skills. Even if you have experience in a totally unrelated field (lawyer, in my case), you will have picked up many, many skills that you can use in counselling. Highlight those! Interpersonal communication, critical thinking, sound administration and compliance skills, problem solving, working with challenging personalities, eye for detail, good communication skills, etc., etc. And if counselling is the first job you've sought, highlight the fact that your knowledge is up to date with the latest developments, that you are still fresh and unbiased, that you're eager to learn, and that you have stacks of energy to apply to the role.
- **Network, and network some more.** Write to GPs; contact local community organisations; volunteer in mental health-related fields; become a member of your local Chamber of Commerce or other local networking groups (Business Network International, privately run business network groups); contact and form relationships with Allied Health professionals for mutual referrals, etc.
- **Keep adding new knowledge and practice to your skillset,** even at your own expense (if you don't have a job yet). The more knowledgeable and experienced you are, the more employable you will become.
- I often jokingly say that the older and greyer you get, the more valuable you become in this industry. Add experience and knowledge on top of this, and I am very hopeful that you will ultimately carve out a great counsellor position for yourself, which will last you as long as choose to remain involved in the industry.

So you want to be a counsellor ...

Michelle Sparkes,
Supervising Counsellor,
Butterfly Foundation

Tell us about your work.

I work with individuals, 16 years and older (and their families, carers and partners, as appropriate), to help them recover from the grip of disordered eating and body image concerns. Ultimately, these issues reflect a way of coping with challenging self and life experiences.

I love this work and have been helping individuals recover from disordered eating for over 25 years. I take a holistic, whole-person approach to these challenging health and life-consuming problems, drawing on my professional experience as a physical and mental health clinician, and my lived experience of anorexia, eating disorder not otherwise specified (EDNOS) (now called OSFED – other specified feeding and eating disorders) and binge eating in my teen and early adult years. I also work as a supervising counsellor for the Butterfly National Helpline (Australia's national charity for eating disorders), providing oversight, training and supervision to helpline counsellors and working directly with consumers to provide information, support, guidance and referrals.

Do you love your work? Why?

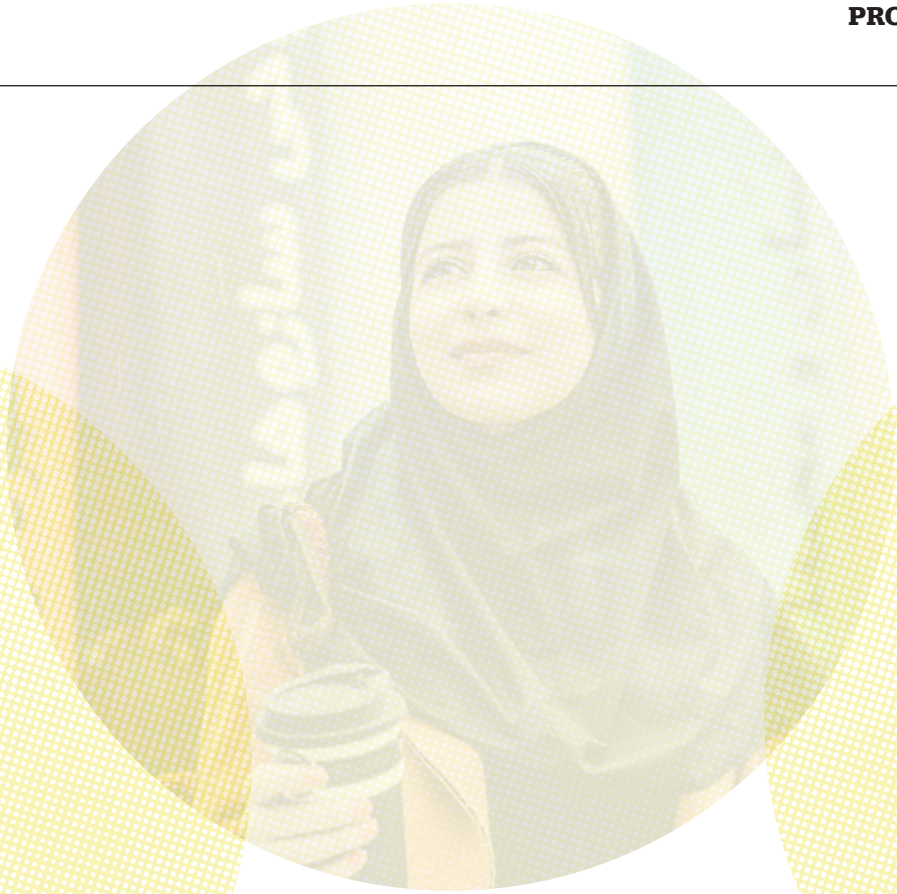
My work at Butterfly gives me the opportunity to provide in-the-moment support to consumers and to invest in the training, upskilling and supervising of new/er counsellors. My private work gives me the opportunity to work with individuals in a deeper, more substantial way and to witness their transformation over time. It is a pleasure and a privilege to do this work.

Looking back to your final year as a student (before you started your counselling career), what are the top three pieces of advice you give?

1. There are no stupid questions. Glean as much as you can from the practitioners you are learning from – your questions and their answers will help everyone.
2. Value the relationships and the different perspectives and life experience of your teachers and colleagues. You are members of the counselling body, and we are all richer for our diversity of insight, understanding and experience.
3. Volunteer for role-plays – these are rich opportunities for learning. Hearing and feeling yourself respond to a counsellor's presence, tone, attitude and questions are incredibly valuable and you may never have a better opportunity to do this.

Imagine yourself entering your first counselling session as a qualified counsellor. What is the knowledge or advice you wish you had had?

Relax, you don't need to know everything. Put your training and



About the counsellor

Michelle Sparkes B. App Sc (Physiotherapy), Grad. Cert. Emotion Focused Counselling, Credentialed Eating Disorder Clinician, MACA, CEDC (ACA Membership Level 2).

Principal, Michelle Sparkes, Women Worth their Weight, Manly NSW; supervising counsellor, The Butterfly Foundation National Helpline, Crows Nest NSW.

expectations to one side and focus on the person in front of you. Your capacity to connect with this person, to understand their needs and concerns and their hopes and desires is the most important thing for you to focus on right now. Be present, be warm, be relaxed, listen, listen, listen, never assume, observe, reflect, respond and let this process gently unfold and guide you.

Would you change your decision to be a counsellor or psychotherapist? Why?

I love being a counsellor in the eating disorder space – it's a bit of an umbrella term, but it allows me the opportunity to provide the support that is right for the person I'm working with.

A frustration for me is that, despite being registered as a counsellor since 2006 and amassing a huge amount of clinical experience and further training, I can't offer my clients the benefit of a Medicare rebate under the Eating Disorder Plan, while a psychologist with the eating disorder credential can. Nor can I (based on my current ACA level) offer my clients much in the way of health fund rebates. It's a frustration for me and a disadvantage for my clients. I am a credentialed eating disorder clinician, I've worked in the eating disorder recovery space for over 25 years, I've authored books and developed eating disorder recovery programs and training, I've supervised counsellors on the Butterfly Helpline for the past three years and I've helped hundreds of people recover from disordered eating in private practice. This Medicare rebate regulation doesn't feel like a match or true reflection of my accumulated training, knowledge, skills and experience.

There are no stupid questions. Glean as much as you can from the practitioners you are learning from – your questions and their answers will help everyone.

What is your definition of counselling?

I like this definition: Professional counselling is a safe and confidential collaboration between qualified counsellors and clients to promote mental health and wellbeing, enhance self-understanding and resolve identified concerns. Clients are active participants in the counselling process at every stage. ■

COUNSELLING IS ...

We asked counsellors how they would define counselling. Some of their responses are below.

a dyadic experience where one is able to hold a safe (professional and ethical) space for another to explore the self.

a therapeutic service where people can access as series of modalities including talking, somatic and expressive therapies with the goal of alleviating distress and promoting overall wellbeing

a professional activity with the purpose of utilising an empathetic interpersonal relationship between therapist and client to help the client make changes in their lives through the resolution of personal, relational or psychological problems. This is achieved by the counsellors providing professional training, experience and insight to their clients

seeing the person as a whole and helping the individual to explore that themselves, taking into consideration all the complex influences that make each individual who they are ... seeing the messy, complex whole of a person

a service provided by a registered or licensed practitioner

active listening and reframing in a non-judgemental, solutions-focused partnership

an essential service within the mental health system, providing psychological interventions that support the consumers' journeys through rehabilitation and recovery

talk therapy for improving mental health

Facilitating change through listening and engaging with the client in a collaborative relationship

is a process of helping and empowering an individual or group clarify issues of concern to them and explore possible solutions through goal setting

the process of supporting people within a non-judgemental therapeutic relationship, to work through personal, social, emotional and psychological issues and difficulties, with the purpose of managing these better and improving mental health and wellbeing. The process can use a variety of therapeutic modalities and approaches. It includes shorter solution-based processes through to longer term approaches that explore the deeper roots and patterns that contribute to issues and difficulties. It may be talking-based but can also include therapies that work with the body and creative expression

empowering people to develop strategies to manage and heal their phobias and addictions ... in order to live a full and happy life

THE SHADOW OF CHILDHOOD SIBLING LOSS IN ADULT RELATIONSHIPS

CONTENT WARNING
The following article contains stories and depictions of the deaths of children, sibling loss and grief. This content may be disturbing to some readers.

By **Benjamin Croot** and **Zoë Krupka**

ABSTRACT
Losing a sibling in childhood is a devastating experience that can negatively impact a person's health, self-image, family dynamics and future interpersonal relationships. This study is a small research project in which four participants were interviewed about their experience of sibling loss during childhood. The use of semi-structured interviews allowed for the participants to share their rich experiences of childhood sibling loss. Through the use of interpretative phenomenological analysis (IPA), three major themes were identified: older siblings taking on more responsibility in the family, emotional independence rather than interdependence, and a loss of innocence. Subthemes included increased self-responsibility and a greater responsibility for younger siblings following the loss. These themes provide a deeper experiential understanding of the persistent effects of sibling loss on adult relationships, and how the experience of sibling loss can alter the surviving siblings' outlook on the world.

BACKGROUND

On the authors

The authors of this article have a personal connection with the experience of childhood sibling loss. This, combined with a deep passion for developmental psychology and the ways in which early experiences shape an individual's worldview, formed the foundation of interest in this subject matter. Upon delving into the subject and noticing gaps in the literature, the authors saw an opportunity to add to the understanding of childhood sibling loss and hope to contribute meaningful research that may be used to enrich the lives of others.

On the literature

The negative impacts of sibling loss can last a lifetime and fundamentally change the way a person sees the world. Significant and varied negative outcomes of this type of loss have been identified over the past 20 years. These include negative effects on family structure (de Andrade et al., 2018; Funk et al., 2018), feelings of unresolved grief across the lifespan (de Barros & da Encarnação, 2018; Howard Sharp et al., 2018) and persistent higher rates of depression in the sibling-bereaved population (Burns et al., 2020).

Sibling bereavement is an under-researched area across family bereavement studies (Funk et al., 2018). Within this limited research, very few studies that examine sibling loss (de Barros & da Encarnação, 2018; Funk et al., 2018; Jonas-Simpson et al., 2015) are qualitative in design.

Photo: Annie Spratt/Unsplash


Photo: Annie Spratt/Unsplash

What the quantitative studies do not adequately capture is the lived experience of a sibling-bereaved individual. For example, while it has been found that people who lose a sibling in childhood have higher rates of substance abuse disorders (Burns et al., 2020), it is not known why this is the case, why individuals use these substances, what substances are being used and at what stages in life it occurs.

Mental and physical health

Sibling loss in childhood has been observed to result in numerous negative outcomes such as higher levels of substance use disorders (Burns et al., 2020), learning disabilities (de Andrade et al., 2018), psychosomatic symptoms (de Andrade et al., 2018) and higher anxiety and depression (de Barros & da Encarnação, 2018; Funk et al., 2018). Although these outcomes have been noted, it is not yet understood why these outcomes occur or how they are experienced. The missing component of many prior studies is the lack of the phenomenological experience being captured.

Exploring that phenomenological experience through semi-structured interviews and phenomenologically focused analysis is the core of what this study aims to do (de Barros & da Encarnação, 2018).

Family dynamics

A common theme identified in the literature is that when multiple siblings are present, the oldest surviving sibling will often take on a caregiver role to their younger siblings (de Barros & da Encarnação, 2018; Funk et al., 2018). This often comes as a result of the parents undergoing a grieving process and being unable to fulfil their previous duties (Funk et al., 2018). Adopting this caregiving role can increase the level of expected responsibility and the level of stress experienced by the child (Funk et al., 2018).

Jonas-Simpson and colleagues (2015) identified four major themes that impact a child post-sibling loss. These were:

- the connection and integration of the deceased sibling into their lives;
- the impact of parental grief on the child's grief;
- navigating stigma and judgement to find support; and
- growth in compassion and empathy.

Of particular note is the theme of parental grief impacting child grief. Jonas-Simpson and colleagues (2015) found that children may supress or downplay their emotions and engage in a form of role-reversal where they act as a caregiver to their parent. This is similar to the established caregiving role adopted toward fellow siblings. While this study serves as an excellent foundation by identifying potential themes, these are not explored long term and, therefore, there is limited data on how these themes manifest in adult life.

Adult relationships

Some studies that identified common themes related to interpersonal relationships did so through narrative analysis of a sibling-bereaved individual's stories (Funk et al., 2018) and analysis of effective interventions through

TABLE 1 DEMOGRAPHICS

Name	Gender	Age	Age at the time of sibling death	Sibling age at time of death	Cause of sibling death
Layla	Female	47 years	4 years	2 years	Childhood illness
Amber	Female	35 years	4 months	4 months	Sudden death
Gemma	Female	70 years	8 years	5 years	Childhood illness
Andrew	Male	54 years	8 years	17 years	Accidental death

All four participants described significant negative effects stemming from the loss of their sibling and spoke at length about the connections they made between this historical loss and their way of being in relationships and in the world.

quantitative surveys (Howard Sharp et al., 2018). These narrative studies touch on themes such as trepidation in forming close bonds, but they do not capture the individual's reflection on their own feelings in these relationships in the way that an interpretative phenomenological analysis (IPA) study does (Miller et al., 2018; Smith et al., 2009).

There does exist some research into this field using IPA, such as de Barros & da Encarnação's 2018 study. They aimed to capture phenomenological experiences and found that participants reported unease when forming new bonds with people, with the main reason being a fear of losing someone again and re-experiencing grief. Participants also perceived themselves to be controlling or overbearing in relationships, which was attributed to a fear of situations beyond their control (de Barros & da Encarnação, 2018). These results do indicate that there may be adverse impacts on the interpersonal relationships of sibling-bereaved individuals; however, there would need to be more research into this field. That is what this study aimed to achieve. By adopting a phenomenological approach and focusing specifically on the impact on interpersonal relationships, we aimed to build upon the established literature.

METHOD

Participants

The four Australian participants (three female and one male) in this study were all adults between the ages of 35 and 70, currently residing in Australia. The participants all experienced sibling loss prior to the age of 15, with traumatic causes of death such as murder or suicide being excluded to minimise potential comorbidities (de Barros & da Encarnação, 2018). The participants were also all parents of children five years and older. Each online interview was approximately 45 minutes, with questions relating to key areas of relational experiencing such as forming close bonds, levels of perceived support and feelings of interpersonal compassion.

Analysis

The interview process and analysis was conducted using IPA. IPA is best suited to small sample sizes in which the groups are mainly homogenous (Pietkiewicz & Smith, 2014, Smith et al., 2009; Miller et al., 2018) and is congruent with the research question of the study because of its focus on how people reflect on the experience of a specific phenomenon in context (Larkin & Thompson, 2011; Miller et al., 2018; Smith et al., 2009). While generalist hermeneutic analysis aims to describe lived experience (Miller et al., 2018; Starks & Trinidad, 2007), IPA adopts a double hermeneutic approach, interpreting how the participant makes sense of their own lived experience (Miller et al., 2018; Smith et al., 2009). IPA was chosen over other types of analysis such as transcendental or hermeneutic specific methodologies because of this focus on a doubling of the reflexive process (Miller et al., 2018).

Findings and discussion

All four participants described significant negative effects stemming from the loss of their


Photo: Annie Spratt/Unsplash

sibling and spoke at length about the connections they made between this historical loss and their way of being in relationships and in the world. They viewed this loss as a significant life event that shaped their close adult relationships. Amber echoed the sentiments expressed by each participant when she described her life after the loss as "surviving, not living". Their stories present three superordinate themes: taking on parenting responsibility, emotional independence and a loss of innocence.

Present were also subthemes including personal responsibility and care for others, emotional independence in relationships, understanding death and the search for justification.

Theme 1: Taking on parenting responsibility

For the participants in this study, the death of a sibling often resulted in older siblings taking on more responsibilities. Each of them spoke in depth about helping take care of younger siblings and those who were elder siblings described an outright role-reversal where they acted as a caregiver to the parent following the loss. The existing literature describes how older siblings often feel as though they need to 'step up' and fill a parental role for their younger siblings following the loss of a sibling (de Barros & da Encarnação, 2018; Funk et al., 2018). Sibling loss studies have shown that even siblings who only became the eldest after the loss also reported similar feelings of taking on more post-loss responsibility (de Barros & da Encarnação, 2018; Funk et al., 2018). Children who have lost their siblings have also reported tempering their needs in order to protect their grieving parents (Jonas-Simpson et al., 2015)

Layla had a second sister who was born after the death of her younger sister. She described herself as being a "second mum" to her young sister and described her younger sister as a "saviour" due to a large amount of attention being directed toward her and away from the family's grief. Layla also described an "adultness" to the relationship with her parents, stating that she felt as though she had to take care of her grieving parents following the loss. She believed her experience and relationship with her parents is different to the experience her sister had. She felt she missed out on being parented and in a close relationship with her parents.

Amber spoke of feeling as though she grew up more quickly than most children. She was able to cook her own meals at the age of six, stepping up into this role due to her mother being "so consumed with grief". Gemma's mother died not long after the death of one of her younger brothers. This left Gemma, her youngest brother and their father. She said that her father was "clueless" after both deaths and that grief made her father more absent, which forced her to

The study also identified subthemes including personal responsibility and care for others, emotional independence in relationships, understanding death and the search for justification.

act as caregiver to her younger brother. Although she feels as though she was able to process the loss and come to terms with her grief, she did not feel that the same could be said of her brother. Andrew was the youngest of six siblings. After the loss he spoke about how the siblings would take care of one another and how, as the youngest, he was often the recipient of this care. All of the participants provided examples of an experience of role-reversal in the family, where the child takes on a caregiving role to the parent, echoing some of the sibling loss findings in the early research literature (Jurkovic, 1997).

The ability to process grief and an awareness of death following sibling loss is something experienced more by older than younger siblings (de Barros & da Encarnação, 2018; Funk et al., 2018). Andrew stated that he did not quite understand death until much later in life, and this was similar to Gemma's recollection of her younger brother not processing the death of their sibling until he was much older. Layla also reflected on how she perceived her younger sibling's handling of the loss, saying that her sister was "massively impacted" by being born into a family that had experienced this loss. It would be useful in future to interview more siblings of different ages to examine the role that birth order may play in this theme.

Theme 2: Emotional independence

Another superordinate theme was emotional independence. Participants often showed pride in their ability to take care of themselves and their ability to not have to rely on others. They were not avoidant of relationships, but they feared dependency within them.

In 2018, de Barros & da Encarnação conducted an IPA study of adults who lost a sibling during childhood. Many of their participants spoke of trepidation when it came to getting attached to others, due to the fear of re-experiencing loss. Similar to the findings of this study, these individuals did not avoid relationships, but they were cautious of who they became attached to and who they allowed themselves to be emotionally vulnerable with. They also expressed a desire to be in control in the relationship – something also present in our findings and in those of Funk and colleagues (2018) and Howard Sharp and colleagues (2018), whose studies into sibling bereavement also found a persistent need for control in intimate relationships.

Layla said that she feels "independent emotionally" and expressed that she found it easy to manage her emotions alone.

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She stated that when it comes to intimate relationships, she has a desire to "be parented" and for someone to "absolutely adore" her but also that she is quite good at ending relationships, which she attributed to the fact that she is not reliant on them. Amber stated that she had issues with commitment and often found it difficult to get close to people. She also expressed that she found it easy to terminate relationships and was not particular bothered by them ending, stating: "I don't give a shit if my husband walks out on me tomorrow". She was clear that this was not due to a lack of love for her husband or a lack of desire to be in an intimate relationship, but rather that it was reflective of her desire to not be dependent on someone else. She said that she "didn't allow" herself to become reliant on others due to a fear of experiencing loss again. Amber also used the term "surviving" to describe living in this careful, guarded way. She got through many hardships due to her emotional strength and her ability to survive emotionally on her own, describing the experience as "surviving, not living". Gemma also spoke of survival, describing herself as a survivor of this experience of sibling loss. For Gemma, this survival was similarly conceptualised as her ability to handle her emotions on her own. When it comes to forming relationships, she explained that she does not have a consistent group of friends and that, often, she can lose contact with people and she is not too bothered by this. She did not describe her friendships as being close and says that she has "let go of people too easily".

Andrew, who was the only youngest sibling in the group, described himself as someone who is friendly and can form friendships easily, but also can just as easily abandon them. An important qualifier here is that when asked whether these relationships ending bothers him, he states that it does not, "as long as it's me ending it".

Theme 3: Loss of innocence

Loss of innocence reflects how sibling-bereaved individuals face the inevitability of death and the unfairness of the world much earlier than many people and the participants here were very aware of this outlier position. They spoke about how other children would not share their style of thinking this early in life, indicating that they noticed a difference between a normative experience and their own.

Layla said that the loss of her sibling gave her an awareness that life is temporary. She stated that she feels most people go through life not being aware of death or believing it will not happen to someone close to them. She believed that she is different from others in this regard. Layla said that she knows that no-one will be here forever and has accepted death as an inevitable part of life that is not to be feared. Amber spoke of how "the universe is bullshit and unfair". She often questioned why the loss occurred, wondering why her twin brother had died and not her, saying that her brother never got a chance at life and it was unfair and cruel that he was taken from her so young. She often wonders what life would look like had he survived, or what life would look like had she died. Gemma stated that she was not prepared for that type of experience and believes that children often are not ready for it. She said that prior to the death she did not have much of an understanding of death, and the unexpected confrontation of it was difficult to handle. She described the sudden loss as being "terrifying". The belief that her sibling would be a lifelong partner and then having that ripped away was confronting. She also expressed that she realised everything was temporary and that this realisation came "much too early". She often compared herself to others, believing that other people did not have the same understanding of death and the temporary nature of life as she did.

Andrew, in contrast, spoke of how he did not fully understand death until much later in life, stating that he believed his deceased brother to be "still somewhere in the world". Apart from gender (Schmiege et al., 2006), birth order is one difference between Andrew and other participants, which could possibly be a factor in creating this difference in experience in a similar way to the theme of taking on more responsibility. Older siblings taking on a more caregiving role with younger siblings may be a protective factor that results in younger siblings not having the same early awareness of the finality of death (Gass, Jenkins & Dunn, 2007). Gemma stated that she believed her younger brother never truly processed the concept of death, and Layla stated that her younger sister's experience was different than her own. Future research could explore the possibility of moderating effects

that older siblings may have on a younger sibling's experience of sibling loss. Jonas-Simpson and colleagues (2015) found that sibling-bereaved children often feel that their grief is not taken seriously by others and that their emotional needs were not met. de Barros & da Encarnação (2018) also touched on how there is often a search for justification of the death among sibling-bereaved individuals.

CONCLUSION

This study identified three major themes and subthemes, which provide insight into how the experience of losing a sibling during childhood affects adult relationships. A potential area for future research is to examine the differences between younger and older siblings. This could be expanded upon further to examine the potential mediating effect that having multiple older siblings may have on the youngest sibling. The sample was not as homogenous as it could have been as three of our four participants were female. The difference between how males and females process and experience death may also be a contributing factor in the differences in outcomes. Research indicates that males and females process grief differently following the death of a parent, with females being more internalising and males exhibiting more externalising behaviours (Schmiege et al., 2006). This could be explored further to examine whether the same difference exists with the processing of grief following a sibling death.

It is clear from these findings and previous research that the experience of sibling loss has impacts on individuals that persist into adulthood, impacting multiple facets of life including self-image and relationships. This study has supported themes found in prior literature, such as the experience of taking on more responsibilities and the desire for emotional independence in relationships (de Barros & da Encarnação, 2018; Funk et al., 2018; Howard Sharp et al., 2018; Jonas-Simpson et al., 2015) amongst those bereaved by sibling loss in childhood. This study has also found a new theme of a loss of innocence, which encapsulates the experience of being confronted with concepts such as death and the unfair nature of the world at a young age. Finally, it is unclear how secondary factors such as gender, birth order, age, cause of death or other life experiences may impact both current and past findings. More studies designed to address these dimensions will be useful in determining how these factors affect the long-term outcomes for this population. ■

It is clear from these findings and previous research that the experience of sibling loss has impacts on individuals that persist into adulthood, impacting multiple facets of life including self-image and relationships.

References

Briegel, W., Greuel, J., Stroth, S., & Heinrichs, N. (2019). Parents' perception of their 2–10-year-old children's contribution to the dyadic parent-child relationship in terms of positive and negative behaviors. *International Journal of Environmental Research and Public Health*, 16(7). https://doi.org/10.3390/ijerph1607112

Burns, M., Griese, B., King, S., & Talmi, A. (2020). Childhood bereavement: Understanding prevalence and related adversity in the United States. American *Journal of Orthopsychiatry*. https://doi.org/10.1037/ort0000442

de Andrade, M. L., Mishima-Gomes, F. K. T., & Barbieri, V. (2018). Children's grief and creativity: The experience of losing a sibling. Psico-USF, 23(1), 25–36. https://doi.org/10.1590/1413-82712018230103

de Barros, R. & da Encarnação, S. (2018) Losing a brother until adolescence: Experience in adult life. *Journal of Nursing UFPE / Revista de Enfermagem UFPE*, 12(9), 2349–2360. https://doi.org/10.5205/1981-8963-v12i9a23 6401p2349-2360-2018

Edgar-Bailey, M., & Kress, V. (2010). Resolving child and adolescent traumatic grief: Creative techniques and interventions. *Journal of Creativity in Mental Health*, 5(2), 158–176. https://doi.org/10.1080/15401383.2010.485090

Funk, A. M., Jenkins, S., Astroth, K. S., Braswell, G., & Kerber, C. (2018). A narrative analysis of sibling grief. *Journal of Loss and Trauma*, 23(1), 1–14. https://doi.org/10.1080/15325024.2017.1396281

Gass, K., Jenkins, J., & Dunn, J. (2007). Are sibling relationships protective? A longitudinal study. *Journal of Child Psychology & Psychiatry*, 48(2), 167–175. https://doi.org/10.1111/j.1469-7610.2006.01699.x

Herberman Mash, H. B., Fullerton, C. S., & Ursano, R. J. (2013). Complicated grief and bereavement in young adults following close friend and sibling loss. *Depression and Anxiety*, 30(12), 1202–1210. https://doi.org/10.1002/da.22068

Hoffmann, R., Kaiser, J., & Kersting, A. (2018). Psychosocial outcomes in cancer-bereaved children and adolescents: A systematic review. *Psycho-Oncology*, 27(10), 2327–2338. https://doi.org/10.1002/pon.4863

Howard Sharp, K. M., Russell, C., Keim, M., Barrera, M., Gilmer, M. J., Foster Akard, T., Compas, B. E., Fairclough, D. L., Davies, B., Hogan, N., Young-Saleme, T., Vannatta, K., & Gerhardt, C. A. (2018). Grief and growth in bereaved siblings: Interactions between different sources of social support. *School Psychology Quarterly*, 33(3), 363–371. https://doi.org/10.1037/spq0000253

Jonas-Simpson, C., Steele, R., Granek, L., Davies, B., & O'Leary, J. (2015). Always with me: understanding experiences of bereaved children whose baby sibling died. *Death Studies*, 39(1–5), 242–251. https://doi.org/10.1080/07481187.2014.991954

Jurkovic, G. J. (1997). Lost childhoods: T*he plight of the parentified child*. Brunner/Mazel.

Larkin, M., & Thompson, A. R. (2011). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101–116). Wiley-Blackwell.

Miller, R. M., Chan, C. D., & Farmer, L. B. (2018). Interpretative phenomenological analysis: A contemporary qualitative approach. *Counselor Education & Supervision,* 57(4), 240–254. https://doi.org/10.1002/ceas.12114

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, 20, 7–14. doi:10.14691/CPPJ.20.1.7

Schmiege, S. J., Khoo, S. T., Sandler, I. N., Ayers, T. S., & Wolchik, S. A. (2006). Symptoms of internalizing and externalizing problems: Modeling recovery curves after the death of a parent. A*merican Journal of Preventive Medicine*, 31(6), 152–160. doi:10.1016/j.amepre.2006.07.004

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, and research*. Sage Publishing.

Starks, H., & Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research*, 17, 1372–1380. doi:10.1177/1049732307307031

Stocker, C. M., Gilligan, M., Klopack, E. T., Conger, K. J., Lanthier, R. P., Neppl, T. K., O'Neal, C. W., & Wickrama, K. A. S. (2020). Sibling relationships in older adulthood: Links with loneliness and well-being. *Journal of Family Psychology*, 34(2), 175–185. https://doi.org/10.1037/fam0000586.supp (Supplemental)

United Nations, General Assembly (1981) *International Youth Year: Participation, Development, Peace*. A/36/215

Appendices

TABLE 1 QUOTES THAT SUPPORT THEME 1: TAKING ON PARENTING RESPONSIBILITY

Participant			
Layla	Amber	Gemma	Andrew
"I lived with grieving parents who- who were really messed up."	"The answer to your question is a flat-out no." (in response to question about whether she felt supported).	"I needed someone who knew how to listen and who could just let me unload."	"You can share that experience with five siblings or uhh four other siblings and umm … comfort each other."
"Our family dynamic was completely impacted by it."	"I felt like I had no-one there prote- to protect me."	"My father was completely clueless."	"I haven't really had this … had this conversation with my siblings like how did it affect them?"
"The impact all the way through my life has been about their [parents,] reaction to- to the grieving uh and how it altered their relationship with me."	"I knew how to make my own food, because my mum was so consumed with grief that she couldn't take care of us."	"[younger brother] said he wanted to know what dad thought of him, because he never said."	"I think we all sort of watched out for each other."
"I didn't sort of feel that connection that- that a lot of people seem to feel with their parents."	"What six year old knows how to cook their own food? Or knows how to steal? Or you know clothe themselves?"	"Absolutely not" (in response to a question about whether she felt supported by her father).	"Probably being the youngest it was more receiving that care."

TABLE 2 QUOTES SUPPORTING THEME 2: EMOTIONAL INDEPENDENCE

Participant			
Layla	Amber	Gemma	Andrew
"I think that mas- has made me quite independent emotionally."	"I am so petrified of it happening to my- to my ch- children."	"Well that things will happen again" (in response to a question about what her anxieties were).	"Like I can you know have- get … get close to people pretty easily but probably just as easily drift apart."
"I think I'm quite good at um … uhh … pulling out of relationships because I'm not reliant on them."	"I've always had issues with commitment."	"I wouldn't cry about things I wasn't- I didn't have an immediate emotional response to things."	"I will probably describe myself as someone who's quite friendly to people umm … and can go into any sort of talk *laughs* you know but may just as easily abandon them."
"I definitely don't rely on anyone."	"I always figured if something always happens, and this is the mindset you get into, if that something happens, 'Eh, doesn't matter, I've dealt with worse."	"So in a way I'm the survivor."	"As long as it's me ending it" (in response to question about whether was unphased by relationships ending).
"There's not much point in sharing my stuff because I don't really believe they're … I think, you know they've got their own stuff."	"I didn't have a serious relationship until I was in my 30s."	"Sometimes think I've let people go too easily."	"They'd (older siblings) wanna be independent and not have a little … little brother hanging around."

TABLE 3 QUOTES SUPPORTING THEME 3: LOSS OF INNOCENCE

Participant			
Layla	Amber	Gemma	Andrew
"I think that it has meant that I am very aware that life is temporary."	"The universe is bullshit and unfair"	"Understanding much much too early that- that everything is temporary."	"I didn't understand what that meant. Um, I thought he was still somewhere in the world."
"They [parents] were pre-occupied with their own grieving. So I think that mas- has made me quite independent emotionally."	"Why did it happen?"	"My main rival suddenly being taken away like that it's very difficult."	"I didn't really understand it until my late 20s when my mother died."
"I feel like umm … yeah I never take for granted that I'm gonna be here forever or that anyone else is."	"He was meant to survive, not me."	'NA'	"I don't know how it affected me um, I'm not really conscious of … yeah."
"That gave me a pretty early understanding of what- um … yeah what life was and how it- it could disappear."	"There was no reason for him to … there's no reason for SIDS, like there's no reason for him to die and it's just bullshit and unfair and it's cruel."	'NA'	"I guess I was the least affected probably."

OMISSIONS, LACUNAE AND OCCLUSIONS: HOW GAPS ADVERSELY AFFECT THE GROWING CHILD AND THE IMPACT IN LATER LIFE

By **Coleen Jones**

Abstract
The author contrasts the effects of acts of commission (trauma) with the effects of acts of omission, experiences that are often excluded from consciousness, becoming almost invisible. This paper examines how clients are impacted as young children when actions deemed essential to their development, security and wellbeing fail to happen – in other words, they are omitted, for whatever reason, leaving psychic occlusions that are interpersonally confusing in later life. It gives examples of how adverse childhood experiences (ACE) – as observed in neuroscientific studies – negatively affect individuals and hamper the fragile architecture of the child's developing brain, often leading to individuals experiencing insecure attachment and difficulties in adulthood and in maintaining good interpersonal relationships.

Introduction

Two categories of crimes are defined in jurisprudence (law). They are acts of commission and acts of omission. The verb 'act' itself indicates that an action has taken place. An act is defined as a bodily movement in relation to an identifiable person or object. A criminal act of commission occurs when something injurious – an act – is committed by an alleged perpetrator, such as theft or assault. While an act of omission describes an action that should have been performed by an individual under the law, but which fails to happen – the action is omitted. Examples of this are tax evasion and child protection issues (such as failing to provide adequate care or neglecting a child's emotional needs). Commission refers to committing harm, while omission is about failing to act.

Clinical considerations

Analogously clients present in therapy with symptoms of distress and confusion, with 'symptoms' falling into one of these two categories. Acts of commission cause injury, suffering and harm; these are acts that have been deliberately perpetrated against the client, such as assault, rape, child sexual abuse, arson, terrorism or bullying. We can list a vast range of 'bad' things perpetrated against clients that present in therapy. In certain instances, because of the seriousness of the injury, the trauma may be repressed and the client temporarily dissociated from the experience.

Photo: 123rf


Photo: 123rf

We know that with safety, a secure base, a good working alliance with the therapist and sufficient 'slow' time, the client can begin to explore what happened and begin to understand what may have been repressed.

It is clear from the work of neuroscientists and trauma experts such as Babette Rothschild and Bessel van der Kolk that clients initially need support to establish a secure therapeutic base from which to explore details of the injury. We know that with safety, a secure base, a good working alliance with the therapist and sufficient 'slow' time, the client can begin to explore what happened and begin to understand what may have been repressed. Bringing the client into the 'presentness' of time is efficacious. This might be referred to as 'present remembering', which facilitates healing and may hopefully bring clarity and ease.

Moving on to what I regard as acts of omission; often, clients falling into this category are referred to therapy for non-specific symptoms. They may present with difficulties in interpersonal relationships, an inability to sustain relationships, often with a history of going from therapist to therapist in an attempt to try different approaches. (I use the term 'therapist' to include a wide range of mental health practitioners.)

These clients are frustrated because they are not getting to the nub of the issue, confused because they do not know what is seemingly wrong with them and puzzled because their siblings may all be doing well and their parents may be elderly and kind. They cannot seem to remember anything really 'bad' or traumatic happening to them as children. They often worry reactively that they may have been sexually abused or have experienced some other trauma when they were young, without having any clear recall in the present. The workplace and their intimate relationships seem to be the areas where their difficulties play out and where they experience a great deal of turbulence. These clients may go from job to job, relationship to relationship and therapist to therapist, still unable to manage the demands of these relationships. They often feel disgruntled with therapists and may be referred to as 'borderline'. This leads them to question, "What is wrong with me?" They consequently believe that they are defective or lacking in some undefinable way. This undermines their confidence. They lose faith in themselves and others, especially therapists. It causes them great distress and fear. They may feel misunderstood and, in turn, respond aggressively. They are left perplexed and wondering why other people are so disagreeable when they (the clients) are so pleasant and considerate. It may lead them to the ask, "What is wrong with others?"

Either way, there is a confusing conundrum facing the client, who is suffering, fearful, despairing and feeling alienated from others. The

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client is mystified and left feeling frustrated. There is a negative progression of their symptoms and experiences, as they feel worse and worse, mostly disgruntled and disappointed with family members and a swathe of health professionals who they believe are incapable of pinpointing the problem. They may resort to medication, which might add another 'fuzzy' layer to the depth of the confusion. As one woman said in therapy, "I am not anxious nor am I depressed – either way, medication is not going to help." She feels confused and anxious realising she does not know, but she knows that something is amiss.

Health professionals, psychiatrists and counsellors, along with psychologists and psychotherapists, might pause to question themselves, "How do we get to know what we do not know?" In the book *The Little Prince*, de Saint-Exupery suggests that to "know yourself" is to be known by another and that living is about being born … slowly. This process of discovery relies on a level of intuition on the part of the therapist who is willing to explore the client's history intuitively and carefully using inductive reasoning appended to what I call 'whispers' that the client might bring in the form of dream images, associations, mistakes, parapraxes (Freud) and projections. These usually point to some or other omission or occlusion where something has been left out of awareness.

Vignette 1

The author, drawing from her own clinical experiences, presents a plethora of cases creatively woven together in order to maintain client confidentiality, which illustrate some of the gaps and lacunae that might cause confusion and distress.

Mary, a new client, begins her first session by telling the therapist that she had a dream about her (the therapist) the previous night. Mary laughs as she shares her dream in which she saw the therapist in her car that had a registration plate numbering 1984. The therapist waits judiciously before asking Mary what had happened that was significant to her in the year 1984. Mary was surprised, became tearful and then related how, in 1984, she had found herself struggling to cope when her eldest sister – who was put out for adoption as an infant and who was never mentioned or spoken about – contacted her mother and wanted to connect with Mary and her brother.

If we think of therapy in relation to acts of omission, we find that a significant fact, event, experience or person has been omitted from the client's awareness. In the case cited above, Mary was not aware of having an older sister. She was not able to understand why her mother was always detached and distant from her during her childhood. As a child she assumed that it must be her, Mary, who was unlovable or deficient in some way. In time, the full picture unfolded to reveal that, during Mary's childhood, her mother was grieving the loss of her first-born daughter and hiding her shame at conceiving out of wedlock. Consequently, Mary grew up with the belief that she was deficient and unable to draw or hold love to her. When someone is left out of conscious awareness, it affects the entire family system. The system needs to remember, needs to bring into consciousness the missing person, family member or facts. It needs to bring what has been omitted back into conscious awareness in order to fully understand the emotional turmoil, influences and misunderstandings that, over the years, have caused such confusion. Good secure attachment is never established in the mystery and fog of omissions. The client – initially as a child, then as an adult – is puzzled, feels abandoned and believes themself to be unlovable and the problem. This psychical shaky ground sets the whole corrosive and erosive process in motion.

> The patient says that he feels there is a fault within him, a fault that must be put right. And it is felt to be a fault, not a complex, not a conflict, not a situation … There is a feeling that the cause of this fault is that someone has either failed the patient or defaulted on him; and … a great anxiety invariably surrounds the area, usually expressed as a desperate demand that this time the analyst should not – in fact must not – fail him. (Balint, 1968, p21)

Attachment

From a neurological perspective we know that the basic architecture of the brain is laid down in utero. Later development of the infant may be hampered by what does not happen – what is omitted in the early months. As a result of adverse childhood experiences (ACE) the dyadic interactions between mother and baby may not be secured. Consequently, there is an absence of soothing and attunement, which would normally lay down the neural circuitry for secure attachment. Templates for contactful relationships are thus left out of the equation; they are not imprinted in the early months. The baby is unable by inference to adequately embody empathy, unable to attune

or connect bodily processes with felt affective turbulence. When this baby becomes a mother, these omissions and deficits may surface in the form of post-natal depression. John Bowlby's attachment theory, developed in the 1950s, is a psychological, evolutionary and ethological theory that provides a descriptive and explanatory framework for understanding interpersonal relationships between human beings. It shows that maternal disturbances negatively influence the attachment behaviour trajectory of a child's life. The new mother's lack of her own secure attachment and imprinting as a child may be a major factor in her incapacity to nurture her own infant. Fathers and partners may be similarly affected. The maturation of the infant's brain is experience dependent, and these experiences are embedded in the attachment relationship (Schore, 1994, 2001).

"Research carried out with Romanian orphans has shown that those poor children who were deprived of loving and responsive contact, left in their cots all day, suffered not only mentally but also physiologically, having a "virtual black hole" where their orbitofrontal cortex should be." (Gerhardt, 2004, p38 quoted in Watson, 2008, p25)

Vignette 2

Michael and his wife Liz came to couples therapy because Michael had suddenly begun overindulging in gay porn soon after the birth of their first child. This fact alarmed both of them. Over time, in therapy, he remembered as a little boy running around naked when the family had visitors. He considered and then said that if he had been the parent in that situation, he would have taken that little boy and comforted him and held him lovingly. This encouraged Michael to talk to his elderly father and enquire as to his behaviour as a youngster. His father revealed that before Michael was born, his sister – just older than him – had tripped over a stone garden fence (placed there by himself, the father) and had died of serious head injuries. Both parents, in their horrific grief, never mentioned the sister. Mother immediately became pregnant with Michael as a way of avoiding her sorrow. This meant that he was born into a dark, grieving family. In this grief-stricken family constellation, he was unconsciously drawn to replace the sister who had been lost. This fact, which he was later to mourn, was not known to Michael until he came to therapy. It was a tragic act of omission that contributed to massive confusion.

Some clients give up because they never find true understanding. This results in them being dispatched to a category usually with a diagnosis of a non-specific personality disorder. Healing requires that the therapist stay close to their intuitive wisdom, being almost 'sleuth-like' knowing that there must be something, searching for some fact that has not been brought fully into the light of consciousness. Reparative work requires that the therapist first establish a good working alliance, then adopt a stance and proceed to work with "clinical precision and creative indifference" (Bion, 1970, p42). It behoves the therapist to stay like a stylus in the groove of a vinyl record. In time, this plays out and reveals the full story. It brings coherence such that the client can then establish "narrative competency" and begin emotionally relating to their own story. This brings fluidity, it fills in the occlusions, it brings coherence and hence a clearer understanding. The client's life story previously had gaps, unbeknownst to them. There was an absence of connection relating to relationships. What should have been switched on – love and tenderness – did not happen in their early years. Prior to therapy, Michael was not fully awake or born as a beloved son.

"Memories that are not so much about something terrible happening but, in D.W. Winnicott's words, about 'nothing happening when something might profitably have happened'." (Epstein, 1995, p165)

Vignette 3

Elaine came from an extremely 'alcoholic' home. Food, clothing and schooling were provided but no real love and security. As an adult woman she struggled to trust any prospective lover in the belief that she was the problem. She found herself unable to sustain intimate or work relationships. She clung to a belief about her childhood that it was never that bad, that "it must be me who is deficient and wrong". She believed that she was the problem because she also struggled to relate to her siblings. Through careful work and understanding in therapy, Elaine began to realise the depths of deprivation that she had suffered with two parents drunk most of the time. There was no duty of care. In her case, love, encouragement and protection were omitted. As a child, Elaine was not aware of what was absent and missing from her life. How was she to know that? She had never experienced any secure attachment to significant figures.

The work in therapy is relational and restorative. It works to develop a coherent narrative and to connect the dots. This allows clients to incorporate what is absent so they can understand their younger selves and adjust their thinking around the information in order to reorganise their psychical cohesion.

She believed that caregivers and therapists were also inadequate. These omissions played havoc in her personal life. She believed that she was the problem and, as such, was undeserving of love and respect. Elaine was unaware that her siblings also suffered from a deficit of love and care. Each believed that the others got all the attention when, in fact, none of the children in this family received adequate love and care. Elaine's siblings were mostly envious of each other and unable to relate warmly to one another.

Vignette 4

Jane, a mother in her forties, came to therapy worried and heartbroken about her eldest son being distant from her and preferring her husband. In therapy she revealed that, after the birth of her son, she had experienced five miscarriages – the first at full term, which was dreadfully traumatic. She had needed time to recover, away from the home and away from her toddler, who was just 15 months old at the time. This meant that her young son was predominantly and carefully cared for by his father. This eldest boy was totally unaware of the reasons for his mother's absence. Like Jane, he had no awareness of her emotional distance and the depths of grief. Jane was grief stricken during her son's early years as she lost baby after baby before finally conceiving and producing a healthy daughter. As she became more aware and started healing, she was able to mourn, bring to mind the need for memorials for her babies and begin to fill in what had been omitted from consciousness. Her newly discovered understanding and compassion allowed her to talk to her eldest son, fill in the gaps and explain what was missing from his early years, thereby drawing closer to him as they mourned and remembered.

According to Christopher Bollas (1987, in Stern, 2004, p116), "Implicit knowledge is transposable into words … [he] has coined the term 'the unthought known' as a major clinical reality."

When a client experiences some or other omission – such as not knowing consciously about another sibling or a prior termination, or where a step-sibling is excluded from the second family or where cultural or religious divides exclude family members – clients are unconsciously affected by what they do not know. It interrupts the normal attachment process of belonging. Children who are deprived of their right to love, protection and respect, as in the case of a child being neglected by a step-parent after the death of their mother, may believe themselves unworthy. There might be misattributed paternity, or the ignorance of a parent being sent to prison. The omission is usually invisible to the child. But what is omitted often leads to insecure attachment, a psychical disorganisation that plays out in later years and affects most relationships.

In the cases of children who grow up with gaps, such as being left in hospital for treatment for tuberculosis without visits from their parents (that being the practice in the early part of the twentieth century) or left for months in a nursery awaiting adoptive parents, a misbelief can form in the mind of that child of either "I am defective/unworthy/unlovable" or "everyone else is at fault". This is problematic when attempting to form close, adult, enduring relationships. The therapeutic relationship is often quite challenging. It requires careful and steady holding by the therapist. Children who were raised by very demanding or critical parents are similarly deprived of compassion and softness. This omission leads them to drive either themselves or others in their remit or care to despair. Omissions are usually invisible to the individual who, although capable, well-educated and wealthy, is incapable of sustaining relationships and blind to what is missing, confusing and troubling. Further examples are cases where a death occurs and the body is never found, for example due to drowning, mishap at sea or political unrest or violence. All these gaps and omissions cause a great deal of pain to those family members left, as something essential is left out of the equation.

Conclusion

The work in therapy is relational and restorative. It works to develop a coherent narrative and to connect the dots. This allows clients to incorporate what is absent so they can understand their younger selves and adjust their thinking around the information in order to reorganise their psychical cohesion. In time, they may establish a secure attachment to the therapist, to the self and, thereby, facilitate intra-psychic repair. The transferential and reparative relationship with the therapist is what is facilitative.

"The present can change the past … it is changed functionally and experientially, and that is where we live" (Stern, 2004, p201).

This approach allows the client in the present moment, to address the trauma from a wiser, safer perspective instead of struggling with past events, feeling like a vulnerable child, a naïve teenager or a helpless victim at the mercy of discombobulating flashbacks and dreams. There is time enough in therapy to deal with what has occurred or been omitted – overwriting the past in the present – filling in the occlusions. The adage "hasten slowly" is an appropriate imperative. The therapist simply needs to hold clients safely, allowing them time to discover, unburden their psyche and free themselves from the impact of the past so they can gradually integrate their current understanding and the safety and security established in therapy and, thus, begin to mourn the past. ■

References

Balint, Michael (1968) *The Basic Fault: Therapeutic Aspects of Regression*, Tavistock; London

Barrett, Lisa F (2020) *Seven and a Half Lessons About the Brain*, Picador: UK.

Bion, W.R. (1970) *Attention and Interpretation*, Basic Books; NY

Bollas, Christopher (1987) *Cracking Up*, Routledge; London.

Bowlby, J (1988). A Secure Base: *Clinical Applications of Attachment Theory*, Routledge; Lon

Epstein, Mark, (1995) *Thoughts without a Thinker*, Basic Books; NY

Gerhardt, S (2004) *Why Love Matters*, Brunner/ Routledge: Hove

Jones, Coleen (1997) P*sychotherapists and their health: a qualitative analysis of awareness as expressed by a random group of psychotherapists*, University College Cork.

Jones, Coleen (2020) *Love, Hate & Health Professionals. Irish Journal of Counselling and Psychotherapy, Vol 20, Issue 3,* Autumn 2020.

Jung C.J. (1944) *The Psychology of the Transference. The Practice of Psychotherapy*, CW 16

McGilchrist, Iain: (2009) *The Master and his Emissary, London*: Yale University Press

Schore, A. N. (1994) *Affect Regulation and the origin of the Self*, Hillsdale: NJ

Schore A.N. (2001a) *The Effects of a Secure Attachment Relationship on Right Brain Developmen*t. Infant Mental Health Journal, 22:7-60

Shonkoff J, Richter L, Van der Gaag J, Zulfiqar A Bhutto (2012) Paediatrics, 10.1542/peds 2011- 0366

Stern, Daniel (2004) *The Present Moment: In Psychotherapy and Everyday Life*, Norton &Co; NY & Lon.

Van der Horst FCP (2011) *John Bowlby – From Psychoanalysis to Ethology*, Wiley-Blackwell: Oxford UK

Watson, G (2008) *Beyond Happiness*, Karnac: London

Winnicott, Donald (1947) *Through Paediatrics to Psychoanalysis,* Collected Papers: London: Hogarth 1975: Reprinted by Karnac 1992.

Winnicott, Donald (1971) *Playing and Reality*, London: Routledge

Winnicott, Donald (1990): Home is where we start *from*, London: Penguin.

About the author

Dr Coleen Jones is a psychotherapist and supervisor in practice in Cork, Ireland. She has worked in the field since 1976 in Johannesburg and in Ireland since 1990. She worked at University College Cork in applied psychology for 15 years and subsequently was on the board of Irish Council for Psychotherapy and represented Ireland on the board of the European Council for Psychotherapy. She also spent time on the accreditation committee and governing body of Irish Association for Humanistic and Integrative Psychotherapy and supervision committee of Irish Association of Counselling and Psychotherapy. Visit coleenjones.com or corkpsychotherapy andcounsellingcentre.com, or email coleen@coleenjones.com.

DEIDREE TAYLOR

In this feature, *CA* interviews a counsellor and ACA member about their profession, their journey and what they've learned along the way. By **Nicole Baxter**

What prompted you to move into counselling as a profession?

When I was working as part of an allied health nutrition team in a hospital-based setting, I decided I wanted to be equipped with the knowledge to better assist clients who struggle emotionally with issues surrounding health and nutrition. I studied for, and earned, a master's degree in counselling to build on my bachelor's degree in health science majoring in nutrition. I now offer my clients a more holistic approach to their sessions.

What is the biggest reward of being a counsellor?

Helping people find hope when their 'sky' has felt grey and cloudy brings me immense joy. I feel amazing when they see the sunshine emerge through the clouds and their smile returns. Seeing someone, who previously sought comfort in food, develop different coping skills is a particular privilege.

What is the biggest challenge about being a counsellor?

Helping the wider community understand the many health benefits that can be found from counselling. When we have an open wound, we immediately seek medical attention. However, unfortunately, emotional wounds are not always prioritised in the same way.

Name a highlight of your Australian Counselling Association (ACA) membership

Finding my supervisor through the ACA has been invaluable. She helped me to gain confidence and assisted me greatly in forging a path forward as a counsellor. I enjoy communicating with other counsellors in their areas of expertise and keeping up to date with the latest research.

How would you like to see the counselling industry change in the future?

I would like to see wider recognition among the public of the expert skills and tangible support that ACA-accredited counsellors offer to clients.

Describe a valuable learning experience that you had as a counsellor

When I became a counsellor, I initially did not promote my health science and nutrition skills. Over time, I realised these skills, in addition to my counselling experience, could add value to what I can offer to clients in a therapeutic setting. Every day I aim to build on these skills by keeping the door open to new experiences. I love learning and that is a big part of who I am as a counsellor.

How many clients do you see each week?

It varies, depending on the individuals I am seeing and the number of groups I am running, or the educational presentations scheduled.

What do you love about running your own professional practice?

I love the positive difference I can offer in the areas of nutritional and emotional wellbeing. I love that every day is different. I love showcasing that positive change can be contagious and beneficial for all.

What pearls of wisdom would you offer to a student counsellor or a colleague?

Find a mentor and supervisor with whom you connect. Never be afraid to ask questions. Determine where you are a little bit 'sketchy' and learn about how to improve that area. Be curious. Act and enjoy your lifelong continuing education. ■

Deidree Taylor
Photo: Supplied

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- The body of the paper must not identify the author.
- Articles are to contain between 1500 and 5000 words.
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- Articles may be returned for rewording or clarification and correcting prior to being accepted.

Conditions

- References are required to support both arguments and personal opinions and should be listed alphabetically.
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