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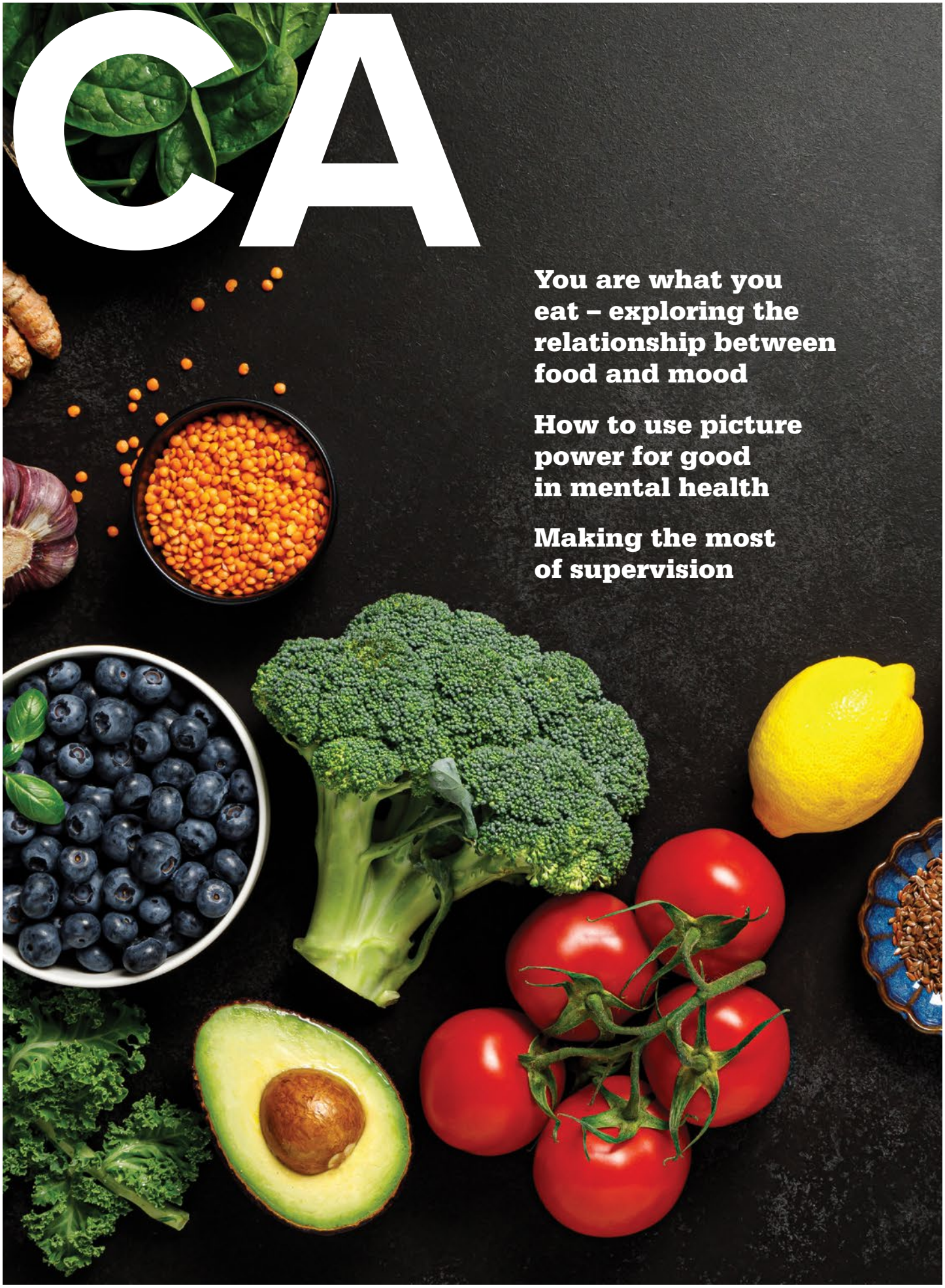

You are what you eat – exploring the relationship between food and mood

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Will, AIPC Higher Education Graduate

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Editor
Dr Philip Armstrong
FACA

Technology adviser
Dr Angela Lewis
MACA PhD

Cover: Fiona James
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Editorial advisory group
Dr Tom Edwards
PhD
Dr Ann Moir-Bussy
PhD
Dr Philip Armstrong
FACA

Production design
coretext.com.au

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The Editor
Australian Counselling Association
PO Box 88
GRANGE QLD 4051
aca@theaca.net.au

See page 50 for peer-reviewed article submission guidelines.

Editorial

Finding an escape network from self-doubt

Philip Armstrong
Editor

We are not alone. No, this is not the opening to an intergalactic thriller but a statement of fact about the shared professional challenges faced by counsellors and psychotherapists the world over.

People everywhere need the same professional support for much the same reasons. This has long been the case, but possibly amplified in recent times by geopolitical tensions, climate change and the openly shared experiences in just about every country and society of the COVID-19 pandemic and its aftermath.

The pandemic certainly raised community awareness of mental health and the adequacy, or otherwise, of support services in different parts of the world. This shared experience also extends to mental health care professionals and was one of the common threads running through the annual conference of the Irish Association for Counselling and Psychotherapy in Galway in October.

It was a privilege to attend the conference, themed 'Can your brain be shaped?', and to meet with distinguished leaders. We also met with the International Counselling Association, the American Counselling Association, and the British Counselling and Psychotherapy Association.

From these conversations it was clear that we are not alone in Australia in having to campaign continuously against challenges to our profession's legitimacy among other allied health professionals.

ACA members will be well aware of our efforts to achieve equal recognition and our tireless campaign against the incongruity of the demand for our services rising exponentially while our clients are denied Medicare support for the professional care and support we provide.

This is a global disparity within healthcare services, so it will be of ongoing value to monitor the progress of counselling and psychotherapy associations in other countries.

Other common ground clearly apparent globally was the priority everyone places on delivering good healthcare outcomes, and also the increasing awareness of the role that mental health plays in achieving the UN's global Sustainable Development Goals. The flipside is the frustrating gaps in access to this care that continue to exist.

One measure being rolled out, as in Australia, is the ongoing development and provision of telehealth as a way to overcome some access challenges. There is also a need for greater regional representation in Asia-Pacific region, more easily transportable counselling and psychotherapy qualifications, and international standards to support counsellors and psychotherapists.

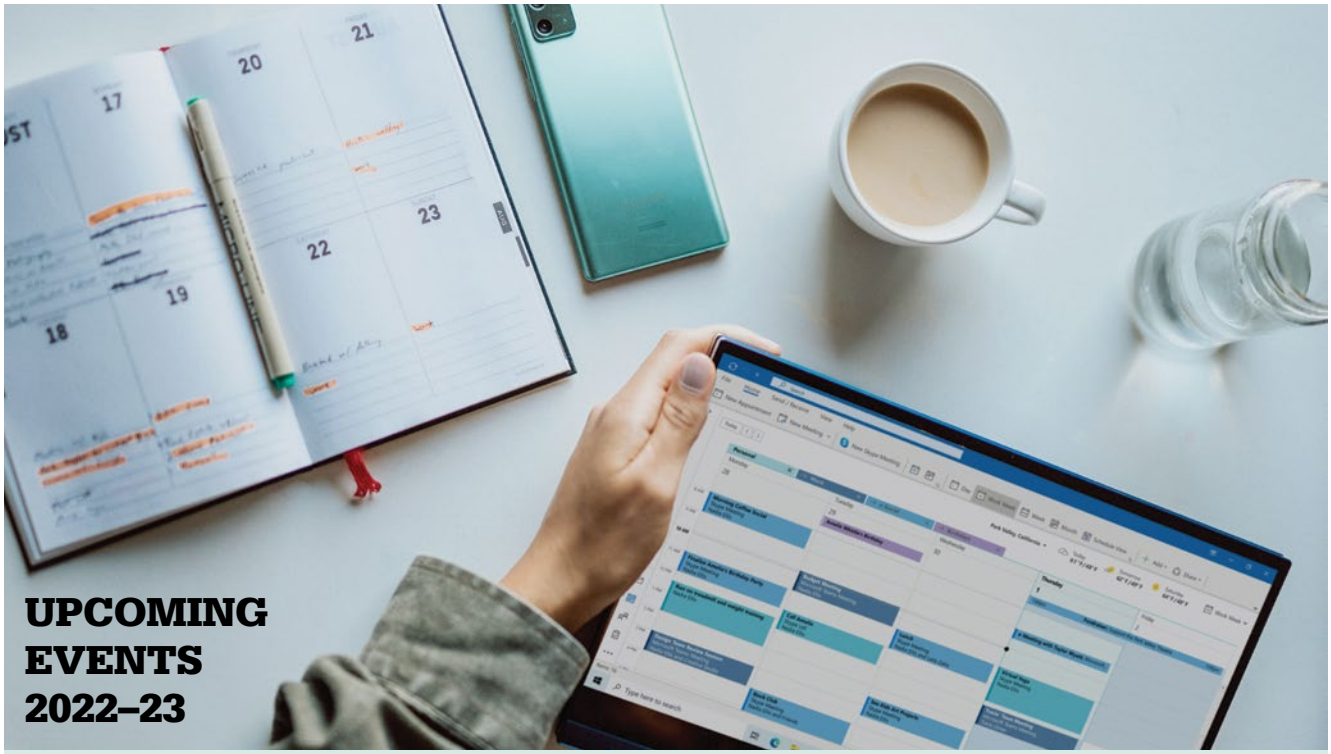
Closer to home, this edition of *Counselling Australia* also looks at the fascinating research of Professor Felice Jacka, who leads the Food & Mood Centre at Deakin University. Her work in the emerging field of nutritional psychiatry and the links between diet and the risk of mental disorders is at the forefront of preclinical, observational and clinical research in this field.

I have a nutrition qualification and, as a counsellor, I personally grapple with the question of what comes first, food or mood? Either way, the relationship and entanglement of food and mood is incredibly powerful – whether it's what is in the food, the size of the meal or the lack of nutrients that sets up a mood boost or depressor.

We also take a members' opinion on the recent literature review, which aims to summarise recent research about the efficacy, or otherwise, of drug intervention, and we provide an update on how to watch for scams and cyber protect yourself given the recent Medibank private data breach.

In all, it's a great summer 2022–23 edition that we are proud to bring to you. ■

Be published
Share your research and articles with the editor of *Counselling Australia* by emailing to editor@theaca.net.au.
See page 50 for the submission guidelines.



UPCOMING EVENTS 2022–23

Ovarian Cancer Awareness Month

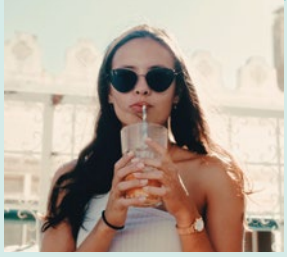
1 to 28 February

Ovarian Cancer Awareness Month is held each year in Australia to raise awareness of the signs and symptoms of ovarian cancer. ovariancancer.net.au

febfast

1 to 28 February

Support disadvantaged youth in Australia this February with febfast by giving up a vice of your choice for the whole month and raising funds for drug and alcohol programs. Or you can choose febfit – get moving for 25 minutes a day to help young people walk away from addiction. Are you in? febfast.org.au



REDFEB

1 to 28 February

Wear red this February and donate to fund heart research into the prevention, diagnosis and treatment of heart disease. #wearredanddonate heart-research-red-feb.raisely.com

World Cancer Day

4 February

This is a positive global movement led by the Union for International Cancer Control to raise global awareness, improve education and accelerate personal, collective and political action. It works to reimagine a world where millions of preventable deaths by cancer are saved and access to life-saving treatment and care is equitable to all. worldcancerday.org

Safe Internet Day

7 February

Safer Internet Day is a global event that brings together communities, families, schools and organisations from more than 200 countries to help create safer online spaces. esafety.gov.au/newsroom/whats-on/safer-internet-day-2023

National Day of Action Against Bullying and Violence

17 March

Australia gears up to observe National Day of Action Against Bullying and Violence on the third Friday in March every year. nationaltoday.com/national-day-of-action-against-bullying-and-violence

World's Greatest Shave

15 to 19 March

Get sponsored to shave, colour or cut your hair and help families facing blood cancer. worldsgreatestshave.com

UN International Day of Happiness

20 March

As the world faces evermore unprecedented challenges, the importance of wellbeing also rises. When we choose to help others, we also benefit, and we set an example of kindness that can ripple outwards. dayofhappiness.net

Technology Update

Photo: Unsplash

Australian Centre for Cyber Security

With an increasingly high volume of reported scam incidents, Australians are focusing hard on cyber security. The threat is real, every day, and should be front and centre both personally and professionally.

Got an ABN? Visit the 'Small and medium businesses' tab at cyber.gov.au, which has a raft of assessment and support options, including the Cyber Security Assessment Tool. It was developed by the Department of Industry, Science and Resources to help improve cyber security skills among Australian small and medium businesses.

With the assessment tool, you can:

- identify the cyber security strengths of your business;
- understand areas where your business can improve; and
- know how to improve your cyber security and where to find help.

More information:

digitaltools.business.gov.au/jfe/form/SV_0dnd9cF15I8LnH8?ref=acsc

Scams

ACA asked Scamwatch to share with us educational resources to help stop scamming.

Scammers are continually developing new ways to catch people out. We need to increase our vigilance in checking for those little clues that can alert us that something is a scam.

Scams cost Australian consumers and businesses, and the economy, hundreds of millions of dollars each year and cause serious emotional harm to victims and their families.

In 2021, Australians made more than 286,600 reports to Scamwatch and reported losses of around A$324 million. By the end of August 2022, Australians had lost even more, with reported losses of over A$381 million.

As alarming as these numbers are, we know that around one-third of people who are scammed never tell anyone, so the true numbers are likely much higher.

Visit scamwatch.gov.au during Scams Awareness Week (7 to 11 November annually) for more information and tips on how to protect yourself from scams.

Scamwatch tools and resources

The Scamwatch and Australian Competition and Consumer Commission websites contain

In 2021, Australians made more than 286,600 reports to Scamwatch and reported losses of around A$324 million. By the end of August 2022, Australians had lost even more, with reported losses of over A$381 million.

a range of tools and resources about scams:

- Scamwatch Report Form: if you've come across a scam, you can report it using this form (scamwatch.gov.au/report-a-scam);
- Scamwatch reporting statistics: provides up-to-date statistics on scams reported by Australians (scamwatch.gov.au/scam-statistics);
- Targeting scams reports: yearly report on scam trends and statistics (accc.gov.au/publications/targeting-scams-report-on-scam-activity/targeting-scams-report-of-the-accc-on-scam-activity-2020);
- Helping a friend or family member who is a victim to a scam: useful information if someone close to you has been scammed (scamwatch.gov.au/get-help/help-a-family-member);
- Be safe, be alert online: information on organisations who may be able to help when someone has been scammed (accc.gov.au/publications/be-safe-be-alert-online);
- Where else to get help: other organisations who might be able to help when someone has fallen victim to a scam (scamwatch.gov.au/get-help/where-to-get-help); and
- *The little black book of scams*: information on identifying a scam, available digitally in a range of languages (accc.gov.au/publications/the-little-black-book-of-scams).

TYPES OF SCAMS

Remote access scams

Remote access scams try to convince you that you have a computer or internet problem and that you need to buy new software to fix the problem.

Attempts to gain your personal information

Scammers use all kinds of sneaky approaches to steal your personal details. Once obtained, they can use your identity to commit fraudulent activities such as using your credit card or opening a bank account.

Identity theft

Identity theft is a type of fraud that involves using someone else's identity to steal money or gain other benefits.

Phishing

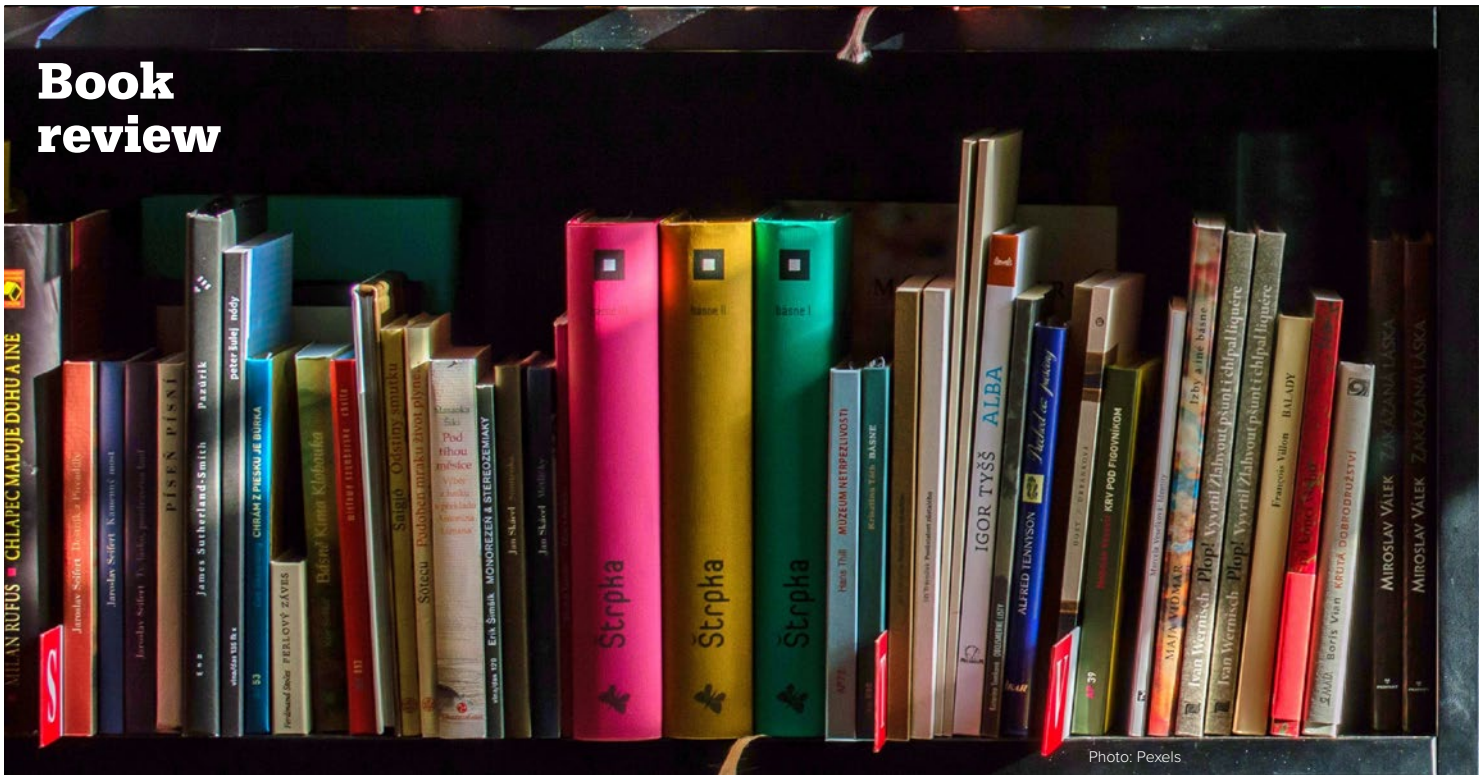
Phishing scams are attempts by scammers to trick you into giving out your personal information such as your bank account numbers, passwords and credit card numbers.

Hacking

Hacking occurs when a scammer gains access to your personal information by using technology to break into your computer, mobile device or network. ■

Source: Based on ACCC data © Commonwealth of Australia.

Book review



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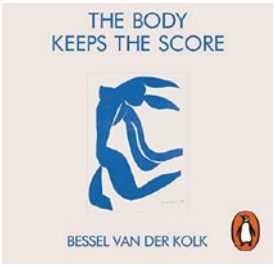

The body keeps the score: mind, brain and body in the transformation of trauma
By Bessel van der Kolk

Reviewer
Elizabeth Aplin
Level 4 ACA Member

Bessel van der Kolk is one of the world's foremost experts on traumatic stress, with his professional life dedicated towards the understanding and healing of trauma. During his forty-year career as a psychiatrist, he has held the position of professor of the Boston University School of Medicine, is currently president of the Trauma Research Foundation, Brookline Massachusetts, and throughout his career has travelled widely, including to Australia to share his research.

Written in 2014 from a wide perspective, and appealing to a broad audience through an easy-to-read style, this book remains a source of very helpful research and observation that includes compassionate, heart-stopping stories of people whose lives were stultified by trauma, but who were able to have restoration into normal living through a variety of therapeutic approaches.

Van der Kolk writes from an autobiographical and historical perspective that spans the developmental progress of research into trauma, from Pierre Janet (1859–1947), who discovered and named 'dissociation' as the psychological process by which a person responds to overwhelming trauma, to the present use of body therapies in therapeutic trauma work.

On this journey, van der Kolk provides views of the medical system from within and without, including phases and trends led by research and through the influence of government, politics, wars, and drug and insurance companies.

And although trauma is complex, he presents it as simple to understand, and also as the root cause of many currently identified mental health disorders. Thus, he calls for more research on a proposed category of 'developmental trauma disorder' for inclusion in the DSM.

His study and interest have extended towards preventative trauma programs in schools, which have been incorporated into the education systems of European countries. He provides research data from these programs that supports their value through lowered national incarceration rates and healthcare costs.

Van der Kolk encourages the protective factors of self-regulation, a good support network, engagement in activities involving communal rhythms such as choir singing, marching, chamber music, walking and drama productions, free personal writing and drawing and the positive attachment effect of horses and dogs.

He also discusses, in detail, a range of therapeutic options including early intervention in education settings, eye movement desensitisation and reprocessing, internal family systems therapy, Pesso Boyden system psychomotor therapy, neurofeedback, therapeutic massage, mindfulness and yoga.

As a bestseller, this book has sold millions of copies, perhaps achieving the author's intent of bringing light and societal change into the pervasive area of trauma.

If you work with clients who have childhood trauma or post-traumatic stress disorder and are interested in a deeper overall understanding of trauma or in adding a new therapeutic approach, this is an enjoyable, helpful and inspirational read. Van der Kolk charts a path of healing from trauma into "restoration of executive function, self-confidence and the capacity for playfulness and creativity".

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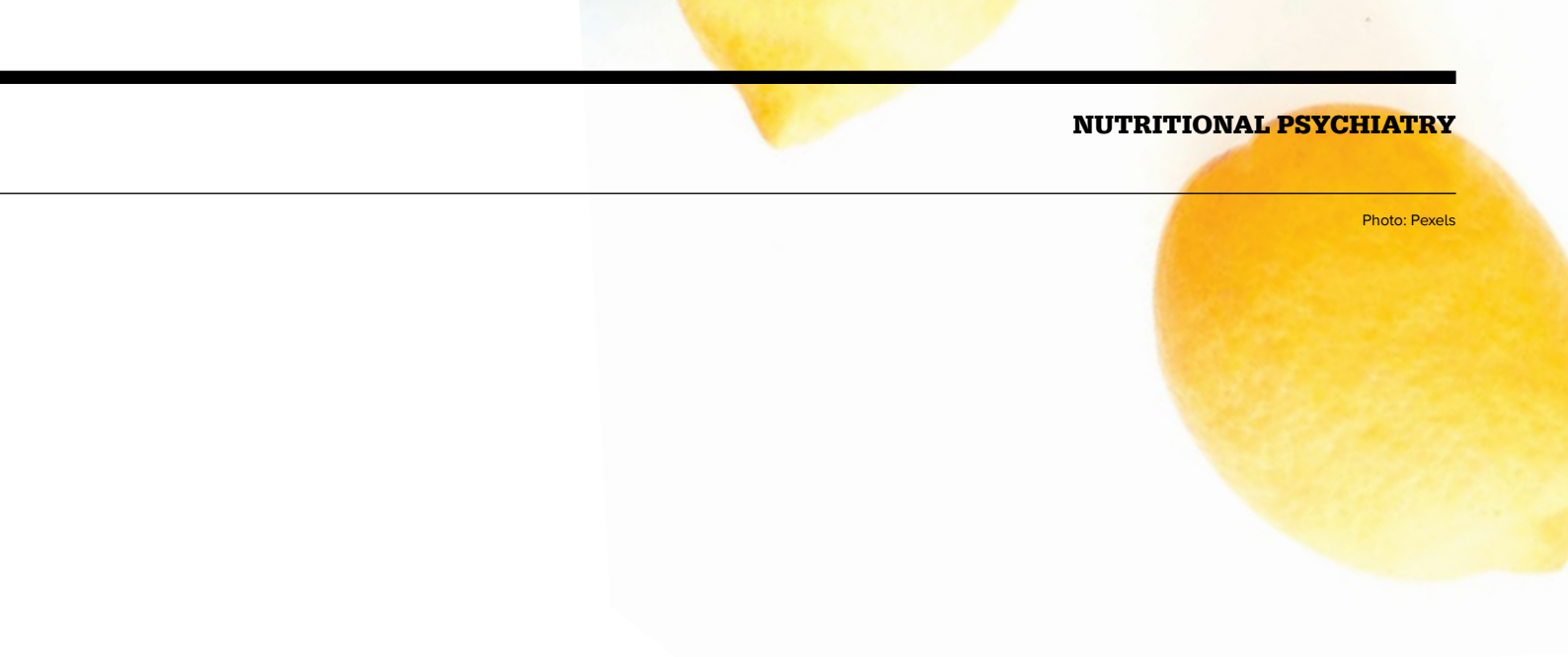

Photo: Pexels

You are what you eat – exploring the relationship between food and mood

Healthy diet is now established as a key pillar of mental health. We spoke with Alfred Deakin Professor Felice Jacka OAM, the founder and driving force of 'nutritional psychiatry', about the role this growing field of scientific research can play in counselling and psychotherapy to improve the quality and length of people's lives. By **Melissa Marino**

When Professor Felice Jacka embarked on her PhD – the first study of its kind investigating the link between diet quality with clinical depressive and anxiety disorders – it raised a few eyebrows.

"Everyone thought I was a bit barmy because it was just not considered credible or worth looking at," she says.

But little more than a decade after her research was published with great acclaim on the cover of the *American Journal of Psychiatry*, her conviction has been vindicated many times over. "I always knew there was something in it, so it's very satisfying to be able to say, 'I told you so'," laughs Professor Jacka, who in 2021 received an OAM for her extensive body of work.

Today, Professor Jacka sits at the helm of nutritional psychiatry – a burgeoning field that she is widely credited with founding and that is now setting health agendas in Australia and internationally, influencing World Health Organization and other global influential policy documents and informing clinical guidelines to improve mental health through diet.

In the first recommendation of its kind, for example, the Royal Australian and New Zealand College of Psychiatrists' (RANZCP) latest clinical guidelines place lifestyle change, including diet, at the 'foundation' of treatment for mood disorders.

This came as no surprise to Professor Jacka, who has led dozens of influential studies in the field and is co-director of the world-leading Food & Mood Centre at Deakin University, where more than 50 researchers are working to understand the way diet influences our brain, mood and mental health.

"We've known for a long time that people's mental health affects their physical health, but our research shows their physical health also affects their mental health," she says. "So if you get the physical health basics right at the

"We've known for a long time that people's mental health affects their physical health, but our research shows their physical health also affects their mental health, so if you get the physical health basics right at the foundation, other forms of treatment are more likely to work."

Professor Jacka believes the relatively new discipline of nutritional psychology has gained so much traction in such a short timeframe because it puts the power of transformation in people's hands. Unlike static risk factors for mental health disorders, such as early life trauma or genetics, people can take control and change their diets. "So for people to understand that they have some agency in modifying this risk factor is very powerful and it's of great interest," she says.

Evidence base

Supporting the elevation of diet (along with other lifestyle factors such as physical activity, sleep and substance cessation) into mental health policies and guidelines is a growing amount of clinical research pointing to the critical role food plays in our mental wellbeing.

"It used to be that psychiatry and psychology thought about the mind and body as being separate, but we now know we are one complex, highly integrated system," Professor Jacka says.

There is now a comprehensive evidence base linking the quality of people's diets to their risk for depression, she says. This begins from the very start of life – from diet in utero to childhood, adolescence and adulthood.

When multiple studies are combined it appears that, on average, people who have a healthier diet reduce their risk of developing depression by 30 to 35 per cent, she says, and this is independent of important factors such as education, income and body weight.

Importantly, the research also shows that diet is not only a predictor of mental ill-health, but also is proven as a treatment for mood disorders such as depression.

And this holds great promise for health professionals in informing their own practice and providing options as waiting lists for therapy blow-out. "Clinicians won't do their patients a disservice if they refer them to a dietitian while they're waiting see a counsellor," she says.

The Food & Mood Centre's internationally recognised SMILEs trial – the first randomised controlled trial looking at dietary improvement as a treatment for depression – found diet had a significant impact on mental health.

The trial, published in BMS Medicine, found that when supported by a clinical dietitian, one third of participants (all who were diagnosed with moderate or severe clinical depression) went on to achieve full remission.

"It's very powerful for people who are experiencing a major depressive disorder that we saw very large changes in people's mental health from dietary change," Professor Jacka says. Importantly, this did not arise from weight loss or other potential explanations. This finding has now been replicated in three other randomised controlled trials.

Real-world impact

Findings of this nature are important because people's lives are at stake, she says.

Poor diet is the leading cause of early death around the world, she says. And on top of that, there is a startling 20-year mortality gap between people with and without a mental health disorder.

"And that's not because of suicide," she says. "It's because of poorer cardiometabolic health related to medications, and the fact that they are often treated as if they are just a brain on legs and their physical health is not considered to be particularly clinically relevant. And often they do not have the

support to choose healthy foods or get moving."

Clinical practices are traditionally some of the worst offenders, she says. In-patient clinics provide sweet muffins as snacks, fast food is ordered in and there are smoking areas and a lack of physical exercise programs.

But, she says, with appropriate support, improvements can be swift and significant.

In Sydney, the Keeping the Body in Mind group showed that with minimal intervention (a student dietitian, exercise physiologist and second-hand gym equipment), people commencing anti-psychotic treatment, who would usually be expected to gain between seven and 20 kilograms, maintained a stable weight.

Professor Jacka's research has also shown that using mental health as a goal has a more profound effect on people's eating habits than using weight loss or heart health as a motivator.

"Body weight is a silly thing to focus on because it's very difficult to change. People give up and feel stigmatised. So focussing on the fact that people's mental health could be affected very quickly based on dietary change seems to prompt changes in dietary behaviours," she says.

In line with the understanding that changes in diet can improve gut health quickly, benefits to mental health can be seen in as little as three weeks, she says.

How it works

Professor Jacka explains that our mental health is affected by diet through a number of physiological mechanisms that researchers are continuing to work to understand.

Diet influences the hippocampus – the 'plastic' part of the brain responsible for learning and memory as well mental health – and serotonin levels, mitochondrial function that enables stress adaptation, the expression of genes, oxidative stress and inflammation.

Linking all these factors and profoundly influenced by what we eat, she says, is our gut microbiota. In breaking down the food we eat, our unique gut microbiota release thousands of molecules that drive physiological processes in our bodies, including those related to our mental and brain health. So a healthy gut microbiota appears essential to our mental health.

A healthy gut microbiota requires a higher intake of plants, whole foods, quality fats and proteins and some fermented foods, and lower intake of ultra-processed foods.

And the key, Professor Jacka says, is diversity. People can develop a diverse gut microbiota by eating 30 different types of plants per week. They don't have to be exotic, she says, just wide in a variety of fruits, vegetables, grains, legumes, nuts, seeds, herbs and spices.

Myth-busting a common misconception, Professor Jacka says a healthy diet does not have to be expensive. A cost analysis showed that in the SMILEs trials, healthy

What counsellors can do

- Consult the Food & Mood website and point clients to it for a range of resources
- Complete a short course, including a free online resource available through the Food and Mood Centre website
- Take nutrition seriously
- Ask clients what they ate for breakfast. If they say 'Nutri-Grain', suggest an alternative such as porridge.
- Attend a conference – the next International Society for Nutritional Psychiatry Research conference will be held in in Cairns in March 2023.
- Read, or listen, to a book – Professor Felice Jacka's two books, *Brain changer* (for adults) and *There's a zoo in my poo* (for children), are both widely available.

"So even though the brain and the gut microbiota are very complex, what you need to do to have a healthy gut microbiota is actually pretty simple."

but accessible foods such as frozen vegetables, tinned beans and fish were cheaper than junk food-heavy diets participants had been consuming.

"So even though the brain and the gut microbiota are very complex, what you need to do to have a healthy gut microbiota is actually pretty simple," she says.

New paradigm

The function of gut microbiota in relation to mental health is now under the microscope at the Food & Mood Centre.

Researchers are investigating the impact of fermented dairy on the brain; future research hopes to investigate nuts, mushrooms, herbs and other fermented food such as kombucha and sauerkraut that contain components that could be important in psychiatric disease.

Other research at the centre is comparing diet and exercise programs with cognitive behaviour therapies and the role of apps to treat depression through dietary education and improve diets in pregnancy and childhood.

The centre has also just published the first set of international guidelines for therapists using lifestyle-based care in treatment for depression, based on three years of research by the global taskforce it led.

Professor Jacka's team is at the forefront of translation working with RANZCP to develop Nutri-Psyche – the world's first accredited training program in nutritional psychiatry. Launched in October 2022, it follows a free online course available on the Food & Mood Centre website that has been accessed by more than 78,000 people globally.

To enhance cooperation, Professor Jacka, as the founder and president of the International Society for Nutritional Psychiatry Research, also sits on the World Economic Forum's new nutrition initiative designed to counter the global industrialised food system that costs the economy $11 trillion a year in health impacts.

It has been a relentless workload, and not without personal cost. Professor Jacka has battled two bouts of breast cancer and is now actively trying to say 'no' to more – "which is hard when you're the face of nutritional psychiatry," she says. Professor Jacka's work has graced the cover of *TIME* magazine, among others, and she has featured in international documentaries, as well as ABC TV programs *Catalyst* and *Magda's Big National Health Check*.

She's the first to admit she has not always prioritised her own mental health but is now addressing that by prioritising sleep, walking near her coastal home and easing her workload as she focuses in the "important things" – mentoring and getting new ideas off the ground.

Above all, she says the challenges have been worth it. "Not many people get to say that they achieved what they set out to do in their career, and I did. And I hope it's going to help a lot of people." ■

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GUT FACTS

13 truths about gut health everyone should know

95%

95% of our serotonin and **50%** of dopamine is made in the gut with the help of our gut bacteria. Other neurotransmitters made in the gut include gamma-aminobutyric acid and acetylcholine[1].

500

There are over **500** different species of bacteria living in our gut[1].

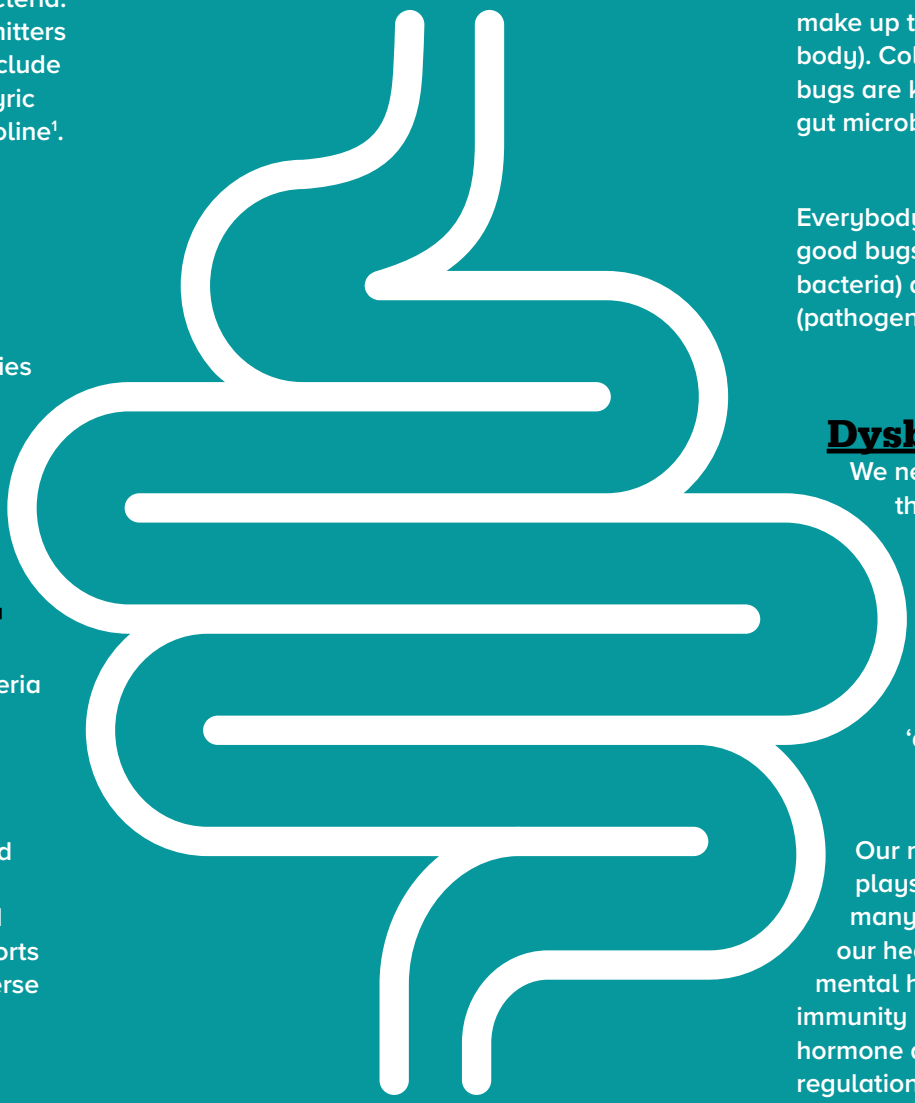
25%

Our stools are made of 25% bacteria (dry weight is up to **55%**)[2].

A varied wholefood diet that includes both insoluble and soluble fibre supports a healthy and diverse microbiome[3].

Probiotics

The term 'probiotics' refers to both the good bugs that live in our gut and also to the supplemental form.



Prebiotics

'Prebiotics' refers to the 'food' that probiotics 'eat' – these are generally fibres that we eat as humans but can't digest. The bugs do this for us. In turn, they provide an energy source for the gut cells[5].

Postbiotics

'Postbiotics' are the waste products of the gut bugs consuming fibre – short-chain fatty acids, vitamins (such as vitamins K and B12) and some enzymes[6].

100

Our gut houses **100** trillion bugs (that's about three times the number of cells that make up the human body). Collectively, these bugs are known as the gut microbiome[1].

Everybody has both good bugs (commensal bacteria) and bad bugs (pathogenic bacteria)[1].

Dysbiosis

We need more of the good bugs and fewer of the bad. An imbalance in favour of the bad bugs is known as **'dysbiosis'**[1].

Our microbiome plays a role in many aspects of our health – mood, mental health, immunity and our hormone and metabolic regulation[4].

The enteric nervous system

The gut has its own nervous system – the enteric nervous system[7].

The enteric nervous system talks to the brain (gut–brain axis) via the vagus nerve[7].

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HOW TO USE PICTURE POWER FOR GOOD IN MENTAL HEALTH

Mindframe's new guidelines for the use of images in the media around mental health, suicide and drug and alcohol misuse have been released and focus on how to help reduce stigma and discrimination while increasing representation and positive outcomes. By **Melissa Marino**.

COVID-19 has put mental health in the spotlight like never before. More public discussion of mental ill-health and drug and alcohol misuse has come with heightened media coverage. And that coverage, while important, can be problematic.

Communication using bleak imagery, such as the 'head in hands' picture that commonly accompanies media reports around mental health, can have a negative impact on people's lives. It can reinforce negative stereotypes, increase stigma and discrimination, and can be triggering for people who have experienced mental ill-health.

But conversely, positive and authentic images of the diverse range of people affected can help reframe the issue of mental health, improving society's understanding and encouraging help-seeking behaviour.

To help reduce harm and maximise benefit in coverage of mental health issues, comprehensive guidelines, along with a collection of images for use free of charge has been launched.

Images matter: Mindframe guidelines for image use is a practical, research-backed resource to help communicators and the media make informed choices about the images they use, to firstly "do no harm" and secondly "aim to do good".

To play its role in reducing harm and stigma, and increasing help-seeking and hope, the Mindframe guidelines ask that the media:

- use a diverse range of images;
- use images of people who have personal or lived experience only with their knowledge and permission;
- use images that model hope and support;
- consider images can be helpful or harmful depending on the context, issue or purpose; and
- consider practical elements such as accessibility or style.

Christine Morgan, CEO of the National Mental Health Commission, which funded the work, says the evidence-based guidelines, developed by the mental health and suicide prevention institute Everymind, drew on extensive

Photo: Salty Dingo/Mindframeimages

Stigmatising imagery illustrating mental health issues in the media hurts people, but a more positive, normalised representation helps to create a safe environment of hope.

consultation with media and health professionals. Importantly, central in that process were people with lived experience of mental ill-health.

One of them was project co-chair and CEO of The Inner Ninja Foundation, Stefani Caminiti.

She says it's offensive, depressing and potentially triggering to see representation of people experiencing mental ill-health as 'crazy' or in other ways that are stigmatising.

But by encouraging the use of images of people in everyday situations, living productive lives or experiencing happiness, the guidelines will help change audience perspectives on mental ill-heath.

"This project is really dear to my heart because I feel that it can change those narratives and normalise our mental ill-health, because it's something that we all experience at some point in our life. And if we don't directly experience it, we will know someone who has," she says.

Ms Morgan says images are powerful – "they stick in our brains, they influence us".

Stigmatising imagery illustrating mental health issues in the media hurts people, but a more positive, normalised representation helps to create a safe environment of hope in which people can identify themselves and potentially be encouraged to reach out and talk about their experiences.

Accompanying the guidelines are a set of resources for media including:

- a checklist to tick-off key considerations;
- guidance cards for specific issues such as image selection relating to suicide, self-harm or eating disorders; and
- a royalty-free photo library of more than 1000 high-resolution images.

Dr Zac Seidler, Movember director of mental health training, hopes that the easily accessible Mindframe resources will empower the media to be more thoughtful in its editorial choices. Instead of the well-worn clichéd pictures such as a person sitting on the edge of a cliff, imagery used with stories about mental health or suicide prevention should be aspirational, he says.

"It should be talking about what is possible when it comes to recovery … and [reflect] that individual responsibility on its own is not the way that we are going to get out of what are really complex mental health issues," he says. "The head in the hands imagery is done." ■

Photos: Salty Dingo/Mindframeimages

IMAGE MATTERS: DOS AND DON'TS

Imagery is a powerful thing. The images we use to communicate ideas about mental ill-health, suicide, and alcohol and other drugs can create positive or negative associations and leave a lasting impression with audiences.

DO:

- use images that model hope and support;
- seek to minimise harm, stigma and discrimination through imagery;
- aim to inform, support and empower;
- use images that reflect diversity, including:
- > ages
- > genders
- > cultures and ethnicities
- > relationships
- > body shapes and sizes
- > geographies;
- use images of people who have personal or lived experience;
- always ask permission to use images of people with lived experience;
- depict people accessing support from services or loved ones;
- consider practical elements such as accessibility or style;
- consider the context of the work when selecting images; and
- consider the image's potential impact.

DO NOT:

- use images that portray hopelessness or negativity;
- use stereotypes of mentally ill people as a certain age, ethnicity or body type;
- show images of drug paraphernalia or alcohol;
- show images of suicide or self-harm;
- use images that depict a power imbalance (e.g. between counsellor and client);
- use images that associate mental illness with darkness, pain or violence;
- use images of people who have passed away without seeking permission from their community;
- depict people alone; and
- use images framing mental illness in a negative way – it can perpetuate stereotypes.

Eating disorder and body-image imagery

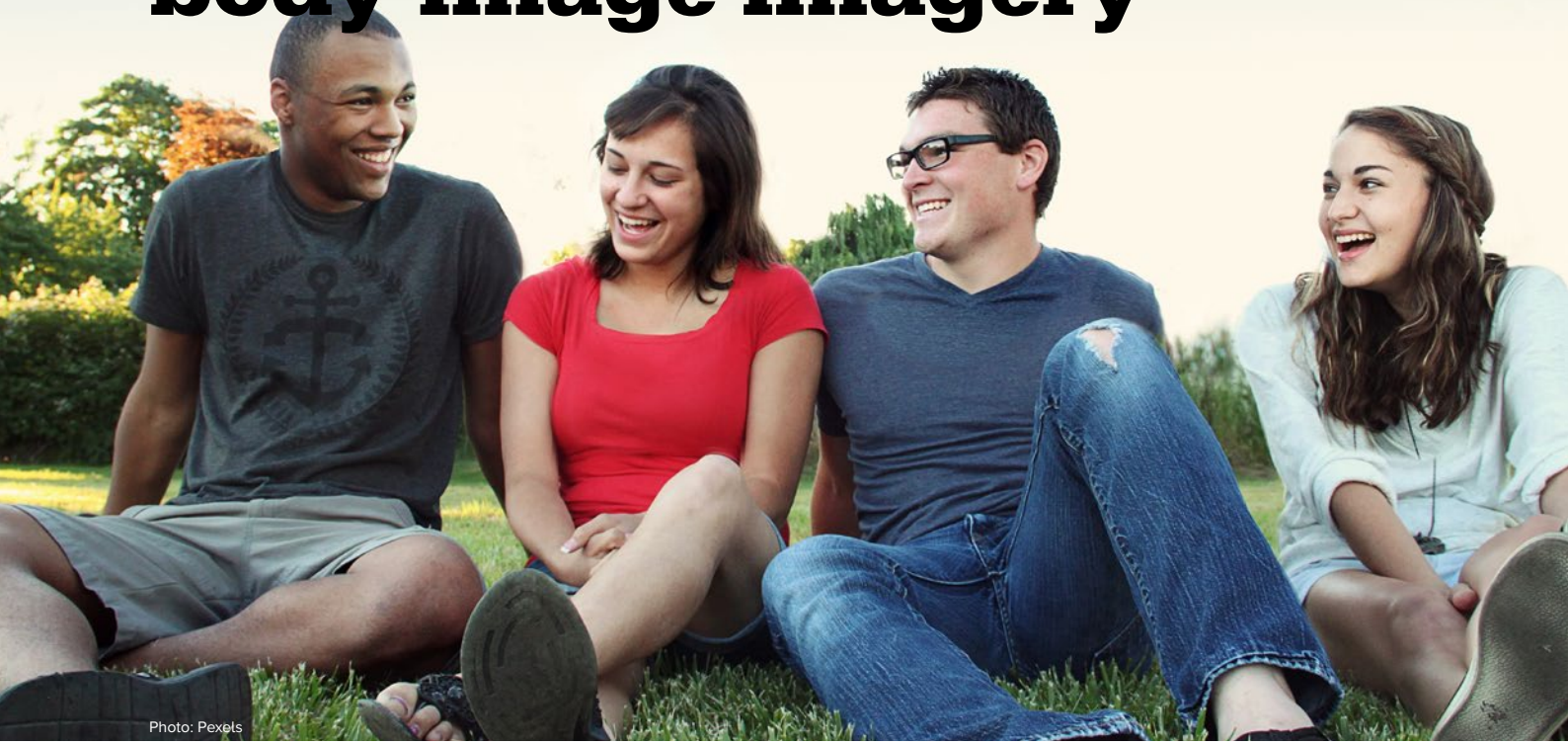

Photo: Pexels

Eating disorders and body image issues are complex mental illnesses that affect a diverse range of people. The Butterfly Foundation estimates that over one million Australians are currently experiencing an eating disorder, and that nine per cent will experience one (or more) in their lifetime. These illnesses can have serious physical consequences for the sufferer.

Every person's experience of an eating disorder is unique and different. Eating disorders can be difficult to portray sensitively and accurately in media.

Recent guidelines for use of imagery released by the national Mindframe program advise that some ways of communicating about eating disorders can lead to harmful impacts, such as greater body dissatisfaction or reinforced disordered eating behaviours in those at risk.

Images communicating eating disorders and body image issues should convey hope, support and recovery. They should avoid:

- specific methods used for weight control (such as scales or laxatives);
- measurement details (such as weight, BMI or kilojoules/calories);
- items used to measure weight or size (such as tape measures or scales);
- focusing on body parts (such as ribs, collarbones, waistlines or thighs); and
- problematic websites or places where people can access harmful or triggering information (such as eating disorder forums or 'thinspiration' sites).

The guidelines specify that care should be taken with images depicting extreme body weights or shapes, as these can encourage harmful behaviours, and they may also reinforce misconceptions of what an eating disorder looks like.

Instead, use images that represent health and wellbeing and strengthen the notion of hope for recovery. It is helpful to include images that show a variety of ages, cultures and ethnicities, socioeconomic backgrounds, genders and body types.

Image checklist:

- What is the purpose of the image and the story?
- Do the images sexualise or objectify the individuals depicted? Consider whether the images you are using represent one gender, people dressed provocatively or posed in a submissive way.
- Is the image used to illustrate a harm-reduction campaign or clinical resource?
- Does the image have a prevention focus?
- Is the problematic detail incidental to the image (for example, scales in a general image of a clinical setting)? ■

More information

These guidelines can be read in further detail in Image matters: Mindframe guidelines for image use. mindframeimages.org.au

COUNSELLING TAKES CENTRE STAGE IN NEW SANE-GUIDED SERVICE

As demand for mental health care has surged across the country, Australians living with complex mental health needs have been particularly impacted by overwhelmed health systems. A new digital service delivered by SANE provides an evidence-based safety net for those waiting for face-to-face care or needing tailored, supplementary support. By **Emma Tyers, SANE**

People living with complex mental health needs, and especially those living with severe, long-term conditions or combinations of conditions, typically require both clinical and psychosocial care to maximise recovery and quality of life.

Sadly, many fall through the cracks of our current mental health and social support systems. As outlined in the recent Productivity Commission Inquiry into Mental Health, an estimated 690,000 Australians living with mental illness need psychosocial support but only around 100,000 have been able to access it (Productivity Commission 2020).

As the national mental health organisation representing this particularly vulnerable community, SANE is working to close this gap through the delivery of a new digital support service designed specifically for those living with complex mental health needs.

A new type of support service

Designed in partnership with ALIVE, the National Centre for Mental Health Research Translation, and funded by the Australian Government, the SANE-guided service involves regular access to qualified counsellors, one-on-one guidance from trained peer support workers, connections to moderated lived experience discussion forums and access to a range of therapeutic activities designed to support recovery and help participants learn the skills to better manage their mental health.

Participants receive a login to their own online portal containing a personal support plan, calendar of key appointments and events, booking tools for sessions, SANE surveys and the ability to plot a personal recovery journey including tracking progress and accessing instant support. Participants also receive recommendations for, and linkage to, relevant community and social services.

Importantly, the service is free, can be accessed via self-referral, and is accessible through any internet-enabled device – meaning it can overcome some of the existing barriers to care experienced by this community.

How can this service support counsellors?

The guided service is suitable for adults living with one or multiple mental health conditions that significantly impact their daily life. Carers and family members can also receive support through the program.

SANE counsellors are specifically trained in complex mental health issues, are trauma-informed and use a strength-based approach to build connection, personal skills, confidence and self-knowledge. They use evidence-based counselling techniques including cognitive behavioural therapy, motivational interviewing, mindfulness, open dialogue and acceptance and commitment therapy. This means they are capable of providing an effective treatment bridge for individuals waiting to access more formal, ongoing care.

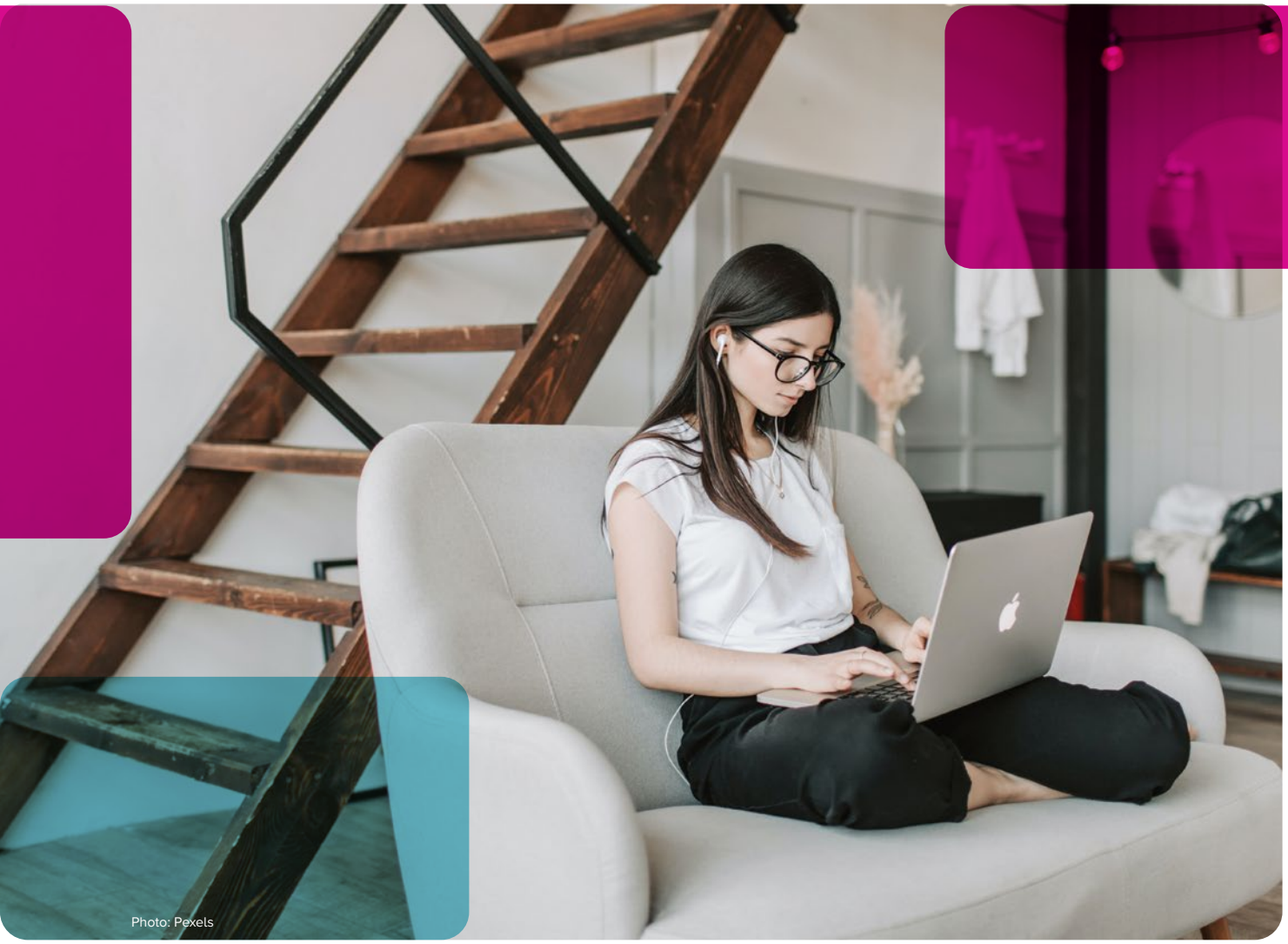

Photo: Pexels

The service is also designed to complement and extend existing treatment pathways by incorporating goal setting and measurement to encourage accountability and enable tracking of actions.

Uniquely, the service also supports those living with co-occurring neurodiversity or intellectual impairment or disability, with all service workers receiving 3DN and ABA training. This makes it a highly useful adjunct tool for counsellors working in the community services or National Disability Insurance Scheme (NDIS) space.

What impact has the service had to date?

The SANE-guided service launched in June 2022 and, currently, access is limited to adults living within 13 Primary Health Network regions (a list of eligible regions can be found on the SANE website).

Since the launch, there have been over 1000 referrals to the service, with the majority of service users being self-referred consumers who identify as female. There has also been a significant uptake by individuals reporting co-occurring autism and attention deficit hyperactivity disorder. There are currently just under 100 carers accessing support via the service.

Involvement in the program lasts for an average of six to 12 weeks, but most participants are remaining to continue their involvement in peer group discussions and SANE webinar events. Referrals assessed as unsuitable for the program were directed to other SANE support services or external support services.

External referrals have come from a range of sources including treating mental health professionals, GPs and community health providers and the feedback we have received from these groups has been overwhelmingly positive.

SANE is rolling out the service in a number of locations across the country with hopes of this being extended to all regions in the future. ■

More information

To learn more or to refer a client, please visit sane.org/referral.

About the author

Emma Tyers is manager, counsellors at SANE, and holds a Bachelor of Psychology and a Graduate Diploma of Psychology.

MAKING THE MOST OF SUPERVISION

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By **Dr Judith R Boyland**

Illustration: 123rf

Supervision is a process familiar to all practitioners who work in the field of allied health, and to a wide range of professionals who work across diverse fields of human service. So, where did it all begin? According to Watkins (2013), Freud is typically credited with having initiated the possibility of supervisory practice by way of three events. These are recorded as being:

1. consultations with Breuer practitioners about their patients' hysterical symptomatology during the 1890s;
2. the holding of weekly theoretical and case discussion meetings in his home beginning in 1902 (Davies, 2020); and
3. the tutoring, or 'supervising', of the father of a little boy about how best to work with his son (referred to as 'Little Hans') who was experiencing a host of psychological problems.

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

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


Illustration: 123rf

practice as the "cathartic method" (Gay, 1988, p. 65).

Moving into the 20th century, the Berlin Poliklinik, which opened on 16 February 1920, was the first clinic in the world to offer free psychoanalysis. It came to be the model for future institutes. It was the first establishment to use psychoanalysis as a treatment and to establish a tripartite training model of psychoanalytic education to prepare and supervise future psychoanalytic practitioners.

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

- seminars – didactics focused on grounding in theory and conceptualisation of that theory into practice;
- training analysis, where each student engaged in personal experience of psychoanalysis; and
- supervised practical work.

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

Professional supervision – what is it?

Since its inception, supervision for the allied health professional has attracted a diverse range of definitions, highlighting the clinical, personal experience and teaching/learning aspects of the supervisory process. Stoltenberg and Delworth (1987, 34) focus on the clinical aspect when they define supervision as "an intensive, interpersonally focused, one-to-one relationship in which one person is designated to facilitate the development of therapeutic competence in the other person". For Lane and Herriot (1990, 10) it is "a therapeutic process focusing on the intrapersonal [sic] and interpersonal dynamics of the counsellor and their relationship with clients, colleagues, professional supervisors and significant others". And for Marais-Styndom (1999), 'support and learning' is highlighted with reference to "a formal process of professional support and learning which enables individual practitioners to develop knowledge and competence, assume responsibility for their own practice, and enhance public protection and safety in complex situations."

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

review, reflection, critique and replenishment for professional practitioners.

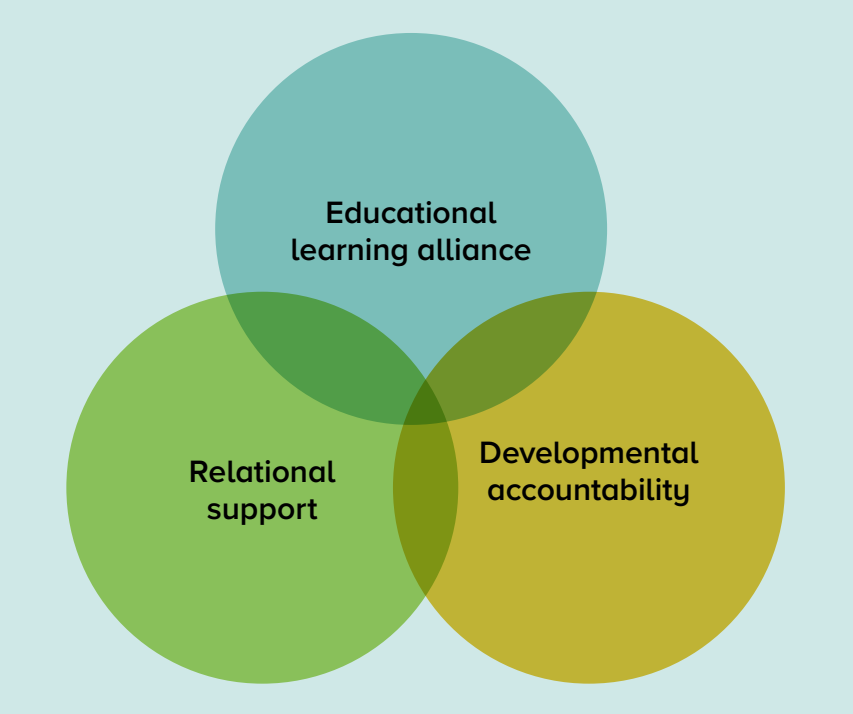
What is becoming evident is that supervision is a professional activity in which practitioners are engaged throughout the duration of their careers, regardless of experience or qualification. The participants are accountable to professional standards and defined competencies and to organisational policy and procedures."

However, not until 2003 was the concept of business issues considered as an integral element for discussion in professional supervision. This development was introduced by Armstrong and subsequently tweaked to the current wording as featured in Armstrong (2018). Armstrong's definition enunciates supervision as "the process whereby a professional can discuss personal issues (where appropriate and impacting on work); professional/clinical issues; business issues; and industry/work-related issues with a qualified professional supervisor, who is usually more experienced than the supervisee, in order to identify and resolve professional concerns and emotional issues, and help the supervisee to evolve professionally in a positive manner." (Armstrong, 2018).

Key functions of professional supervision

Reflecting on the collective nature of the notions put forth in defining 'supervision', it could be perceived as a forum for reviewing practice alongside policies and procedures and the ethical and practice guidelines and standards of the industry. Attention is focused on accountability for client outcomes while assisting the counsellor to clarify role and responsibilities within and across practice context. Thus, it might be ascertained that the key functions of professional supervision are educational, relational and developmental (Figure 1). These are not discrete – they overlap, interplay and complement.

FIGURE 1: THE KEY FUNCTIONS OF PROFESSIONAL SUPERVISION



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

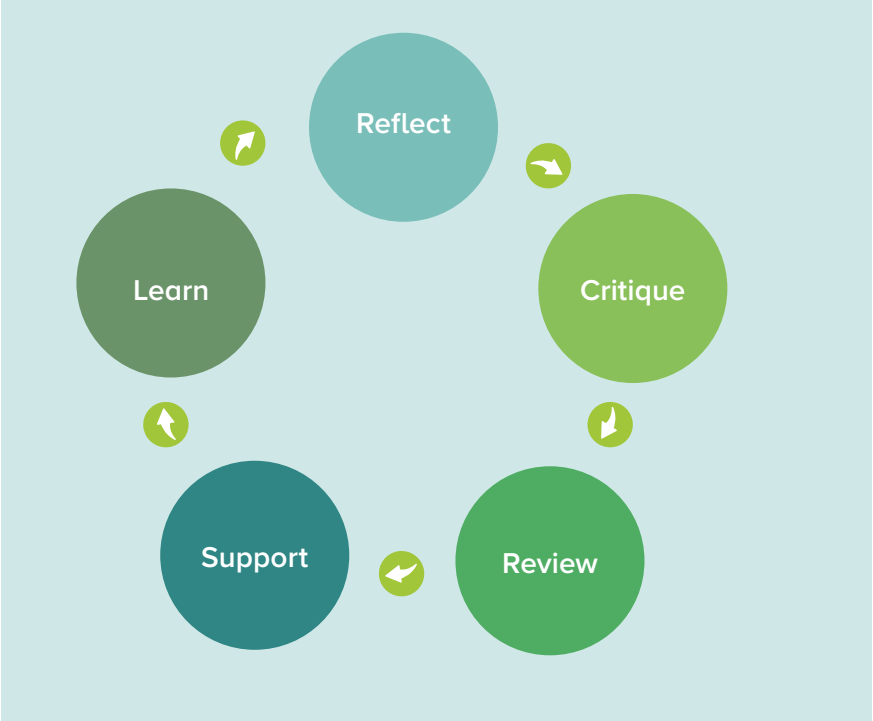
The quality of the supervisory relationship is an important ingredient in the success of supervision. There needs to be a degree of warmth, trust, authenticity and respect between supervisor and supervisee, and recognition of the personal impact counselling practice can have on the practitioner as well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

Why supervision?

Practitioners engage in professional supervision because of the need to meet requirements for industry-specific registration, to meet requirements for membership with a professional association, or to comply with requirements within an organisational structure. For example, the code of ethics and practice for the Australian Counselling Association (ACA) references the need for supervision as defined in articles 4.12.(a)i and 4.12.(a)ii:

4.12 'Competence'

FIGURE 2: THE SUPERVISORY CYCLE



4.12.(a)i Counsellors must have achieved a level of competence before commencing counselling and must maintain continuing professional development as well as regular and ongoing supervision.

4.12.(a)ii Counsellors must actively monitor their own competence through counselling supervision and be willing to consider any views expressed by their clients and by other counsellors (Australian Counselling Association, 2022. p.14)

Also stated in Queensland's *Clinical Supervision Guidelines for Mental Health Services* is the mandate that "ongoing supervision for all clinicians involved in the delivery of mental health services is critical to ensure quality assurance in mental health practice, regardless of experience and level of appointment" (Queensland Health, 2009. p6).

More significant than compliance with a 'need' imposed from sources outside of self is the 'want' that emanates from one's internal professional motivation, resulting in participating in supervision not because I must, but because I want to.

In consultation with a supervisor, the supervisee creates opportunity to reflect on all elements of practice – to look back on therapeutic engagements with clients and critique what was done, what was said, somatic transferences and counter-transferences, and the counsellor/client therapeutic alliance. One reviews what worked and what did not, and discerns what might be done differently next time. One also explores the impact that work is having on wellbeing and the cyclical flow of wellbeing impacting work. This is the space where the practitioner seeks and accepts support and where there is engagement in mentoring and learning activities that will be beneficial for both personal and professional development.

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

- monitor and promote welfare of clients seen by supervisee;
- where supervisee is also a supervisor, monitor and promote welfare of clients seen by supervisee's supervisees;
- monitor supervisee's holistic wellbeing and self-care;
- promote development of supervisee's professional identity and competence;
- fulfil requirement for supervisee's professional accreditation; and
- fulfil membership and registration requirement of recognised professional body.

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

Role of the supervisor

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

The supervisor also has an ethical responsibility to ensure the supervisee is aware of the importance of their own physical, emotional and psychological health, and support the supervisee in sustaining a healthy, holistic state of wellbeing. An additional element of responsibility that accompanies

The supervisor's primary role is to ensure the supervisee's clients are receiving appropriate therapeutic counselling... This is to enable the practitioners, in turn, to ensure their clinical clients are receiving appropriate counselling and therapeutic support and intervention.

the supervisory role is being alert for any symptoms of burnout, transference, countertransference, dependency, co-dependency or hidden agendas in the supervisee and/or in the supervisee's practice.

Where signs or symptoms of these reactions are detected, they need to be discussed with the supervisee and – if it is felt that there is potential risk to either the supervisee or the supervisee's clients – the supervisor's role is to direct the supervisee to seek relevant support. Furthermore, depending on the severity of the condition, the supervisee needs to be directed to cease practice until presenting issues are resolved. If the supervisor discerns the supervisee's clients are at risk of harm – physically, emotionally or psychologically – the supervisor must report to the relevant professional association and, in extreme circumstances, directly to the Office of the Health Omudsman, the Health Care Complaints Commission.

Duties and responsibilities of the supervisor

Summarising recommendations suggested in Pelling et al (2009 and 2017), the following list of supervisory duties and responsibilities is offered for reflection:

- challenge supervisee to validate approaches and techniques in professional practice;
- intervene where client welfare is deemed to be at risk – that is, welfare of supervisee, welfare of supervisee's clients and – where applicable – welfare of clients engaged with supervisee's supervisees;
- provide information relating to alternative approaches for the supervisee to consider;
- monitor basic micro-skills and advanced skills, including transference and counter-transferences and dependency and co-dependency issues;
- encourage supervisee's ongoing professional education;
- ensure supervisee is aware of scope of practice and ethical guidelines and commits to maintaining professional standards across all areas of practice;
- challenge and support supervisee in professional growth;
- monitor supervisee's holistic wellbeing;
- provide consultation when necessary;
- discuss administrative procedures; and
- for supervisees who are in private practice, discuss business practice issues as may be relevant.

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

Role of the supervisee

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

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

Duties and responsibilities of supervisee

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

In a similar vein as defining duties and responsibilities of the supervisory role, the following list of supervisee duties and responsibilities, sourced through personal discussion with clinicians and extracted for Pelling et al. (2009) and Pelling et al. (2017), is offered for reflection:

- uphold ethical guidelines and professional standards;
- discuss client cases with the aid of written case notes and video/audio devices as may be appropriate in relation to specific contexts;
- validate diagnoses and professional judgements made;
- validate approaches and techniques used to address presenting issues;
- consult supervisor or designated contact person in cases of emergency;
- maintain a commitment to professional growth, ongoing education and the profession;
- complete homework tasks as may be either negotiated or directed;
- implement supervisor directives in subsequent sessions; and
- be open to change and incorporate alternative methods of practice.

Qualities and skills of an effective supervisor

Referencing the emergence of 'counselling supervision' as a professional specialty, Dye and Borders (1990) highlight the notion that professional supervisors require specific training in processes of supervision and in industry-related topics. They also highlight the notion that effective counsellors are not necessarily effective supervisors. According to Armstrong (2020), "professional supervisors are generally experienced, well-rounded professionals who have experience in leadership roles, policymaking, motivating others, administration, working at the coalface, and some form of knowledge that is parallel to any speciality areas in which their supervisees work" (p.33).

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

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

Within supervision sessions, effective supervisors use basic counselling skills such as listening, reflecting, mirroring, empathy, compassion and encouragement. They facilitate the process of supervision so that supervisees are enabled to define their own goals, to reach their own decisions and to become self-directed. They judge without being judgemental and offer clear guidance and direction when needed. They also encourage professional development and suggest resources for the supervisee to consider.

Effective supervisors are available for consultation between sessions (within reason). They support their supervisees through personal issues that may impact best practice and they promote reflective practice by providing a safe space for reflection to transform practice and promote professional growth. They demonstrate practice skills and expertise by relating practice to theory and disclosing professional knowledge that is relevant to the supervisee's presenting concerns. They ask open questions, give

frank and honest feedback and, where applicable, discuss business practices and business management strategies. They discuss industry-focused ethics and legislation and support innovative practice by encouraging supervisees to bring new ideas into their practice and service delivery.

Context of supervision sessions

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

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

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

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

Types of supervision

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

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

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

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

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

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

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

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

Line supervision: The focus of line supervision is on day-to-

Good supervision is not about control. It is about empowerment – empowerment of the supervisee, which leads to empowerment of the client. It will help practitioners to reflect on their own therapeutic practice, to provide the absolute best professional service to clients, and manage the complex situations and conflicting work pressures that arise.

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

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

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

Supervision models

Models of professional supervision can be aligned under three umbrellas, reflecting the three differential functions: educational, relational and developmental.

There are psychotherapy-based models where theoretical orientation informs the observation and selection of clinical data and where focus is on the meaning and relevance of the selected data.

Approaches underpinning psychotherapy-based models include:

- psychodynamic, which draws on clinical data;
- feminist, which affirms that the personal is also political and is oriented towards gender fairness, flexibility, interaction and life-span integration;
- cognitive-behavioural approach, which focuses on cognition and behaviour; and
- person-centred, which is grounded in Rogerian theory and focused through a perspective of collaboration (Frawley-O'Dea & Sarnat, 2000; Haynes et al., 2003; Lambers, 2007; Liese & Beck, 1997).

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

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

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

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

and supervisors in the field.

Characteristics of **individual** models include:

- agenda that is tailored to individual needs of supervisee;
- allowing for actual case studies to be discussed and examined without concerns of breach in confidentiality;
- enabling supervisee to explore practice weaknesses without feeling defensive or exposed;
- ad hoc sessions, as they are useful for providing more immediate support and learning from difficult situations that arise;
- a trusting and supportive supervisory relationship, which can develop quickly;
- allowing for more in-depth reflection and discussion in relation to both personal and professional matters;
- no sense of inferiority in the presence of other practitioners who may be more experienced or more vocal;
- supervisor and supervisee are appropriately matched;
- resource and time-intensive; and
- experienced and trained supervisors providing reliable ad hoc as well as scheduled sessions.

Characteristics of **group** models include:

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

Characteristics of **peer** models include:

- participants tend to feel less threatened and more comfortable in using skills and resources of trusted colleagues to support reflection on practice;
- peers will usually be familiar with the situation being discussed;

- as a sole method, this is less appropriate for the less experienced practitioner;
- there is risk of sessions becoming chat and complain forums;
- sessions may become too informal, lacking the process and challenge to enable growth;
- limited opportunity for accountability and education when peers are inexperienced;
- in the absence of a group leader, there is greater need for a clear structure and specific outcome objectives;
- there is opportunity to be highly productive when participants are experienced; and
- they require greater commitment from the group.

Content of supervision

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

When using Armstrong's RISE UP model of professional supervision (2020/2018/2003), focused discussion will incorporate aspects of:

- evaluation (anything to do with people – such as clients, colleagues, workplace relationships, interactions within the supervisee's practice);
- education (modalities, interventions, professional documents, theory);
- administration (anything to do with paper – such as ethics documents, scope of practice documents, policies, procedures, recording/reporting documentation); and
- personal and professional support (holistic wellbeing).

For supervisees in private practice, aspects of business building and business management will also be discussed. This holistic model of professional supervision is in contrast to pure clinical supervision, where the focus is on reflection, critique and review of the evaluation component as it relates to clinical work. As referenced by Queensland Health (2009), "Clinical supervision can be seen as a process that promotes personal and professional development within a supportive relationship, formed in order to promote high clinical standards and develop expertise by supporting staff and helping them to prevent problems in busy practice settings" (p8).

Good supervision

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

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

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

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In this series, counsellors share with *CA* their professional journeys and the things they have learned along the way. Nutritionist and counsellor **Melinda Overall** tells CA what she wishes she knew in the prelude to her career.

So you want to be a counsellor ...

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?

1. Find a supervisor who you trust and who can help you grow in your practice – and start looking for them early.
2. Remember that you won't be the right fit for every client, they might go elsewhere, and that's totally ok. They need the right person to do their work.
3. Know that you have to keep doing your own work to grow as a person and practitioner.

Remember that you won't be the right fit for every client, they might go elsewhere, and that's totally ok. They need the right person to do their work.

Would you change your decision to become a counsellor? Why or why not?

Absolutely not. I love this work and really appreciate the privilege that it is to work with clients. My understanding of working with my nutrition clients and students has deepened in my 5.5 years of counselling practice.

I had a 25-year career in human resources prior to studying nutrition (I've been a nutritionist for 10 years) and counselling, and I wish that I had studied counselling earlier. I'm currently planning on heading back to university to complete a Master of Counselling.

How do you describe the work that you do?

As I have the three different aspects to my work, describing it depends on which part I'm discussing.

I describe my nutrition work as working with clients to improve their health and wellbeing through increasing their understanding about food and its impact on their health. This can include development of meal plans or general recommendations around diet. Information provided to clients might also include lifestyle recommendations. My work also includes analysis of diets and blood test results to determine any suboptimal micronutrient levels, and assisting to correct them with nutritional supplementation.

As a lecturer in clinical nutrition, I teach fundamentals of the above to students and supervise nutrition students in the student clinic.

As a counsellor, I think I best describe my work as developing therapeutic and healing relationships with clients so that they feel safe to work through, contemplate and develop strategies to manage life's stressors and difficulties. I view myself as a humanistic strengths-based practitioner who aims to assist people develop resilience and to improve their self-view.

Do you love your work? Why?

I do love my work. Mainly because I have three work streams and this ensures variety, different learning and exposure to different people and work settings. I also really appreciate the synergy between my work as a nutritionist and counsellor.

My nutrition clients and counselling clients never shift to the other part of my practice. It is fabulous to recognise how the skills of each practice support the other, and improve outcomes for clients. This is especially so in the context of the gut–brain axis and recognising the significant role that food plays in mood.

In all of my work streams, it is such a gift to be able to support people and to witness their growth. ■

About the counsellor

Melinda Overall

Master of Human Nutrition (Deakin); Grad Certificate of Human Nutrition; Advanced Diploma of Nutritional Medicine; Graduate Certificate of Counselling; Diploma of Counselling; Certificate IV Training and Assessment; Advanced Certificates in Training & Development, and Personnel Management.

Nutritionist and counsellor in private practice in Summer Hill, Sydney. Lecturer, Bachelor of Health Science (Clinical Nutrition) and nutrition student clinic supervisor – Torrens University. Associate – AccessEAP.

How do nutrition and counselling combine and what is their importance to each other?

I am a university-qualified nutritionist and qualified counsellor working in private practice in Sydney's inner west, and I am a lecturer in Nutritional Medicine at Torrens University.

My career mission is to help people obtain optimal health through diet and lifestyle coaching with minimal supplementation.

I am passionate about food as medicine and am a firm believer in the concept of 'food first' wherever possible.

The choices we make around food can significantly impact our health and wellbeing, for better or worse. With a busy lifestyle, it is easy to get lost in those food choices, but with a nutritional guide, you can make better decisions, get back on track and enjoy a healthier you.

SANDTRAY THERAPY: PSYCHOLOGICAL HEALTH AND WELLBEING

By **Fiona Werle**

Abstract

Sandtray therapy is a psychotherapeutic approach to healing based on the research and work of Dr Margaret Lowenfeld (1929), child psychiatrist. This method allows the sandtray therapist to provide the individual a safe and expressive space for exploration of their intrinsic world of emotional and mental states using an indoor sandtray and the vast array of miniature objects that children, adolescents and adults use in different ways to access the implicit image activity of the right brain hemisphere. Sandtray therapy is supported by theoretical frameworks and has been evidenced to adapt cross-theoretical methods into this framework including trauma-informed principles. The aim is for clients, across the life span, to experience good psychological health using this psychotherapeutic approach, where changes to neural plasticity will be of a lifelong benefit, leading towards awareness, new perspectives, a new trauma narrative and self-growth. Sandtray therapy is a non-intrusive trauma-informed approach that is often non-verbal and accessible to ages from three years throughout the life span. This paper will explore these various stages to understand the influence of unmet needs and how these can be met in the exploration of sand worlds.

Introduction

Lowenfeld stated in a paper, 23 March 1938, that "the role of psychotherapy is to make contact with the whole of the patient's mind. My own endeavour in my work with children is to devise an instrument with which a child can demonstrate his own emotional and mental state without the intervention of an adult either by transference or interpretation" (Urwin, 1991).

Photo: 123rf

We often project onto others what we need to see for our own learning. The lessons we learn, sometimes successfully, sometimes not so, are played out in our private playgrounds in which we learn and grow – this could be called the playground of life – which carries all the changes through the life stages that can have a dramatic and profound effect on our lives. The loss of a loved one can take our emotions to places we never knew existed, then at later stages in life we may experience financial difficulties, social issues or changing family dynamics. These can all be triggers that can be experienced as a trauma. It is not the intention of this paper to differentiate the different types of traumas into categories, but simply for the reader to acknowledge the ability of sandtray therapy as a method of exploration of trauma throughout the life span.

Sandtray therapy: psychological health and wellbeing

Towards the end of the life span, we look for a sense of connection. Erikson's psychosocial stages express this as generativity vs. stagnation (McLeod, 2019). Some choose to ground their sense of belonging in faith or religion, others go deep into their psyche and explore their soul equation in search for answers or, perhaps, the meaning of life (through Socratic questioning of the self), asking that profoundest of questions: who am I? Sandtray therapy is a means to guide clients through these psychological processes, unlock thought-provoking and deep aspects of yet uncovered virtues to achieve unmet stages of development, self-growth and good psychological health and wellness.

Lowenfeld (1969) – the original developer of sandtray

therapy, known as 'The World Technique' – entered her own psychotherapeutic work through medicine, and she made explicit links between emotional and physical processes as they emerge in the psychosomatic disorders of childhood (Lowenfeld, 1930). Influenced by her own experience of World War I and the association with shellshock (post-traumatic stress disorder), she came to understand the importance of psychoanalysis through a different route and in a different way. Lowenfeld's interest in psychotherapy and the personality of the child was precipitated by wartime experiences.

Take a moment to think about your own childhood's implicit images, memories and hurtful words. Now come back to be an adult. Do you hear yourself echoing things you heard, repeating your parent's words: 'You can't do that, you're too short/tall/thin/fat/dumb' or 'That's a boys' job, girls can't do that' … and on it goes. All these words we took in to our core, our very being, they formed part of our belief system and those words were stored in our unconscious mind and our body (Maté, 2011; Ogden, 2015; Lipton, 2008) in the form of images and a felt sense. Lipton (2008) in his work on epigenetics and Maté (2011) in his research into the body–stress connection both analyse trauma and how words, actions and emotional felt senses are warehoused in the very cells of our bodies. Individuals carry trauma in different parts of their bodies – this concept forms a part of the theory of psychosomatics, which is a very real area of health and wellness in which unhappy people will undoubtedly create or manifest pain within the body. We see a clear example in children who are unable to express their distress in words, instead they may say "I have a sore tummy". It is important to note that Chinese medicine, with its thousands of years of use, shares this philosophy. The body–mind connection: it is how our systems communicate to us that there is a disease building up. This could be an issue from childhood that was left unchecked, pushed away.

Pat Ogden (2015), an advocate for the body–mind connection, has been able to provide the research that Lowenfeld was not when she talked about the 'whole self' and having the instrument as a healing medium to tap into the different energy zones or modes. Maté (2011) takes this research to another level by suggesting there are certain personality types who are prone to disease. If this is indeed a fact, then it is of utmost importance that children are given this medium of sandtray therapy to express emotional stress before any physical symptoms are manifested. As adults we can say that the following apply:

- Do you get a headache at the mention of someone's name or a task?
- Do you feel sick in your stomach from nerves if you have to do public speaking?
- Does your ankle hurt when you need to step up, move forward, and take control?

This is your body reacting, saying, 'No I can't do it, I won't do it, you told me I couldn't, shouldn't.' You get the picture; our resistance is entirely stored within our whole self. This is the mind–body connection. This is the depth at which the child ego pushed down the hurts and pains for self-protection. It served us then, but as adults, it no longer serves to hold the pains of yesteryear. Left unchecked, this stagnation can erupt into disease, illness or even death in extreme cases, because it was easier to manifest cancer (Maté, 2011) or heartache than to look at the issue that has caused you so much discomfort. Trauma held is a very real and dangerous foe.

As adults we are capable of change, growth, wisdom and knowledge, yet trauma in the form of complexes hinders growth. We can be left with our deep-seated beliefs (think the iceberg effect) where the traumas are lying just below the surface, pushed down into the unseen realm; this is your unconscious mind, it lies just beneath the psyche, the non-thinking place. We see the psyche as the bridge between or integrator of our left and right brain (Badendoch, 2008). In sandtray therapy, this is the realm of great interest, and the area of the brain that is activated by this method is the intrinsic right brain realm. We are often driven by these unseen forces to behaviour fuelled by our complexes; if we have little awareness of these drives, our attitudes are reflected in this behaviour, thinking and way of being in the world – from tantrums in children to aggressive bouts of behaviour in adolescents and adults.

An example of a complex could be not feeling good enough. But how was that seed planted and how can this lead to trauma? This is the nagging voice in your head, rumination, the monkey mind, the wounded ego, the one that

Photo: Fiona Werle

confirms to you as an adult that 'no you can't do that, remember!', 'you aren't smart enough, good enough, pretty enough' – and so we fulfil that complex by not acting because we believe the voice. This voice was a harsh parent, a word said in anger or an angry parent or carer who themselves were treated unfairly. Here we could go on to discuss intergenerational trauma, attachment and abuse; however, as I have stated, this paper will remain focused on the exploration of trauma through the life span. The continuing line of intergeneration trauma has its roots in passing on negative and abnormal behaviours. Sandtray therapy can stop trauma from its energetic flow and profound significance in thinking and behaviour. Through the exploration of the conscious and unconscious mind, this is where deep psychology is found, and this is where we work using sandtray therapy, working through childhood traumas, attachment issues and inner child events that may be affecting adult behaviour and psychosocial development through the life span.

The sandtray miniatures as objects represent memories as implicit images from the ages of two to seven years, according to Piaget's preoperational stage of symbolic thought (Peterson, 2010). To build resilience against a trauma is to relive that moment where you were vulnerable and unable to defend yourself against harm, either physically or verbally (culturally). To cope, you pushed your felt emotions down to a safe place in order to cope in dealing with a situation or a person's behaviour towards you. This is the job of the ego; however, what we need is a healthy balance and that is why presenting issues to the sandtray can open that deep part of our inner self and gently allow an exploration into our implicit self-equation. Sandtray is a gentle, non-retraumatising way of exploration.

Sandtray miniatures are also known as archetypes and are used in the process of creating a visual sand world, forming the internalised world of the creator as an external sand world. These miniatures are given meaning by the client or creator and become the symbol in the tray that may guide the new trauma narrative. An example could be a dinosaur used by a child – not as a dinosaur, but as the hero that rescues the mother and child from the enemy. Now, the dinosaur as an image has taken on the character strengths and virtue of 'courage'. The antagonist, the abuser, is no match for the brave dinosaur, who helps to change the story by giving the child the courage and strength to speak up. A new trauma narrative is created by expressing and verbalising of old beliefs (cognitive behaviour therapy) and the felt sense released through the sensorimotor manner that is sandtray therapy. This body–mind connection is grounded in neuroscience (Badendoch, 2008; Ogden, 2015).

A skilled professional sandtray therapist offers clients a safe and trusted space where children,

adolescents or adults affected by trauma can play out their distress. Often with children this is a non-verbal manner of therapeutic healing. Therapists often observe that children group clusters of miniatures according to their subjective sensory experience of objects and events, and these objects are classified into proto systems. This is a system of grouping and linking between experiences, giving rise to primitive thought structures that Lowenfeld called clusters (Urwin, 1991). Proto systems become the way in which a trained professional can distinguish a trauma sandtray from others, as the sand player – whether child, adolescent or adult – gives meaning to objects in relation with other objects. As a therapist follows a client's sand world series, the objects can reorganise to show a healthy development and more developed cognitive ability. This reorganisation of sand worlds according to Barbara Turner (2005 pg. 285) is the "elemental reorganisation of experience in sensory, feeling laden clusters whereby the client is affecting differentiation in various aspects of their inner and outer experience into coherent meaning systems". In other words, building resilience, creating a new trauma narrative, implanting new images to mind and releasing felt senses.

Metaphor in the sandtray

An awareness as an adult means you can steer your own ship, and yes there will always be a strong wind blowing you off course, dangerous undercurrents and rips and shark-infested waters. But isn't this a wonderful metaphor for life because, on the other hand, you will also experience perfect sun-filled days, calm waters, gentle breeze, dolphins playing and sails billowing in the gentle breeze. These form the Polarity of Balance: we need to experience the extremes in order to find our best place or balance. Here in nature, and life in general, you find opposites, duality and a shadow side where neither can exist without the other. The more you experience adversity with an open mind, the more you can explore the many sides of you. The more you relax into the joy of profound synchronicity, the more you attract good health and wellness. The key is self-awareness and the courage to climb from the depths of self-indifference to the heights of self-awareness – whether the courage is contained in a dinosaur or another image, this is key: find your central figure, your hero or heroine. Let them be your courage, let them walk beside you to explore your trauma in your hero's journey.

Lowenfeld would have loved our modern-day Star Wars characters as images, the fusion between fantasy, reality, the present and the past, and the person we perceive ourselves to be, our persona and our shadow self behind the mask! I mean, who doesn't want to be the hero or heroine in their own story? The rest is how we got to be the characters in our life's story. Just like our dream state, we are connected to each and every character or miniature in the sand world through our unconscious mind playing out our unresolved issues and childhood traumas, leading us to the experiential centre of 'who am I?' and 'what is my purpose?' And importantly, 'how do I heal?'.

Childhood patterns and the inner child

Fundamentally, we heal by allowing the space for our psyche to place the symbols within the

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boundaries of the sandtray to tell our story. This method allows a glimpse at intergeneration where we get to see the patterns of our parents, grandparents and ancestors. Here we can see if a significant other was a threat to us in our childhood, affecting our attachment bonds, such as it is now the case with many victims of childhood sexual abuse – their memory has been triggered by another's story or seeing the abusers on TV. We use images, memory and story to get to the heart of the real issue, and allow the pain stored in the cells of the body to release. The event will never go away, nor will the memory; however, the pain can be eased.

Sandtray therapy allows adult clients to step back and look at dysfunctional behaviour and set patterns and beliefs expressed in sand worlds. For example, are you one of those people who just never finishes anything? Could it be that you were told by your father that you would never amount to anything in life? So you proved him right, that's how you showed your love. Or are you a high achiever, yet your mother thinks you can still do better? If you attract the wrong type of partner into your life (you know the sort I mean, they're just not the right person for you), you may develop low self-esteem – why? This was a pattern you set up as a child to get attention from your parent. These are also perfect examples of a father or mother complex. If you had as your mantra, 'oh I can't do it' and now you believe you can't do anything, even attract a partner you desire or who desires you, in effect you have intrinsically ingested this belief and the complex has become an intrinsic part of your character. Sandtray therapy can help to see this belief expressed as externalised in sand worlds. Once seen, felt and expressed, a reversal is possible – basically, believing you can do it!

A client may have sexual trauma or issues, perhaps they were brought up to be a good Catholic girl and told feelings of sexual desire were bad, so they buried their sexual urges deep within. Consequently, they may have experienced psychosomatic issues such as invisible pregnancies, cancer of the ovaries or miscarriages. So be careful of what you are reading here, what I am saying we have already covered in this section around our cells holding memory and psychosomatics. Tapping into what or who set that idea into the mind of the child can set you free as an adult. Sex is good, good sex is great. No church, religion or state can tell an adult what to do with their body or their natural urges. As you listen to your mind, listen to your body also, it's speaking to you. Here we may enter into mindfulness or yogic states. A child who experienced sexual abuse grows into an adult who experienced sexual abuse. Sandtray cannot undo the traumatic event, but it can help you distinguish those parts

Photo: 123rf

of you that hold onto the hurt, pain and anger, and explore the sexual complex.

As a sandtray practitioner, I watch a client's body language and listen to their verbal language; with adults I listen for any incongruences, such as saying, 'I'm so sad' with a smile on your face. What's going on there? Once we narrow down a current issue, then I invite you to start processing in the sandtray – that's where things start getting interesting. With children in sandtray therapy, it's a little different; they will choose their miniatures and create sand worlds as an extension of play. They do this by moving the miniatures around, burying miniatures in the sand and placing miniatures together in clusters. Boys may create fighting battle scenes, girls (in general) tend to like fairytale archetypal miniatures. The idea is that they are working through issues from the unconscious (where complexes reside), for example, dealing with how their parents argue, the birth of a new sibling, or more traumatic issues. Children use the sandtray as a preventative place of therapy, of sorting through the self-equation and thereby releasing pent-up stress held in their body. Current issues and early traumas are also explored and given a new trauma narrative.

Carl Jung in *The red book* talks a lot about our "other selves" – he shows us how we can be many personalities in one. And I don't mean schizophrenia, I am talking about our different personas, characters we have as traits – such as the rescuer, the martyr, the leader, the enabler etc. – that are found within our whole self, they make up our personality and make us all unique. However, some traits have been adopted from our parents or role models and, because of this, some children or adults may lose their own sense of identity. Erikson represented this as industry vs. inferiority (competency) in ages five to 12 years and identity vs. role confusion (fidelity) in ages 12 to 18 years. The key is to be aware of your personality traits, recognise as many as possible and find the balance. It's important that if you are a rescuer, you allow yourself to be rescued, or if you are a martyr, you recognise that you can't always save the world. These are the very things that the sandtray will highlight through the choice of miniatures and exploration.

> Sandtray therapy is cross-theoretical and works well alongside many different models of therapeutic techniques, including cognitive behavioural therapy (CBT), rational emotive behavioural therapy (REBT), narrative, person-centred, mindfulness, positive psychology, sensorimotor and neuroscience.

Sandtray worlds will reveal, through the chosen miniatures and patterns in the sand, a side to your own true self that you may be unaware of. Remember we spoke of the dinosaur representing a child's courage? Courage is a virtue; it lies dormant if not ignited by the energy of the sand player who instinctively knows to tap into the 'object'. This is your story and as the therapist follows this story of your inner child, they may be curious and ask questions only you know the answers to. Through advanced empathy and by tuning in, the therapist experiences a limbic resonance that serves to bring in the safety and trust – basic elements, but necessary ingredients. If these were unmet needs as a child, then now as an adolescent or adult these needs

can be met through the therapeutic alliance. Buried very deep beneath the ocean lies the true you, ready to be revealed and swim to the surface to finally begin to live a true authentic life, just as Mother Nature intended.

Sandtray therapy is cross-theoretical and works well alongside many different models of therapeutic techniques, including cognitive behavioural therapy (CBT), rational emotive behavioural therapy (REBT), narrative, person-centred, mindfulness, positive psychology, sensorimotor and neuroscience. Sandtray therapy is a therapy that can be used as a standalone method or combined to work collaboratively with other psychological methods. It cannot currently be quantified to satisfy the scientific rigour of today's psychological assessment. However, there is descriptive and correlational approaches to quantitative research to support the proof of the success of this method, documented by Dr Lowenfeld since its inception in 1928 and some of her predecessors. Its success is also echoed by the thousands who have been brave enough to enter its realm, they echo the evidence in their voices and in their advocacy. It is the purpose of this author to continue to explore quantitative research designs, that support this method as a trauma-informed practice used extensively in Asia, the UK, the US, South Africa, Canada, New Zealand and Australia.

Conclusion

In sandtray therapy, the ease at which the miniatures in the sandtray become the language of the unconscious mind, how it awakens a part of the client's cognition and nudges them on to discover more, to go deeper, to reawaken a knowing and awareness that resides within them – this is resilience unfolding. Sandtray therapy holds no barriers; it cares not about your faith, beliefs, language nor culture, nor you age – you can be three or 103 – it does not matter. What matters is that this method enables expression and choice, and choice is a key to healing trauma. It helps to build resilience, awareness, new perspectives, and it opens your mind to other ways of thinking, doing and being. This paper has highlighted the non-verbal and intrinsic nature of sandtray therapy and its ability to embrace the cross-theoretical approaches, yet as a standalone method it holds firm. It is a method used currently throughout the world. Children benefit by simply being able to play out their childhood issues in the sandtray, adolescents and adults benefit by tapping into an expressive non-intrusive method to explore issues or trauma across the life span. ■

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About the author
Fiona Werle is CEO of Opengate Institute and a level 3 ACA member.

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About the author

Peter Baldwin is Head of Clinical Research (Acting) and Clinical Psychologist at Black Dog Institute.

THE ESSENTIAL NETWORK – THE ONE-STOP SHOP FOR HEALTHCARE WORKERS

Peter Baldwin

When the COVID-19 pandemic took a hold on our lives, it shaped the wellbeing of our healthcare workers – many of whom reported feeling a sense of burnout as a result.

In 2020, Black Dog Institute launched The Essential Network (TEN) to help healthcare workers manage burnout and other mental health challenges of the pandemic. Nearly three years on, TEN is still needed now as much as it was then.

To date, more than 82,000 healthcare workers have visited the e-health hub via the Black Dog Institute website and over 15,000 digital mental health assessments have been completed. The free telehealth clinic has seen over 200 healthcare workers who have collectively completed over 600 consultations with a clinical psychologist or psychiatrist. The clinic sees approximately 25 new patients each month and almost all use the five free telehealth sessions available. These sessions are not accessed through Medicare and healthcare workers do not require a referral to access them, so they can rest assured they're completely confidential.

Of all healthcare workers, NSW nurses have used the TEN clinical service the most and were the largest cohort to complete a digital mental health assessment. This potentially reflects the fact that nurses are the largest single group of healthcare workers but also indicates the ongoing strain nurses are under. Medical trainees represented the second largest group using the TEN clinical service, but interestingly only made up a small percentage of those completing a digital mental health assessment.

An evaluation of an earlier version of TEN showed good service acceptability and small but significant improvements in psychological distress. However, the program did not seem to help manage the most widespread challenge facing health professionals: burnout. This finding prompted Black Dog Institute to develop Navigating Burnout – an evidence-based online program for healthcare workers experiencing burnout. Since its launch in April 2022, over 2000 health professionals have accessed the program.

It is promising to see so many healthcare workers seeking help through TEN, and is vital to help more healthcare workers find resources and support to manage burnout and maintain good mental health. For more information, visit blackdoginstitute.org.au/ten. ■

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RECOVERY THROUGH NOURISHMENT

The long road to recovery – mood improvement through nutritional counselling and increased caloric intake in a young woman with an eating disorder

By Melinda Overall

ABSTRACT

Eating disorder diagnoses are becoming increasingly common in Australia, with new types of eating disorders being recognised in recent times. Research on the bidirectional gut–brain axis suggests that food, mood and mental health are interconnected. This case study reviews the improvement in mood and progress in weight gain/management in a young Australian woman following changes in eating patterns, food quality and increased caloric intake.

INTRODUCTION

Eating disorders (EDs) are a complex group of disorders with a number of drivers, often different for each person, and are difficult to treat for mental health providers and nutrition-based practitioners alike [1,2]. EDs are generally considered to be triggered by both personal and environmental issues such as (but by no means limited to) body dysmorphia, trauma and the impact of peer pressure and social media, which lead to a disordered relationship to food [3].

A young woman aged 26, Sophie (name changed for privacy), presented to clinic following a referral from her treating psychologist.

The psychologist advised that Sophie was undertaking cognitive behaviour therapy for suicidal ideation, an ED (type unspecified), relationship issues and a traumatic family history and, as Sophie states, "just living" – all of which are commonly reported foundations for the development of EDs [3,4].

There is evidence to suggest deranged eating behaviours that include severe restriction can alter the gut microbiota [4] and trigger dysfunction of the gut–brain axis, leading to the development of anxiety and/or depression [5]. Furthermore, research now suggests that EDs too may be a result of a dysbiosis (an imbalance of commensal and pathogenic microbiota) [4, 6, 7]. Questions remain, however, as to the order of development of the conditions – did the ED appear first, causing microbiome disruption, or does a disrupted microbiome trigger the ED? [4] Additionally, consideration needs to be given to the impact of each condition on the other.

During the first appointment, Sophie disclosed she was underweight and experiencing a number of health issues related to severely restricted eating, a deranged eating pattern and, possibly, undiagnosed coeliac disease. Nutritional counselling commenced in September 2021 and continues at the time of writing. The following is a discussion of the case presentation, background, treatment and the positive impact of increased food intake and quality on her mood, mental and general health and wellbeing.

While Sophie is still on the road to recovery, and experiences occasional relapses in deranged eating behaviours and weight loss, she no longer purposefully restricts her caloric intake. She states that these relapses occur when she feels overwhelmed by life. Sophie has not dropped back down to her lowest weight since commencing nutritional counselling, but has not yet reached her goal weight.

She had some disruption to her psychological therapy due to her psychologist moving to another intrastate practice, and she was distressed by the loss of that therapeutic relationship. She now attends therapy with a new counsellor/psychotherapist.

CASE PRESENTATION

A 26-year-old Caucasian Australian female, Sophie, presented via teleconference to discuss strategies for overcoming an ED. She weighed 44 kilograms and was 1.64 metres tall. Her body mass index (BMI) was 16.36, indicating that she was underweight. She stated that her goal weight was 50kg so that she would be able to donate blood.

Family history

Sophie has a traumatic family history with both parents – "addicts and alcoholics" – and she stated that her mother had "relapsed a whole bunch of times". Her mother abandoned Sophie's younger brother and sister, and Sophie was required to parent them at a young age. Her parents later became immersed in the church, but her mother relapsed again. Sophie left home at age 16 and is now estranged from her parents.

Coming from a low socioeconomic background, Sophie states that she was malnourished and was always very thin. When her parents did provide meals, they was poor quality, low in vegetables and fruit and often deep fried. Sophie subsequently underwent a cholecystectomy to remove her gallbladder at age 17.

When we met, Sophie was in a relationship with her partner of three years and was the stepmother to his two children from an earlier relationship. She was mostly responsible for food preparation for the family.

Presenting symptoms

Significant and long-term food restriction had negative impacts on Sophie's health. Her symptoms included:

- eating disorder (self-diagnosed anorexia nervosa);
- low body weight;
- experiencing post-prandial cramps, vomiting (not purging), bloating and borborygmi;
- constipation, but also post-prandial diarrhoea;
- daily headaches requiring two paracetamol tablets two to three times daily;
- dyspnoea on exertion;
- chest pain and palpitations (cardiovascular diagnoses eliminated);
- insufficient sleep (five and a half hours);
- constantly anxious and stressed;
- rumination;
- deep joint and bone pain;
- easy bruising and broken capillaries;
- amenorrhoea;
- negative voices in her head that she believed to be her mother telling her to restrict food;
- suicidal ideation; and
- self-medicating – smoking marijuana twice daily.

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Existing diet

Sophie's existing diet was restrictive and repetitive, and generally did not meet the recommended daily allowances of all micronutrients. Sophie did not eat breakfast, lunch, morning tea or afternoon tea. She ate an entire supermarket frozen spinach pizza (always the same) in bed each night, away from the family. The entire pizza provided only 858 calories (3586.44 kilojoules) and only 26 grams of protein – both significantly under her daily requirement.

The only beverages she consumed were 1.25 litres of water, which she consumed only at night with her pizza, and instant coffee without milk or sugar. She stated that she would consume a medium jar of instant coffee fortnightly.

Sophie had a limited list of 'safe' foods and an extensive list of 'unsafe' foods that she wanted to eat but would not allow herself. She would cook healthy and fun meals for her young stepdaughters, but would not share the meals. Sophie had been restricting her diet and eating in bed for 18 months prior to her initial consultation.

MANAGEMENT AND OUTCOME

It was apparent in the initial consultation that Sophie feared food because of the post-prandial digestive discomfort, and that her relationship with food had been dysfunctional for some time. She was fearful of significant changes in her diet, and only very small changes were implemented in the first few sessions.

Initially, Sophie was asked to sip her 1.25L of water during the day to improve hydration to reduce constipation, improve digestive function, reduce headaches and reduce reliance on paracetamol [8]. She was initially resistant until it was explained that this change to her water consumption pattern meant no increase in her daily energy intake.

Two other small changes were discussed in the first session. These were to eat a tiny portion of breakfast that she made for her


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stepdaughters, and to have a small salad with her pizza in the evening.

Sophie adopted all three recommendations and reported improvements in sleep, reduction of headaches (using paracetamol only four to five times in the previous fortnight), and enjoyed improved connection with her stepdaughters, and she had introduced a 600-millilitre smoothie (banana, strawberries, blueberries and almond milk) for morning tea of her own volition. Sophie was pleased to feel more alert, more energised, less sad and more connected.

At the second session, Sophie reported that despite improvements, she still experienced digestive issues. She noted that her mother had been diagnosed with coeliac disease and that Sophie herself was lactose intolerant. Sophie had not undergone any investigations for coeliac disease. We agreed to assume that Sophie was also coeliac and removed gluten from her diet. Lactose was also removed. This meant that going forward, Sophie would need to make her own pizza and that she could experiment with different toppings and flavour profiles.

The removal of gluten and lactose from her diet significantly reduced her digestive symptoms, allowing Sophie to expand her list of 'safe' foods. She started to eat three main meals plus snacks on a daily basis, and she began eating with family at the dining table. Despite these improvements she had lost 1.6kg, decreasing her weight to 42.4kg (BMI 15.76) after six weeks. This may have been due to ongoing relationship issues. She did report that she was no longer experiencing headaches.

After three months, Sophie had no further digestive disturbances, she was experiencing hunger and attending to it appropriately, had increased her portion sizes, expanded her 'safe' food list, felt less guilt for eating and was able to go out to a café for breakfast for the first time in two years.

Following eight months of nutritional counselling, Sophie reached a weight of 48.9kg (BMI 18.18) – just 900g under a healthy BMI of 18.5 and 1.1kg short of her 50kg goal. At the time of writing, Sophie's weight has decreased to 45.9kg (BMI 17.07). This decline in weight followed disruption to the therapeutic relationship, as two replacement psychologists had been unavailable or unhelpful, and ongoing relationship difficulties with her partner. She advises that she appreciates and trusts her current counsellor, and that she and her partner are discussing next steps.

Sophie remains positive about recovery but has fallen into some previous eating behaviours during this time of stress. With continuing development of the therapeutic relationship with both nutritionist and new counsellor, it is considered that Sophie will continue to recover [9].

DISCUSSION

A combination of dietary modification and therapy has proven to be helpful with Sophie's recovery. A key observation

There is a strong connection between the role of food on mental health, and the impact of mental health on food choices.

through this process with Sophie is the significant interaction between gut health and her mental wellbeing and improved resilience.

Key roles of the gut microbiota include neurotransmitter development and efficacy, modulation of the hypothalamic-pituitary-adrenal axis, and inhibition of neuroinflammation and neural oxidative stress [10, 11]. Additionally, gut microbiota plays a role in the production of brain-derived neurotrophic factor, which acts as a growth hormone for the brain, allowing neuroplasticity and thought patterns to change [11]. The gut microbiota require fibre as fuel, amino acids from ingested protein and other co-factors to build mood-enhancing and mood-stabilising neurotransmitters such as serotonin, acetylcholine, dopamine, oxytocin and gamma-aminobutyric acid [5,12].

Sophie's initial presentation of poor gut health was representative of a level of dysbiosis or gut microbiome disturbance due to possible coeliac disease [5]. This suggests that Sophie's ED and co-morbid anxiety and depression may have been triggered by an imbalance to her gut microbiota. Conversely, her deranged pattern of eating, poor nutritional status and low-protein and low-fibre diet may have disrupted her gut microbiome balance and her supply of mood-stabilising neurotransmitters [5].

While this might seem like a question of chicken and egg, the important observation is that Sophie's mood improved, her suicidal ideation diminished (today she states that "there's a lot to live for"), and her stress resilience improved, as has her self-efficacy following her change of diet. This is likely the result of increased food consumption leading to greater energy intake, more food variety, a healthier gut, greater microbiome diversity and better nutritional status.

Many counsellors, psychotherapists and psychologists receive little training in nutrition and the role of food on microbiome balance and health, and how this impacts the gut–brain axis [13]. Nutritionists and dietitians receive little training on supporting clients in times of psychological need [14]. There is a strong connection between the role of food on mental health, and the impact of mental health on food choices. Additionally, there is an opportunity for synergistic interfaces between mental health providers and nutrition-based practitioners to support clients living with mental health disorders generally, not only those presenting with EDs. ■

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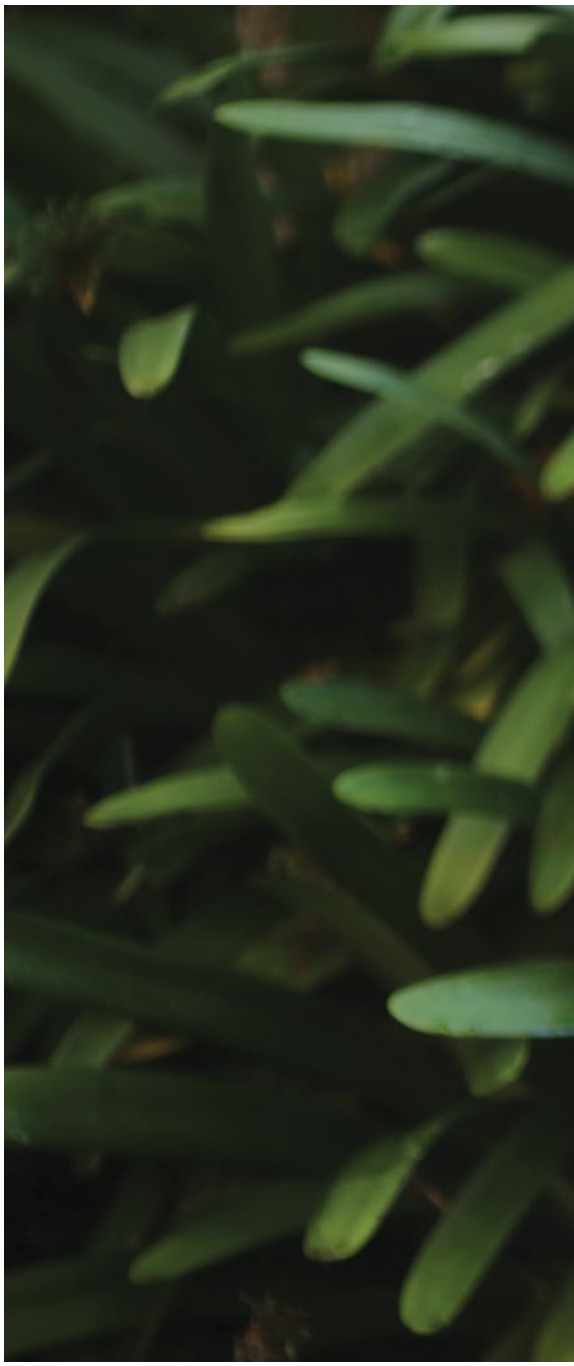
Permissions

Written and verbal consent for disclosure of case details provided by the client.

JULES SILVA



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

What prompted you to move into counselling as a profession?

Existential anxieties emerged at my mid-life that I couldn't ignore. I took pause to reflect on the inevitable vicissitudes of joy and pain I had experienced on my human travels, including the careers (community work, creative arts and communications). It became crystal clear and crucial, for me, to find meaningful work in my final career chapter that is congruent with my deepest-held values. I completed a Master of Counselling and Psychotherapy, and the rest, as they say, is history.

What is the biggest reward of being a counsellor?

When I am with a client, I am taken out of 'self' into 'beginners mind' to give full attention to the unique and precious life of another human who entrusts me with their story. It is a privilege. Fundamental to my professional stance is intentionally sit 'across and with' the client, not 'expert and above'. If I can be helpful to the client, I am deeply rewarded.

What is the biggest challenge about being a counsellor?

I am very busy in my practice. These are difficult times in our uncertain world and the need for psychological support in the community is ever increasing. I continually find it challenging to get the balance right as I pendulate between my personal and professional worlds. This is an ongoing and imperfect process for me.

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

I see the ACA as a strong and vibrant organisation with initiative and an important voice in our field – hard-working, supportive and responsive to its members. I respect and appreciate all of these aspects of the ACA.

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

I am a published researcher on 'climate change psychology', deeply interested in existential concerns emerging for the collective as we face ever-increasing uncertainties. My research findings suggest it is imperative that professional bodies and training institutions provide leadership and guidance to therapists that enables them to support clients, and themselves, facing potentially dire climate crisis realities. The research also points to a need for professional practice to incorporate attention to existential concerns and unconscious processes: by necessity underpinned by therapists' self-awareness of their own processes existing in parallel with the clients'.

Describe a valuable learning experience that you had as a counsellor

I've learned to stay curious. Look for the details and don't assume anything, ever, about a client. Stay humble.

How many clients do you see each week?

I would say that I see too many clients each week, usually 25 and upwards (including part-time PAYG). Again, I'm always working on getting the balance right. Saying

Jules Silva
Photo: Supplied

'no' can be a challenge, but we must be 'self-caring', set those boundaries and, in a sense, model doing so to our clients.

What do you love about running your own professional practice?

I have found setting up and running my own private practice to be a steep learning curve, but I enjoy the independence, flexibility and self-determination of it. Most of all I cherish that it is important and useful work.

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

Study deeply, work hard, always be committed to self-reflection, and if it takes a bit longer to complete your study than you originally planned to get that rich experience, then so be it. Get therapy throughout your training. I wholeheartedly subscribe to the age-old adage, 'Physician, heal thyself'. ■

I've learned to stay curious. Look for the details and don't assume anything, ever, about a client. Stay humble.

Want to be published?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

Why submit to *Counselling Australia*? To get publishing points on the board!

Being published is part of career advancement for most professional counsellors and psychotherapists, particularly those who wish to advance in academia.

All peer-reviewed articles are eligible for OPD points and publishers can claim on their CVs to have been formally published. *Counselling Australia*, a peer-reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285), is now calling for articles and papers for publication.

Counselling Australia is designed to inform and discuss relevant industry issues for practising counsellors, students and members of the Australian Counselling Association. It has an editorial board of experienced practitioners, trainers and specialists. Articles are invited to be peer-reviewed and refereed or assessed for appropriateness by the editor for publishing. Non-editorial staff may assess articles if the subject is of a nature as to require a specialist's opinion.

The quarterly journal is published every March, June, September and December.

Do you have an article you'd like to publish? Email the editor aca@theaca.net.au

Editorial policy

Counselling Australia is committed to valuing the different theories and practices of counsellors. We encourage readers to submit articles and papers to encourage discussion and debate within the industry. Through their contributions, we hope to give contributors an opportunity to be published, to foster Australian content and to provide information to readers that will help them to improve their own professional development and practice. We wish to promote to readers the Australian Counselling Association and its commitment to raising the professional profile and status of counsellors in Australia.

Previously published articles

Articles that have been previously published can be submitted as long as permission to reprint accompanies the article.

Articles for peer review (refereed)

- Articles are to be submitted in MS Word format via email.
- Articles are to be single-spaced and with minimal formatting.
- Articles must be submitted with a covering page requesting a peer review.
- Attach a separate page noting your name, experience, qualifications and contact details.
- The body of the paper must not identify the author.
- Articles are to contain between 1500 and 5000 words.
- Two assessors, who will advise the editor on the appropriateness of the article for publication, will read refereed articles.
- 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.
- Case studies must be accompanied by a signed agreement by the client granting permission to publish.
- Clients must not be identifiable in the article.
- The author must seek permission to quote from, or reproduce, copyright material from other sources and acknowledge this in the article.
- All articles, including those that have been published elsewhere, are subject to our editing process. All authors will be advised of any significant changes and sent a copy prior to the proofing of the journal for publication.
- Authors are to notify the editor if their article has been published prior to submission to *Counselling Australia*.
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- *Counselling Australia* accepts no responsibility for the content of articles, manuscripts, photographs, artwork or illustrations for unsolicited articles.

Deadline

Deadline for articles and reviewed articles is 25 January, April, July and October. The sooner articles and papers are submitted, the more likely they are to be published in the next cycle. ■

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Contributions related to indigenous issues of other cultures, will be particularly welcome. These articles may highlight how the cultural context shapes practice, client experiences, types of interventions and other factors that are of interest to the profession of counselling and psychthrapy.

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