Introduction

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

INTRODUCTION: THE STORY OF THIS OPEN TEXTBOOK

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

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

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

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

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

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

THE OPEN TEXTBOOK FORMAT

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

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

THE CONTENT

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

Terminology

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

COUNSELLING IN AUSTRALIA

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

MODELS OF HEALTH, ISSUES, AND HELPING

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

THE MEDICAL MODEL

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

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

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

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

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

Counsellors assess, not diagnose

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

THE CONTEXTUAL MODEL

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

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

BIOPSYCHOSOCIAL APPROACH

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

RECOVERY-ORIENTED MODEL

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

PERSON-CENTRED CARE

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

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

STEPPED CARE

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

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

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

SCOPE OF PRACTICE

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

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

Who can join PACFA and the ACA?

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

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

COUNSELLING EXPERIENCE

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

COUNSELLING SUPERVISION

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

MONITOR OUTCOMES

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

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

WHEN TO REFER

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

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

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

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

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

Counsellors and medication

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

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

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

HOW TO USE THIS BOOK

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

THE STRUCTURE OF THIS BOOK

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

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

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

ADDICTIONS

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

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

ANXIETY

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

CHILD MALTREATMENT

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

CRISIS

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

DEPRESSION

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

DOMESTIC VIOLENCE

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

GRIEF AND LOSS

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

RELATIONSHIP DIFFICULTIES

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

TRAUMA IN ADULTS

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

TRAUMA IN CHILDHOOD AND ADOLESCENCE

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

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