Rethinking Child Mental Health
Play Therapy Counsellors’
Relational Practices with Parents

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Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person or material which to a substantial extent has been accepted for the award of any other degree or diploma at Charles Sturt University or any other educational institution, except where due acknowledgment is made in the thesis. Any contribution made to the research by colleagues with whom I have worked at Charles Sturt University or elsewhere during my candidature is fully acknowledged.

I agree that this thesis be accessible for the purpose of study and research in accordance with the normal conditions established by the Executive Director, Division of Library Services or nominee, for the care, loan, and reproduction of theses.

Rosa Bologna
24th July 2018
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Professional editorial assistance

This thesis was edited by Kate Leeson. Kate is an accredited editor with the Institute of Professional Editors Australia (IPEd) and has no specialist knowledge in the area of research detailed in this thesis. Editing was limited to formatting grammar and style as detailed in the Australian Standard for Editing Practice (ASEP). Specifically, ASEP Standard D (language and illustrations) and ASEP Standard E (completeness and consistency). Editing did not alter or improve the substantive content or conceptual organisation of the thesis.
Publications arising from this thesis

Peer-reviewed contribution


Conference presentations


Special terms

Child Mental Health Play Therapy (CMHPT) counsellor

I have used the term *Child Mental Health Play Therapy (CMHPT) counsellor* to refer to a qualified mental health counselling practitioner who has gained specialist qualifications to use play modalities in a child mental health counselling context. Qualified mental health counselling practitioners may include psychologists, mental health social workers, psychotherapists, mental health counsellors, mental health occupational therapists, mental health nurses, and psychiatrists. I have used *CMHPT counsellor* rather than *play therapist* to make a differentiation from other practitioners who may refer to themselves as play therapists but do not use play modalities in a mental health counselling setting and/or are not qualified mental health counselling practitioners (e.g., early childhood educators, school teachers, and diversional therapists).

Counselling

Although I acknowledge that some make a distinction between *counselling* and *psychotherapy*, I approach these terms as synonymous to refer to the treatment of mental health issues occurring in a *therapeutic frame* – a distinct confidential, physical, temporal, and emotional container facilitated and managed by the mental health counselling practitioner to optimise emotional safety for the client. For consistency, I have used the term *counselling* throughout my thesis. However, I have used terms such as *psychotherapy* and *therapy* when quoting authors or participants who use these terms.

Child

In the context of CMHPT counselling clients, I have defined *child* to include those between the ages of 3 and 14 years. I chose 3 as the youngest age as it is typically the age children have developed sufficient symbolic thinking to enable them to meaningfully engage in CMHPT counselling. I chose 14 as the maximum age as it is the age in NSW, Australia (the setting for my study) when young people still require their parent’s permission to engage in health services.
Parent

I have defined *parent* as any adult serving as a child's legal guardian. A parent can include a child's biological parent, adoptive parent, foster parent, grandparent, or other family member serving as the child’s legal guardian.

Texts and text interpretation

Consistent with research conducted within a hermeneutic philosophical framework, when referring to my research I have used the terms *texts* and *text sets* rather than *data*; *text construction* rather than data collection; and *text interpretation* rather than *data analysis*. However, I have used the terms data, data collection, and data analysis when referencing authors who use these terms and also in the final chapter when discussing recommendations for future research, as I acknowledge that future research may not use a hermeneutic philosophical framework. Additionally, in the tradition of qualitative hermeneutic inquiry, I have used the first person to reflect the embedded nature of me, the researcher, throughout the research process, including the construction and interpretation of the text sets.
Abstract

A perspective based on relationalism holds that relationships between people are embedded within complex contexts and are shaped by a dialectical relationship between conscious and unconscious influences. My thesis explores the question: What is the nature of Child Mental Health Play Therapy (CMHPT) counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents? This question arose from my observations of several practice issues in the CMHPT counselling field and gaps in the literature pertaining to CMHPT counsellors’ work with parents. A high dropout rate, where parents prematurely take their children out of treatment, is one of a number of practice issues associated with CMHPT counsellors’ interaction with parents.

To comprehensively explore my research phenomenon from a relational perspective with an emphasis on unconscious influences, I adopted a bricolage sensibility which enabled me to form innovative partnerships and dialectical interplays between different disciplines, theoretical perspectives, paradigms, and methods. To define and conceptualise the phenomenon of relational practices, I drew from social constructionism, sociological relationalism, and practice theory. Additionally, I developed a theoretical thought partnership between Pierre Bourdieu and Carl Jung to construct my theoretical thinking tool kit. I used this tool kit to more deeply inform the nature of CMHPT counsellors’ understandings and critical reflexivity regarding personal, social, and collective unconscious influences on their relational practices with parents. I positioned my research at the juncture of social constructivist and critical paradigms and used critical hermeneutics as my philosophical framework. I incorporated and adapted aspects of Paul Ricoeur’s critical hermeneutics and Carl Jung’s active imagination approach to develop my Critical Imaginal Hermeneutic Spiral, which I used as a guide for my text construction and text interpretation processes. My text construction strategy involved conducting a series of three in-depth, semi-structured interviews with seven qualified CMHPT counsellors practising in NSW, Australia. The interviews were conducted over a three-month period (with each participant). Between the first and second interview I asked participants to create images relating to their relational practices with parents. Together with participants, I
unpacked their imaginal products by drawing on Jungian and gestalt traditions associated with imaginal sense-making processes.

My research findings address several gaps in the CMHPT counselling literature pertaining to how CMHPT counsellors’ relational practices with parents are conceptualised and studied and ultimately how they are understood. The outcome of this understanding was the development of my Critical Imaginal Reflexivity Model, which provides opportunities for deeper critical reflexivity and dialogue regarding CMHPT counsellors’ taken-for-granted practices with parents. The Critical Imaginal Reflexivity Model provides a unique, systemic guide for CMHPT counselling practice, education, and supervision, including developing CMHPT counsellors’ critical reflexivity, and in turn minimising the adverse impact of unconscious influences on their relational practices with parents. The model contributes to informing professional practice capabilities required by CMHPT counsellors to effectively work with parents and in turn create best outcomes for children.
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CHAPTER

1

Introduction

_The properly shaped question always emanates from an essential curiosity about what stands behind._
– Clarissa Pinkola Estés, _Women who run with the wolves_

In this introductory chapter, I provide an overview for my thesis. I start by discussing my rationale and personal frame of reference that led me to crystallise my research phenomenon, and how my answer to the question of what phenomenon to study emerged. I then provide a synopsis of the Child Mental Health Play Therapy (CMHPT) counselling literature, including gaps in the study of relational phenomena, particularly the parent–counsellor relationship, and the absence of discussion of how relational phenomena are situated in complex contexts. Considering the gaps in the literature, I discuss the scope and focus of my study including my choice of research participants. I then provide a summary of my research aim, questions, philosophical framework, methods, quality considerations, and the significance of my research outcomes. I conclude the chapter with an outline of my thesis structure.

1.1 Rationale and personal frame of reference

My decision to explore CMHPT counsellors’ relational practices with parents arose from my past experience as a psychologist providing CMHPT counselling to children as well as my current experience as a CMHPT counselling educator and clinical supervisor. Although parents are not typically direct clients themselves, they play a central role in facilitating counselling for their children, and therefore working with parents is an important aspect of CMHPT counselling. Along with my colleagues, students, and supervisees, I have frequently lamented the challenges of working with parents, particularly the frustration that occurs when parents prematurely remove children from counselling. CMHPT counsellors typically raise difficulties encountered working with parents during individual and group supervision contexts; however, I often find that these opportunities are not enough for counsellors to resolve these issues and that
counsellors also frequently discuss parents in their informal discussions during morning and afternoon tea breaks and in the car park at the end of the day. Some of the ideas CMHPT counsellors have formulated and shared with me regarding why they think parents take their children out of therapy prematurely include: some parents want counselling to provide a “quick fix” and expect a few sessions will change their child’s behaviour, and if this does not happen they will cease bringing their child; children’s mental health issues often stem from their parents’ unresolved issues and, if the counsellor recommends the parent undergo their own counselling rather than exclusively focus on their child’s mental health issues, the parent will terminate counselling; some parents do not want to see their child have fun, but instead want to see them “work” in the session, so the more the child enjoys coming to their sessions, the more likely their parents will terminate counselling; and some parents are jealous of the therapeutic relationship their child has with the counsellor so they sabotage the relationship by terminating treatment.

What I found intriguing is that difficulties with parents were reported by both early career and very experienced CMHPT counsellors. It also seemed to be an experience shared by CMHPT counsellors regardless of which professional group they belonged to (psychologists, mental health social workers, psychotherapists, counsellors, mental health occupational therapists, mental health nurses, and psychiatrists), or what theoretical orientation they drew from. I felt that theoretical orientation held particular significance because a vast number of different theoretical orientations are used in the mental health counselling field, with estimates of 300 different approaches (Feltham, 1995). Some of these approaches fall under the broader category of systems theory (e.g., family therapy), where working with parents and other stakeholders in the child’s social system is an integral part of the approach. I expected counsellors who actively worked from a systems perspective would perhaps not have the same challenges; however, they did. I reflected that perhaps the reason why CMHPT counsellors discuss parents informally so much was because it was an experience that cut across their differences.

In 2009, I developed a nationally accredited Australian Qualification Framework (AQF) Graduate Diploma in play therapy. An outcome of the requisite industry consultation I conducted on the course curriculum was that I needed to develop a specific module on “working effectively” with parents and other significant
stakeholders. In consulting the literature on the topic, I found most of the explanations of practice issues concerning parents fell into three main categories: (1) communication issues, (2) parents’ perceptions and misconceptions about what play therapy is and what it is not, and (3) counsellors’ erroneous perceptions of parents as “resistant”. These approaches offered both cause and effect explanations about the problem as well as concrete strategies to attempt to address the issue of working effectively with parents. I incorporated these communication, perception, and resistance theories and strategies into the course module. Although I received positive feedback on the course module from the counsellors I taught and supervised, they still reported experiencing difficulty with parents, and the topic of parents continued to dominate both formal and informal discussions.

Not entirely satisfied with the theories and strategies I had been using, I began to experiment with other theories and models not typically used with parents. For example, I adapted the Stages of Change Model (Prochaska & DiClemente, 1986; Prochaska, DiClemente, & Norcross, 1992) traditionally used in addictions, and applied it to parents. Using the Stages of Change Model provided me with the opportunity to use a typology approach to the issue rather than viewing parents as a homogenous group. That is, I could assess parents’ readiness for change (namely, changing their parenting practices and addressing any personal issues impacting on their children) and then tailor my approach to individual parents depending on the stage of change they were assessed to be operating at. This had positive results both with my own work as well as with the CMHPT counsellors I taught and supervised. However, I discovered that counsellors were using the approach as a culling tool to select the most engaged and motivated parents to work with. I found that private practitioners, in particular, were using the Stages of Change Model to identify and choose to work with parents who were at a more active stage of change rather than those who were at the earlier contemplation stages of change. On the one hand, this could be considered an effective use of resources including time. On the other hand, it meant that children whose parents were assessed as not ready to change their behaviour were being turned away from counselling. For me this presented as an ethical dilemma.

Consequently, I decided to specifically focus on parents who were deemed the most difficult to work with, that is, those that were assessed as being at the pre-
contemplative stage of change (not ready to change). I began to use subjective interpretation concepts such as transference and countertransference, concepts traditionally used with adult clients of depth therapies such as Freudian and Jungian approaches but increasingly used by a number of other theoretical orientations (King & O’Brien, 2011). Of all the approaches that I used in attempting to address the issue of dropout rates and other challenges associated with working with parents, this was the approach that achieved the most positive results, both in my own work with parents as well as according to the feedback I received from CMHPT counsellors I taught and supervised. My reflections on the success of this approach were that it seems to focus predominantly on the heart of the parent–counsellor relationship rather than aspects of the relationship such as communication and perceptions. It is also an approach that is highly contextual and individualised in that not only each parent, but also each encounter with each parent, is approached differently, depending on what the interaction reveals. Perhaps most significantly, the transference and countertransference approach made room for the exploration of counsellors’ fallacies and reactions to parents, rather than focusing predominantly on those of the parents.

There was however, one main difficulty I (and my students) encountered in applying concepts of transference and countertransference with parents. Unlike clients, parents do not have a clearly defined therapeutic frame – a distinct physical, temporal and emotional container for their interaction with the counsellor. Apart from the child’s progress session scheduled every 6–8 sessions, where the counsellor gives the parent feedback on the progress of their child’s treatment, most interactions with parents are brief and therefore counsellors only have a small window of time to interact with them and work through transference and countertransference issues. This appeared to impact most on counsellors working in private practice under the Medicare system, where they are required to have the child in the session at all times in order to qualify for the rebate. Such external policy (structural) influences also appeared to limit the nature and depth of interaction with parents. Thus, while I was making some inroads in terms of effectively working with parents, it felt like the proverbial case of “one step forward two steps back”.

1 In the context of working with parents, transference refers to unconscious feelings, thoughts, and behaviour the parent projects onto the counsellor based on unresolved feelings from other past or present relationships with significant adults in the parent’s life. Countertransference refers to the counsellor’s unconscious reaction to the parent’s transference and can include what the counsellor projects onto the parent based on his/her own feelings from other past or present relationships.
In October 2014, while I was considering a topic for my dissertation, I presented a workshop at an annual play therapy conference and at the end of my presentation I spontaneously asked the audience: “If you could name one of the most challenging aspects of your work with children, what would you name?” Without pause, the unanimous and very loud response that reverberated throughout the room was “parents!” I had two reactions to this response from the audience. Firstly, I was taken aback. I was shocked at the unanimity of the response. Not one single person had offered a response other than parents. Momentarily I felt like I was standing in front of a murder of crows, where the word parents was no longer a word but a caw, hitting me deep somewhere as a message from another realm. Secondly, my heart sank. Having worked primarily (but not exclusively) from a Jungian perspective for more than 20 years, I could not interpret this as a mere coincidence, but rather a clear message in terms of something that need to be addressed and integrated into consciousness. In Jungian terms, this is typically referred to as shadow material – an unowned and unintegrated aspect of the personal, social, or collective unconscious that needs to be explored and integrated into conscious awareness. I was accustomed to the shadow presenting itself in counselling and supervision but naively had not considered its role in my choice of research topics. I did however recall reading somewhere that often a research topic chooses the researcher rather than the other way around. Is this what was happening? I suspected it was but guiltily I did not feel enthused by the topic. I was not sure I was prepared to devote my doctoral research to a topic that had puzzled and at times exhausted me. There were other dissertation topics that interested me and working with parents did not relate to any of them. Despite my weariness, I decided to do further reflecting and reading and, in the process, came across the work of Robert Romanyshyn (2007), who developed archetypal hermeneutics:

the process begins with the acknowledgment that a topic chooses a researcher at least as much as, and more likely even more than, he or she chooses it. Its complex beginnings mean that a researcher is called into a work via his or her complex relationships to the work. In this context, research is re-search, a searching again for something that has already claimed you. (p. 283)

With this, I conceded that I had been “claimed” and returned to the literature once again. Upon further reflection, I realised I needed to look at different literature, that is, literature outside mainstream psychology and mental health counselling. When I looked at literature from different disciplines, with a different set of questions and
different theoretical perspectives, three main features of the CMHPT counselling literature stood out. Firstly, most play therapy studies looked at one aspect of the parent–counsellor relationship (e.g., communication, perception, or resistance) without connecting them to or situating them in personal, sociocultural, and collective contexts. Secondly, play therapy studies approached influences on practices as variables, that is, reified entities that are not only de-contextualised but approached as unconnected to people’s understanding of them. Epictetus’ quotation resonated strongly with me: “People are disturbed not by things, but by the views they take of them”. The quotation captured one of the main features of the social constructivist paradigm, that is, the notion of the construction of multiple realities. I discovered a complete absence of discussion in the literature of CMHPT counsellors’ understanding of their world, their practices, and their practice issues, and in turn an absence of consideration of the meaning-making processes they engaged in. That is, the CMHPT counselling field was approached as one reality rather than a multiverse of realities constructed by people’s understanding of their world. Thirdly, the CMHPT counselling literature was devoid of studies exploring unconscious influences on relational phenomena. I found this particularly significant considering the emphasis in mental health counselling on reflexivity. I found that the CMHPT counselling literature limited reflexivity to work with clients rather than significant stakeholders such as parents. I was particularly drawn to the critical paradigm’s emphasis on the influence of unconscious structural influences on practices. This married well with my Jungian background and its emphasis on unconscious influences on phenomena.

I reasoned that without a deeper, contextualised understanding of the parent–counsellor relationship, including counsellors’ meaning-making and critical reflexivity processes, it would be difficult to confidently understand the complexity of practice issues associated with parents. It appeared that phenomena associated with the parent–counsellor relationship had been under-researched to date because they had been examined predominantly in a positivist paradigm using quantitative methods. This approach did not capture the complexity and richness of the parent–counsellor relationship in situated, contextualised practice where multiple realities are made and re-made and where a complex range of unconscious processes are at play. Departing from the positivist paradigm offered me new possibilities where I could explore the complexity and diversity of parent–counsellor relational phenomena in more depth and in context. This provided a pivotal shift from my reluctance to take on the topic to
a stage where I became excited and curious about what might be revealed behind the issue of working with parents.

1.2 Synopsis of the CMHPT counselling literature

Play therapy modalities in child mental health counselling have a long history that goes back more than 100 years (Nash & Schaefer, 2011). In the early 1900s, several prominent psychiatrists and psychologists including Sigmund Freud, Hermine von Hug-Hellmuth, Melanie Klein, and Anna Freud began to use play in their assessment and treatment of children (Geissmann & Geissmann, 1998). A few decades later, more sophisticated and systematic ways to integrate play with philosophical and theoretical models of practice were developed. For instance, in the 1940s, psychologist Virginia Axline, a colleague of Carl Rogers, developed Child-Centred Play Therapy (also known as Non-Directive Play Therapy). Axline adapted Rogers’ client-centred model of therapeutic practice so that it could be a developmentally and culturally appropriate intervention for children. Axline’s approach involved integrating the philosophical underpinnings of client-centred therapy with play. The model included the systematic selection of play props and mediums as substitutes for predominantly verbal communication found in adult interaction, drawing on play’s inherent curative nature, and interpreting play themes symbolically rather than literally (Axline, 1947/1993).

Since Axline’s pioneering work in the 1940s, other sophisticated models of play therapy have evolved, where, following Axline, counsellors have integrated philosophical and conceptual tenets of established theoretical frameworks of clinical practice used with adults with the systematic selection and use of play props and play activities. These various play therapy approaches are formally known by their theoretical orientation names, for example, Cognitive Behavioural Play Therapy (Knell, 1998), Solution-Focused Play Therapy (Nims, 2007), Psychodynamic Play Therapy (Levy, 2011), Family Play Therapy (Gil, 2003), Jungian Play Therapy (Green, 2011), and Gestalt Play Therapy (Oaklander, 1994). In the literature, play therapy is the term used as shorthand to describe any or all of these approaches.

1.2.1 Practice issues: Misconceptions and dropouts

Researchers who have conducted meta-analyses of CMHPT counselling have concluded it is an effective form of treatment for children with a variety of mental
health issues (e.g., Bratton, Ray, Rhine, & Jones, 2005; Lin & Bratton, 2015). Despite play therapy’s efficacy, CMHPT counsellors encounter a number of practice issues concerning parents. Surveys of CMHPT counsellors have revealed “working with the parents as one of their biggest challenges” (e.g., Tarroja, Catipon, Dey, & Garcia, 2013, p. 212). Some of the challenges identified by the literature include parents confusing play therapy with play, that is, they do not see the therapeutic value of play in a mental health counselling context (O’Connor, 2005; Tarroja et al., 2013); parents becoming jealous of the child’s close relationship with the counsellor (Johnson, 1995); parents not understanding the boundaries and limitations of the CMHPT counsellor’s role, for example, counsellors not providing Family Court support (Killough-McGuire & McGuire, 2001); parents not understanding or respecting that the child’s sessions are private and confidential (Landreth, 2012); and parents being resistant to implementing the suggestions and recommendations made by the CMHPT counsellor (VanFleet, 2000). Associated with these practice issues is parents taking children prematurely out of counselling (Tsai & Ray, 2011).

High dropout rates are recognised as a considerable problem in the broader child mental health counselling field (Deakin, Gastaud, & Nunes, 2012). Although there are a scant number of studies exploring dropouts in CMHPT counselling, two play therapy studies exploring attrition have reported a similarly high dropout rate of 64 per cent (Campbell, Baker, & Bratton, 2000; Tsai & Ray, 2011). The dropout rates in CMHPT counselling are comparable to dropout rates in general child mental health counselling where attrition has been more widely studied (e.g., de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). The high dropout rates for child mental health counselling services is of significance given that in Australia approximately 1 in 7 children meet the criteria for a mental health disorder (Lawrence et al., 2016) and children under 12 years of age are less likely to receive treatment than older children and adolescents (Segal, Guy, & Furber, 2017). In their study of service use by Australian children with mental health issues, Johnson et al. (2016) found that approximately 44 per cent of children with a diagnosable mental health disorder did not seek assistance to address their mental health issues. The low levels of children with mental health issues receiving treatment coupled with high dropout rates indicate that a small proportion of children with mental health issues receive treatment.
Unlike adult mental health counselling where the client receiving treatment makes the decision whether to commence, continue, and terminate counselling, in child mental health counselling it is parents that largely make these decisions (Deakin et al., 2012). A meta-analytic review of child mental health counselling dropouts conducted by de Haan et al. (2013) found that one of the more important influencers of dropouts is parents’ relationship with the counsellor. The parent–counsellor relationship is overwhelmingly neglected in the CMHPT counselling literature. This reflects the general myopic approach to relationships in the CMHPT counselling field where the child–counsellor and child–parent relationships eclipse other important relationships such as the parent–counsellor relationship.

### 1.2.2 Relational phenomena

It has long been recognised within the CMHPT counselling field that relational phenomena play an integral role in achieving positive outcomes for clients (Landreth, 2012). In particular, the field has contributed significantly to the understanding of the importance of the child–counsellor relationship and the child–parent relationship. Despite these two dyadic relationships receiving considerable attention in the CMHPT counselling literature, the CMHPT counselling field has largely neglected the parent–counsellor relationship (Schottelkorb, Swan, & Ogawa, 2015).

**Child–counsellor relationship**

Child-Centred Play Therapy (CCPT) is one of the most prevalent approaches used by CMHPT counsellors and its main feature is that it focuses on the child–counsellor relationship as the primary agent of therapeutic change (Landreth, 2012). Virginia Axline’s seminal book *Dibs: In search of self* (1964) is one of the most quoted texts on the history of CCPT and the significance and curative powers of the child–counsellor relationship. The book became a *New York Times* bestseller (Fisher, 2008) and has been heralded as “one of the most moving books in the behavioural sciences” (Hattie, 2014, p. vii). Exploring some of the book’s main features and tenets provides a foundational understanding of CMHPT counselling’s emblematic approach to relational phenomena, where the child–counsellor relationship typically plays centre stage and other professional relationships such as the parent–counsellor relationship are largely marginalised.
Dibs is written as a case study and provides a moving narrative of Axline’s play therapy sessions with a 5-year-old boy named Dibs who resided in Manhattan with his parents and sister. Dibs was described by the school paediatrician as “a strange one . . . who knows? Mentally retarded? Psychotic? Brain-damaged? Who can get close enough to him to find out what makes him tick?” (Axline, 1964, p. 12). Dibs’ school had exhausted all avenues to engage him and to address his sudden, violent outbursts so they approached Axline as a last attempt before expelling him. Axline proceeded to see Dibs at her clinic for weekly sessions over the course of a year and used CCPT as the treatment modality. Congruent with the Rogerian tradition of client-centred therapy, Axline focused not on changing Dibs’ behaviour or symptoms, but rather on developing a safe, unconditional therapeutic relationship with him. Thus, the child–counsellor relationship was conceptualised within client-centred philosophy and the curative power of the therapeutic relationship. Within this conceptual frame, Axline stresses that CCPT is “a way of being with children rather than doing something to or for children” (Landreth & Sweeney, 1997, p. 17). The text draws on Axline’s recordings of her sessions with Dibs including verbatim dialogue between Dibs and Axline. It illustrates Dibs’ transformation from an emotionally and socially inhibited child to a confident, articulate, socially interactive boy. In the book’s postscript, Axline reveals that a week after Dibs completed his treatment with her, a clinical psychologist administered a Stanford-Binet Intelligence Test to Dibs and the results revealed he had an IQ of 168.

Since the publication of Dibs in the mid-1960s, Axline’s CCPT approach has been widely celebrated as a powerful and respectful way to work with children and a powerful exemplar of the curative powers of the child–counsellor relationship. However, in the mid-1980s criticism began to emerge regarding the perceived exclusion of parents in Axline’s approach and play therapy in general. For instance, Golden (1985) warns of “the seductive potential of play therapy” and “the implicit suggestion that the real therapy occurs between therapist and child. It is all too easy to ignore those problematic variables called parents [emphasis in original]” (p. 88). Fisher (2008) also challenges the “conversion narratives” characteristic of Dibs and play therapy approaches like it, that is, the transformation of unwell children who are then “ultimately declared ‘normal’ (cured, recovered) and even gifted . . . by competent authorities” (pp. 51, 61). Despite some of the criticism, particularly about excluding
parents, CCPT continues to be one of the most popular play therapy models utilised and researched by CMHPT counsellors (Lambert et al., 2007; Tsai, 2013; Tsai & Ray, 2011).

**Child–parent relationship**

At the time Axline published *Dibs* in the mid-1960s, two other American psychologists, Bernard Guerney and Louise Guerney, developed Filial Play Therapy (also known as Filial Therapy), an approach that revolutionised CCPT. Rather than focusing on the child–counsellor relationship as the agent of change, the Filial Play Therapy approach focused on the child–parent relationship as the agent of change (VanFleet, 2005). Filial Play Therapy is largely a psycho-education approach which involves the counsellor training parents in the basic skills of CCPT so that parents can conduct “special” play sessions with their child at home (VanFleet, 2011, p. 153).

The Guerney’s approach was revolutionary and radical for the times not only because they were empowering parents with the tools used by counsellors but because they were challenging the dominant attitude of the 1950s and 1960s which was that children’s mental health issues were largely a result of their parents’ pathology (Landreth & Bratton, 2006). In contrast, Filial Play Therapy is based on the psycho-education premise that children’s mental health issues are largely a result of parents’ lack of parenting knowledge and skills in developing a healthy emotional relationship with their child. In turn, Filial Play Therapy is based on the assumption that, if parents are provided with the training and support to develop these skills, then the child’s issues will be more effectively addressed. In Filial Play Therapy, the child–parent relationship is considered to have greater emotional importance than the child–counsellor relationship (Landreth & Bratton, 2006). The child–parent relationship is framed within attachment and development theory, where the child–parent relationship is considered the fundamental building block for emotional wellbeing and therefore should be the central focus of the treatment.

Filial Play Therapy has grown over the years and has been repeatedly shown in meta-analytic studies to be the most empirically supported play therapy intervention (e.g., Bratton et al., 2005; Leblanc & Ritchie, 2001). However, one of the main limitations of Filial Play Therapy is that not all parents are willing or able to participate in the intervention and many “hope that the therapist can take care of the problem without their involvement” (VanFleet, 2011, p. 166). For reasons that have not been adequately
explored, it remains uncommon for counsellors to include parents as active participants in CMHPT counselling (Hutton, 2004).

**Parent–counsellor relationship**

Although CMHPT counselling has contributed significantly to understanding and facilitating the child–counsellor and child–parent relationship dyads, it has largely neglected the parent–counsellor relationship. Much of the play therapy research and textbooks acknowledge the importance of counsellors’ communication with parents, with many authors offering guidelines on addressing communication and parent perception issues (e.g., Killough-McGuire & McGuire, 2001; Kottman & Ashby, 1999; Kottman & Meany-Walen, 2016; McGuire, McCabe, & Priebe, 2001; Post, Ceballos, & Penn, 2011; VanFleet, 2000); however, there is little conceptual and theoretical treatment of the relationship between parents and counsellors, and little is known about how the relationship is developed and maintained.

Like the general child mental health counselling literature, when the parent–counsellor relationship is featured in CMHPT counselling research, its conceptual treatment is not clearly defined. For instance, terms such as parent collaboration (e.g., Post et al., 2011), parent consultation (e.g., Cates, Paone, Packman, & Margolis, 2006; Kottman & Ashby, 1999; Kottman & Meany-Walen, 2016), parent involvement (e.g., Hill, 2009), parent inclusion (e.g., Hill, 2006), and parent partnership (e.g., Landreth, 2012) are often used interchangeably without clarification of the nuances implicit in the variety of terms. It is also unclear what broader conceptual or philosophical framework these concepts and terms are posited in, how they relate to one another, and how they inform the phenomenon of the parent–counsellor relationship. In short, the parent–counsellor relationship is poorly defined and understood, and remains under-theorised.

The neglect of parent–counsellor relational phenomena is also reflected in CMHPT counselling education. For example, in 2005, the Association for Play Therapy (an International Play Therapy Association based in the United States), organised a Curriculum Development Task Force to design a syllabus guideline to guide educators and supervisors. The guidelines were later revised in 2010. The aim of the guidelines is “to design, market, and teach introductory and other play therapy graduate courses at colleges and universities” (Association for Play Therapy, 2010). Of the 13 learning
objectives outlined in the guidelines, none specifically refer to the parent–counsellor relationship. Three of the objectives refer to relational phenomena but focus exclusively on the child rather than parents.

**Triads, quartets, and other systems**

Although focusing on the nature and importance of dyadic relationships can contribute to improved outcomes for clients, CMHPT counselling is characterised by at least three main parties (the child, the parent, and the counsellor). The triadic relationship dynamic between the parent, child, and counsellor, or the quartet or more if other stakeholders are involved (e.g., other parent, school, Department of Family and Community Services, doctor, paediatrician), are also important yet neglected in the CMHPT counselling literature. One exception is Family Play Therapy, which recognises the importance of the systemic nature of the family and includes parents and other members of the family in the counselling session (Gil, 2011; Miller, 1994). However, many CMHPT counsellors consider that providing therapeutic treatment to children and their family members together at the same time (in the same session) is not a suitable intervention approach for all children, particularly where child abuse is present or suspected and/or where the parent’s own mental health issues are likely to undermine the therapeutic benefit for the child (Bologna, 2009). This notion is echoed in general child health care literature where some commentators such as Coyne, Hallström, and Söderbäck (2016) argue that family-centred approaches can be in conflict with what matters for the child and can undermine the overall best interests of the child.

1.2.3 Contextualisation of relational phenomena

I approach the various relationships discussed in the previous section as interconnected with one another, metaphorically forming a relational constellation. I have argued that, although the CMHPT field has illuminated some parts of the constellation such as the child–counsellor and child–parent relationship, some parts such as the parent–counsellor relationship remain in the dark. Extending the constellation metaphor, I also contend that these relationships not only form a constellation whereby they are interconnected, but they are also situated and embedded within personal, sociocultural, and collective contexts – a relational galaxy or matrix as it were. In turn, these contexts generate respective influences (personal, sociocultural, and collective)
on relationships which are not mutually exclusive, but rather relationally interconnected. Many of these influences operate at an unconscious level of awareness. There is an overwhelming absence of this contextualisation of relationships in the CMHPT counselling literature.

**Personal influences**

In the context of mental health counselling, personal influences refer to conscious and unconscious aspects of a person’s life that influence their understanding of phenomena. They can include the person’s conceptualisation and understanding of a phenomenon. They can also include a person’s memories and experiences of a phenomenon, which typically exert their influence at an unconscious level. Carl Jung (1968/2014) refers to this unconscious level as the *personal unconscious* as it is specific to the person rather than shared with others. In the CMHPT counselling literature, personal influences predominantly involve research exploring parents’ perceptions and experiences of different play therapy approaches based on specific theoretical orientations (e.g., Bavin-Hoffman, Jennings, & Landreth, 1996; Brumfield & Christensen, 2011; Edwards, Sullivan, Meany-Walen, & Kantor, 2010; Foley, Higdon, & White, 2006; Wickstrom & Falke, 2013). There are three main limitations to these studies, which I built on in my research. Firstly, these studies focus primarily on conscious personal influences rather than including unconscious influences. Secondly, they focus overwhelmingly on perceptions and experiences of specific play therapy theoretical orientations rather than common factors associated with all play therapy models of practice. Thirdly, they explore parents’ perceptions and experiences of CMHPT counselling rather than children’s or counsellors’ understandings and experiences.

The CMHPT counselling literature has largely neglected the exploration of counsellors’ personal influences on their practices with parents and how such influences can undermine the parent–counsellor relationship. For instance, there are only a few studies on counsellors’ experiences and perceptions regarding working with parents (e.g., Haslam & Harris, 2011; Lolan, 2011); however, these studies were quantitative studies involving surveys and, although they garnered general aspects of counsellors’ perceptions, they did not include in-depth exploration of counsellors’ understandings of influences on these perceptions. Additionally, counsellors’ own experiences of being parented and their subsequent countertransference reactions to the parents of their child clients are absent from the CMHPT counselling literature.
When countertransference is discussed, it is in relation to working directly with (child) clients rather than parents (e.g., Gil & Rubin, 2005). Additionally, these studies neglect to explore how counsellors’ perceptions are framed by broader sociocultural and collective contexts.

**Sociocultural influences**

In defining sociocultural, I draw on Elwell (2013) and include five main interrelated components: (1) demographic characteristics such as age, race, ethnicity, and gender; (2) social structures including human groups and organisations such as family, economic, and government institutions and systems; (3) ideational predilections including values, norms, beliefs, and ideologies; (4) the material environment; and (5) temporality. Consequently, in this thesis, sociocultural influences refer to a person’s understanding of sociocultural components that influence his/her understanding of phenomena. As with personal influences, sociocultural influences mostly take place at an unconscious level. Earl Hopper (2001), a sociologist and psychotherapist, conceptualises this unconscious level as the social unconscious, which he defines as “the existence of constraints of social, cultural and communicational arrangements of which people are unaware” (p. 10). Hopper points out that the social unconscious does not imply that social systems have an unconscious mind, but rather it is a concept used to discuss the unreflected or unknown sociocultural influences on people.

In CMHPT counselling research, sociocultural influences are approached and conceptualised mainly as independent, static demographic variables rather than as part of a broader sociocultural matrix. This parochial approach to culture is illustrated in the CMHPT counselling literature where most studies examining culture do so from a demographic ethnic or racial perspective and tend to view and recruit parents according to their ethnic, racial, or religious background, for instance, African-American parents (e.g., Brumfield & Christensen, 2011), Hispanic parents (e.g., Garza & Bratton, 2005), Mexican parents (e.g., Hassey, Garza, Sullivan, & Serres, 2016), Chinese parents (e.g., Chau & Landreth, 1997; Yee, 2016), Korean parents (e.g., Jang, 2000), Native American parents (e.g., Glover & Landreth, 2000), and Christian parents (e.g., Bornsheuer-Boswell, Garza, & Watts, 2013). Approaching parents in this way has the potential to pathologise parents and their demographic characteristics (ethnicity, race, religion) and de-contextualise their experiences. Homogeneous characterisations also imply that relationships are static rather than dynamic phenomena that are
influenced by a complex range of intertwined factors. Similarly, the sociocultural context is approached and conceptualised as another independent variable and static demographic rather than something that permeates relational phenomena.

An exception to the contextual neglect is the Ecosystemic Play Therapy approach developed by O'Connor (2011), which offers a conceptual treatment of systems beyond the family such as the child's school and community. This approach also recognises the role of metasystems such as the historical time or period the treatment is taking place in and emphasises the role sociocultural influences have on people's worldviews. Although Ecosystemic Play Therapy offers a sound conceptual start in terms of considering phenomena in a sociocultural context, it has three main limitations. Firstly, the model’s contextualised approach is focused primarily on understanding the child in his/her context rather than the parent, the counsellor, and the parent–counsellor relationship in their contexts. Secondly, its main principles are posited within a specific theoretical approach or model rather than as a common factor in counsellors’ core training regardless of theoretical orientation. Thirdly, the approach neglects the unconscious sociocultural structures that influence practice and the nature of the reflexivity required to unearth unconscious, taken-for-granted assumptions associated with one’s sociocultural environment.

**Collective influences**

In the context of my thesis, collective influences primarily refers to archetypal influences emanating from the *collective unconscious*, as conceptualised and defined by Jung (1968/2014). Collective unconscious or archetypal influences are not specific to personal or sociocultural contexts; rather, they consist of universal patterns of behaviour, emotions, and thinking shared by people across the world. There is almost a total absence of attention to collective unconscious influences in the CMHPT counselling literature. In the few instances where collective unconscious influences are explored, they are considered in relation to the child (e.g., Green, 2008; Peery, 2002; Ryce-Menuhin, 2014) rather than influences on the parent and counsellor or indeed the CMHPT counselling profession at large. The authors of these publications situate their exploration of collective influences as a feature of Jungian Play Therapy, that is, a specific theoretical practice model, rather than conceptualising collective unconscious influences as a common influence on CMHPT counsellors’ practices irrespective of their theoretical orientation.
In summary, a synopsis of the CMHPT counselling literature reveals that relational phenomena are largely de-contextualised, unconnected to people's understanding of them, and studied without consideration of unconscious influences that shape them. These gaps in the CMHPT counselling literature informed the scope and focus of my research.

1.3 Scoping my research phenomenon

In deciding on the scope for my study, I was guided by the basic tenets of practice theory and social constructionism\(^2\) in that I chose to focus on exploring CMHPT counsellors' understandings of their relational practices with parents as the relational phenomenon that informs the parent–counsellor relationship. I did this based on the premise that practices are not merely actions but social activities that are in a dialectic relationship with social contexts (Bourdieu, 1990b), and it is practices that develop and maintain relationships and therefore should be the focus of inquiry (Gergen, 1999, 2009; Hosking & McNamee, 2006). Additionally, considering the gaps I identified in the CMHPT counselling literature, I chose to specifically focus on exploring CMHPT counsellors' understandings\(^3\) of influences on their relational practices with parents rather than exploring influences on counsellors' relational practices as reified entities. This focus on CMHPT counsellors' understandings was based on the social constructivist premise of multiple realities, where a person's understanding of their world and the influences that shape them is of central concern rather than approaching influences as reified entities separate from the person's meaning-making (Krauss, 2005). Understanding in the context of my thesis also aligns with social constructivist notions of meaning-making where meaning is relational: “To grasp the meaning of a thing, an event, or a situation is to see it in its relations to other things [emphasis in original]” (Dewey, 1933/2008, p. 225). Thus, implicit in the notion of understanding and meaning-making is context.

My research is located in the current relational practices of CMHPT counsellors in Australia and is situated in a wider understanding of professional practice. By positioning CMHPT counselling within professional practice, I considered it important

\(^2\) Social constructionism is a variant of social constructivism and is discussed further in Chapter 2.

\(^3\) I have deliberately avoided using the word perception (that is, counsellors' perception of their relational practices with parents) as in the mental health counselling field, particularly psychology, it has associations with sensory processing. Understanding implies a deeper process of interpretation and can also include affective responses.
to include counsellors’ *reflexivity* as part of my focus, as reflexivity is one of the major tenets of professional practice (Fook, White, & Gardner, 2006) and encompasses meaning-making processes involved in understanding phenomena. Additionally, to address my interest in exploring counsellors’ understandings of conscious and unconscious influences on their practices, it was important that I emphasise their *critical* reflexivity, that is, how they identified *unconscious* influences on their practices.

In sum, my research phenomenon was CMHPT counsellors’ relational practices with parents. The aim of my study was to explore CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents, and this exploration informed the broader relational phenomenon of the parent–counsellor relationship.

At a practical level, it was not feasible to involve all stakeholders in my in-depth qualitative study. Therefore, although at least three main groups of people are implied by my research interest (children, parents, and CMHPT counsellors), my research was focused on exploring CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents. I did this with the awareness that this was one of many steps in exploring and unpacking the complexity and richness involved in CMHPT counsellors’ relational practices with parents and their ultimate influence on outcomes for children with mental health issues. Although my research does not directly involve children, it is motivated by the very best outcomes for them.

### 1.4 Research aim and questions

#### 1.4.1 Research aim

The aim of my research was to explore the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents. I did this with the overall goal of informing professional practice capabilities required by CMHPT counsellors to create the best outcomes for children through relational practices with parents.
1.4.2 Research questions

Based on my research aim, the main research question to guide my research was:

1. What is the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents?

To assist me to answer the main research question, I developed three sub-questions:

i. How do CMHPT counsellors understand personal influences on their relational practices with parents?

ii. How do CMHPT counsellors understand sociocultural influences on their relational practices with parents?

iii. What is the nature of CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their relational practices with parents?

1.5 Philosophical framework and methods

Given my research questions were concerned with both understanding and critical reflexivity, it was important that I situated my research in a paradigmatic space that could facilitate both social and critical meaning-making. I did this by positioning my research in both the social constructivist and critical paradigms. I view these two paradigms not as separate paradigms but on a continuum where purist positions pertaining to each paradigm can be found on either end of the continuum, and in the middle there is a liminal space fusing the two. It is at the juncture of the two paradigms that I situated my research. This enabled me to explore both socially constructed and critical understandings of my research phenomenon.

Considering I positioned my research in the social constructivist and critical paradigms, I drew from Paul Ricoeur's (1976) critical hermeneutics to guide my overarching methodological approach as it offered the optimal alignment with my research aim, questions, and paradigmatic positioning. Ricoeur's critical hermeneutics incorporates both the social constructivist tradition (philosophical hermeneutics) and critical theory (structural analysis), or what Ricoeur (1976, p. 73) refers to as “understanding and explanation” respectively. Ricoeur’s critical hermeneutical spiral includes subjective (understanding) and objective (explanation) “moments” of
meaning-making which incorporate aspects of both the social constructivist and critical paradigms. I adapted the moments in Ricoeur’s spiral to create my *Critical Imaginal Hermeneutic Spiral*, which I used to guide my text construction and text interpretation process. Specifically, my spiral includes four moments of understanding: (1) an initial understanding moment, (2) a deeper understanding moment, (3) a critical and imaginal distanciation moment, and (4) an imaginal appropriation moment.

I used the moments of my Critical Imaginal Hermeneutic Spiral as a guide to construct my empirical text sets as well as a text interpretation strategy. My overall text was constructed from a series of three semi-structured in-depth interview transcripts derived from each of seven participants (three interviews per participant). As I was interested in exploring unconscious influences, I deemed it necessary to utilise nonverbal communication methods that facilitated this exploration (Romanyshyn, 2013), specifically, imaginal expressions. In the tradition of Henry Corbin (1972) and Carl Jung (1964/1978), I conceptualised the imaginal as the intermediary space between the conscious and unconscious realms and chose to include it as part of my text construction strategy as it aligned with the aim of my study to explore participants’ critical reflexivity regarding unconscious influences on their relational practices with parents. In turn, I incorporated a hybrid communication approach in my interviews where I explored the research phenomenon with participants through both verbal in-depth dialogues and asking participants to produce visual expressions of the phenomenon. I refer to the creation of these visual expressions as *imaginal product-making* and the exploration of them as *imaginal sense-making processes*.

### 1.6 Overarching approach to quality and rigour

In qualitative research design, there is increasing recognition that the quality and rigour of a study needs to be built into all aspects of the inquiry process (Morse, 2018). Given my research involved exploring and navigating intermediary spaces, (e.g., conscious/unconscious, social constructivist/critical paradigms), I deemed it necessary to adopt a corresponding, congruent hybrid approach in all facets of my study to enhance the quality and rigour of my research. The overarching approach I adopted to study my research phenomenon and achieve this congruence was characterised by a bricolage sensibility. I drew on the definition and conceptualisation of bricolage offered by Kincheloe (2005), namely ensuring rigour in qualitative research by embracing “numerous modes of meaning making and knowledge production” (p. 345). At its most
basic level, bricolage celebrates, promotes, and facilitates the dialectical possibilities between disciplines, theoretical perspectives, paradigms, methodologies, and methods. However, bricolage does not simply involve eclectically stitching together different ideas, approaches, and methods in a crude, amateurish fashion, which may be implied by its original French meaning where bricolage refers to a do-it-yourself construction in the spirit of a handyman/woman. Rather, the notion of bricolage as presented by Kincheloe (2001, 2005) is steeped in notions of complexity, skill, and artistry. One aspect of this complexity is that bricoleur-researchers engage in an ongoing, thoughtful, and deeply engaged “tinkering” process to shape and construct their approach (Kincheloe, 2005, p. 325). This tinkering process typically involves carefully creating a dialectical relationship among more than one discipline, paradigm, theoretical perspective, methodology, and method but not necessarily fusing them or collapsing them together. That is, it allows each respective construct to sing solo when they need to rather than always in chorus.

I adopted a bricolage approach to all aspects of my research including the overarching disciplines I drew from (psychology, sociology, professional practice, and philosophy), my choice of theoretical perspectives (Bourdieuian and Jungian), paradigmatic positioning (social constructivist and critical paradigms), philosophical framework (critical hermeneutics based on philosophical hermeneutics and critical theory), and methods (verbal dialogues, imaginal product-making, and imaginal sense-making processes). Chapters 3 and 4 provide further examples and discussion of the bricolage I created among these various facets of my research. In sum, my research was a relational inquiry not simply because it was concerned with the exploration of relational phenomena, but because it involved a complex relational and dialectic engagement between different disciplines, theoretical perspectives, paradigms, methodologies, and methods.

1.7 Research significance

My research addressed several gaps in the CMHPT counselling literature pertaining to how CMHPT counsellors’ relational practices with parents are conceptualised and studied and ultimately how they are understood. Adopting an interdisciplinary bricolage sensibility enabled me to address the gaps by developing innovative theoretical and methodological approaches to explore socially constructed and critical understandings of the research phenomenon. The outcome of this understanding was
the development of my Critical Imaginal Reflexivity Model which provides opportunities for deeper critical reflexivity and dialogue regarding CMHPT counsellors' taken-for-granted practices with parents. The significance of deepening CMHPT counsellors' critical reflexivity is based on the premise that CMHPT counsellors can only meaningfully change their practices (that is, institute fundamental change) if they are aware of the unconscious influences on them. Without this awareness, change is likely to be superficial and continue to reproduce embedded unconscious structural influences on practices. These outcomes have significance for CMHPT counselling practice and education, and for improving the parent–counsellor relationship and enhancing overall outcomes for children.

1.8 Thesis structure

My thesis is divided into eight chapters. Following this introductory chapter, in Chapter 2 I provide a conceptual and sociocultural contextualisation of my research phenomenon. In Chapter 3 I develop a theoretical thought partnership between Bourdieu and Jung to construct my theoretical thinking tool kit. In Chapter 4 I present my philosophical framework and methods, which includes my Critical Imaginal Hermeneutic Spiral that I used to guide my text construction and text interpretation processes. I also discuss quality and rigour considerations pertaining to my research strategy. Chapters 5, 6, and 7 are my findings chapters, each of which represents a different yet related interpretation of my study’s texts and builds on the findings from the previous findings chapter. The three findings chapters also correspond to the first three moments of my Critical Imaginal Hermeneutic Spiral. Specifically, Chapter 5 focuses on answering my first research sub-question (How do CMHPT counsellors understand personal influences on their relational practices with parents?) and corresponds with the initial understanding moment of my Critical Imaginal Hermeneutic Spiral. Chapter 6 focuses on answering my second research sub-question (How do CMHPT counsellors understand sociocultural influences on their relational practices with parents?) and corresponds to the deeper understanding moment. Chapter 7 focuses on answering my third research sub-question (What is the nature of CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their relational practices with parents?) and corresponds to the critical and imaginal distanciation moment of my spiral. Chapter 8 corresponds with the imaginal appropriation moment of my Critical Imaginal Hermeneutic Spiral and discusses my understanding of the research phenomenon that arose from considering the findings
from the three preceding moments. This is presented as a meta-synthesis of my findings. The final chapter also includes my Critical Imaginal Reflexivity Model, a discussion of the unique contributions of my research to the CMHPT counselling field and other related fields, a critique of my study, recommendations for future studies, and my final reflections.
In this chapter, I provide a sociocultural and conceptual context for my research phenomenon. I approach this chapter as a sketch for my study where I metaphorically prepare my thesis’ canvas and outline the landscape in which the phenomenon of CMHPT counsellors’ relational practices with parents is located. I start the chapter by discussing the international CMHPT counselling context, particularly dominant influences on CMHPT counselling education and research. I then discuss key sociocultural features of the broader mental health counselling field, which CMHPT counselling is a subfield of, specifically, the Australian mental health counselling field. This includes discussing significant features, issues, and debates in the field and how these broader contexts influence the CMHPT counselling field’s approach to relational phenomena. In the second half of the chapter I sketch my position regarding the conceptualisation of the terms relational and practices. I do this by drawing from the traditions of relational constructionism, sociological relationalism, and practice theory. In further sketching the landscape for CMHPT counsellors’ relational practices with parents, I depict relational practices in the context of professional practice, that is, the broader professional context my research phenomenon is enacted in. I do this by situating my research phenomenon within the three main dimensions of professional practice: reflexivity, ethics, and professional becoming.

2.1 International CMHPT counselling context

Although CMHPT counselling has its origins in Europe in the early 1900s (Geissmann & Geissmann, 1998), it developed as a subdiscipline and specialisation of child mental health counselling primarily in the United States, particularly since the inception of the Association for Play Therapy (APT) in 1982. The APT was formed primarily to establish
play therapy as a specialised treatment approach within the field of mental health (Bratton et al., 2005) and stresses that “play therapy is not the same as regular, everyday play . . . [but] is a systemic and therapeutic approach . . . and should only be utilized by specially trained mental health professionals” (APT, 2018). Although the APT is an international society dedicated to the advancement of play therapy, its main influence has been in United States where the overwhelming majority of play therapy education and research takes place. For example, the APT lists 173 graduate courses on play therapy offered by universities internationally, 97 per cent (168 courses) of which are in the United States. Canada, Turkey, Ireland, Mexico, and Taiwan make up the remaining 3 per cent (five courses). There are three universities in the United Kingdom that offer play therapy courses and two universities in Australia; however, these are not included on the APT list, possibly because they are not specifically focused on applying play in a mental health counselling context. Although the APT figures focus on courses offered by universities rather than accredited vocational education training institutions, they highlight that play therapy education is overwhelmingly concentrated in the United States.

As with CMHPT counselling education, CMHPT counselling research is primarily conducted in the United States. For example, in the five-year period between January 2013 and January 2018, 89 per cent of publications (a total of 93 articles) in the International Journal of Play Therapy (published quarterly) were from authors from United States universities. Only 3.8 per cent of publications were from Australia (four articles), followed by 1 per cent from Germany, Hong Kong, Israel, Philippines, Switzerland, and Taiwan (one article each). This United States dominance of the literature is echoed by play therapy textbooks, which are also overwhelmingly written by American authors. For instance, except for a handful of texts written by Canadian and British authors, the APT’s list of over 200 recommended play therapy–specific texts are written by American CMHPT counsellors.

Although some features of the United States’ mental health counselling landscape and its challenges may be comparable to other developed countries such as Australia (e.g., several professions deliver mental health counselling and government funding primarily supports short-term mental health counselling), there are also important nuances and differences in the various mental health counselling contexts found in other countries that are not considered by the literature. Commenting on the broader
mental health counselling field, Leung (2003) argues that models and paradigms espoused in the American literature “continue to display an ethnocentric bias” (p. 414) whereby authors do not typically consider and include international contexts in their work. Consequently, Heppner, Leong, and Gerstein (2008, p. 71) contend that it is imperative that the mental health counselling literature be more inclusive of international contexts and cultures to create a more comprehensive and inclusive mental health knowledge base, referring to this as “international multiculturalism”. My research responds to this call for more international and contextualised mental health counselling research by situating my research phenomenon in the Australian mental health counselling context, and in turn contributing to new knowledge.

2.2 Mental health counselling in Australia

Mental health counselling in Australia is characterised by considerable complexity. In this section I highlight this complexity by discussing the varying legislative regulation, government recognition, and formal education among mental health counsellors; the multiplicity of names for mental health counsellors and mental health counselling practice; the government subsidies available for mental health counselling delivered by different professions; the competing theoretical orientations used in mental health counselling interventions; and the workplace diversity that characterises mental health counselling in Australia.

2.2.1 Legislative regulation, government recognition, and formal education

Unlike disciplines such as law, medicine, engineering, and dentistry that are “owned” and practised by one profession, mental health counselling is practised by several different professions and occupational groups (Mahler, 1995). These professions and occupational groups include psychiatrists, psychologists, mental health occupational therapists, mental health nurses, mental health social workers, psychotherapists, and counsellors. Some of these professional and occupational groups differ quite significantly in terms of whether they have a protected title under the National Law (Health Practitioner Regulation National Law Act) and therefore registration with the Australian Health Practitioner Regulation Agency (AHPRA); whether they are recognised as a mental health profession by the Australian government; and in terms of the nature, accreditation, and length of their core training.
Regarding legal regulation, the professions of psychology, psychiatry, occupational therapy, and nursing are regulated via AHPRA and therefore their titles are protected by legislation. Although the social work profession is recognised as a mental health counselling profession by the Australian government in that it is a profession approved by Medicare, it is not currently regulated by AHPRA. Psychotherapy and counselling are not recognised by the Australian government as mental health professions and therefore are not approved to provide mental health counselling under Medicare. Nor are psychotherapists and counsellors regulated by AHPRA. As such, the titles “psychotherapist” and “counsellor” are not protected by Australian legislation. This means anyone can use these titles without any qualifications and/or membership with a professional clinical body.

Regarding their formal education, in Australia, apart from psychologists, all mental health counsellors first obtain qualifications in their core profession and then undertake specialist training and/or supervised practice in mental health counselling. Psychiatrists, psychologists, mental health occupational therapists, mental health nurses, and mental health social workers are required to obtain their core professional qualification through an Australian Qualifications Framework (AQF) accredited higher education institution delivering a nationally recognised AQF qualification. These professions are recognised by the Australian government as mental health professions and therefore are approved to provide mental health counselling via various Medicare schemes. The length of formal education to obtain the core qualification also varies amongst the seven professions. Psychiatrists are required to undergo a minimum of 11 years of core training and five years of supervised practice in psychiatry; psychologists a minimum of four years training and either two years supervised practice or a two-year Masters degree; occupational therapists a minimum of four years of core training and two years of supervised mental health practice; and nurses are required to undergo a minimum of three years of core training and one year of either supervised mental health practice or completion of a postgraduate course in mental health nursing. Social workers who wish to deliver mental health services via Medicare must be members of the Australian Association of Social Workers (AASW) and certified by the AASW as an Accredited Mental Health Social Worker. Accreditation with the AASW requires a minimum four years of core training and two years of supervised mental health

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4 Medicare is publicly funded universal health care available to all Australians.
practice. Given counsellors and psychotherapists are not regulated as a profession and are not recognised as mental health professions by the Australian government, technically speaking, there is no minimum training as anyone can legally open a practice as a counsellor or psychotherapist with no qualifications or membership with a professional board or association.

In Australia, there are no legal or government-regulated stipulations or specialist endorsements regarding the provision of mental health counselling services to children. Although most of the above professions’ codes of conduct stipulate practitioners should only provide treatment in areas they have competency in (e.g., child mental health counselling), how to determine such competency is not clearly stipulated and remains at the discretion of the practitioner. Additionally, there are no guidelines within the mental health professions or among the professions regarding the curriculum focus for child mental health counselling education. This lack of guidance perpetuates the issue of mental health counselling for children being based on adult treatment models, where the focus is on working with the client (child) to bring about individual change rather than on the child’s social contexts such as their families (Dishion & Stormshak, 2007; Kazdin, 1995). The lack of legal and government regulation regarding the provision of mental health counselling to children and lack of guidance regarding child mental health education further adds to the disparities among those providing mental health counselling to children. Table 2.1 provides a summary of the legal regulation, government recognition, core qualifications, and specialised training of the professional groups delivering mental health counselling in Australia.

### 2.2.2 Naming mental health counsellors and practice

Given the number of different professions that provide mental health counselling, there is considerable irregularity in how counselling practitioners from these groups refer to themselves and the services they provide. The considerable complexity and confusion of mental health counsellors’ naming of themselves and their practice, is pertinent when studying relational phenomena in the Australian CMHPT counselling field as it indicates substantial variability in how CMHPT counsellors position and identify themselves and their service, particularly to parents. This disparity also indicates there is not a uniform profile for a CMHPT counsellor, something that is not sufficiently highlighted in the literature. For instance, some mental health counsellors...
Table 2.1

Summary of stratification of professional groups delivering mental health counselling in Australia

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Legal regulation</th>
<th>Government recognition</th>
<th>Core qualification</th>
<th>Mental health specialisation</th>
<th>Child specialisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>Yes</td>
<td>Yes</td>
<td>AQF higher education course (minimum 4 years), minimum 2 years full-time supervised practice</td>
<td>Minimum 5 years full-time supervised practice</td>
<td>Nil</td>
</tr>
<tr>
<td>Psychologists</td>
<td>Yes</td>
<td>Yes</td>
<td>AQF higher education course (minimum 4 years) and minimum 2 years full-time supervised practice or 2-year Masters course</td>
<td>N/A</td>
<td>Nil</td>
</tr>
<tr>
<td>Mental health occupational therapists</td>
<td>Yes</td>
<td>Yes</td>
<td>AQF higher education course (minimum 4 years)</td>
<td>Minimum 2 years full-time supervised practice</td>
<td>Nil</td>
</tr>
<tr>
<td>Mental health nurses</td>
<td>Yes</td>
<td>Yes</td>
<td>AQF higher education course (minimum 3 years)</td>
<td>Minimum 1 year supervised practice or postgraduate qualification</td>
<td>Nil</td>
</tr>
<tr>
<td>Mental health social workers</td>
<td>No</td>
<td>Yes</td>
<td>AQF higher education course (minimum 4 years)</td>
<td>Minimum 2 years supervised practice</td>
<td>Nil</td>
</tr>
<tr>
<td>Counsellors</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Psychotherapists</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Note: 

a Legal regulation = AHPRA regulated  
b Government recognition = Medicare approved to deliver mental health counselling
use titles that correspond with their profession (e.g., psychologist), a specialisation within their profession (e.g., clinical psychologist), their workplace (e.g., school counsellor), their area of specialisation (e.g., sexual assault counsellor), the client group they work with (e.g., child and family therapist), or their theoretical orientation (e.g., psychoanalyst). Compounding the complexity, for some professional and occupational groups such as psychotherapists and counsellors, counselling is their core business, whereas for others such as psychiatrists, psychologists, mental health occupational therapists, mental health nurses, and mental health social workers, counselling may not be their core business, but rather is one area of practice among others. Consequently, membership of a profession or occupational group alone does not identify a person as a mental health counsellor and nor does a person’s employment or job title. This indicates that determining who is delivering mental health counselling is not a straightforward process, but rather is convoluted and ambiguous.

Additionally, there is considerable variability regarding how mental health counsellors refer to themselves and the service they provide. For example, general nouns used to describe mental health service providers vary and include counsellor, therapist, psychotherapist, analyst, clinician, and practitioner. Descriptions of the service provided include counselling, therapy, psychotherapy, applied psychology, psychological therapies, and focused psychological strategies. Some of these terms are used interchangeably by some mental health counsellors; however, some make clear distinctions among the terms. Commenting on the issue over 20 years ago, London (1986) concludes that it is easier to undergo or to practise counselling that it is to explain it. Unfortunately, the ambiguity and convolution of terms continues to characterise the field of mental health counselling.

The variability in how mental health counsellors describe themselves and their practice has serious implications for mental health practice and education. As Cross and Watts (2002) argue, it undermines potential clients’ ability to make informed decisions about the service and in turn the counsellor’s capacity to achieve genuine informed consent from clients. Name and title ambiguity also undermines the identification of core capabilities required of counsellors and in turn the education, supervision, and research of counselling practice. Findings from The second Australian child and adolescent survey of mental health and wellbeing, conducted during 2013–2014, reveal that parents of children aged 4–17 years of age with a mental disorder
were more likely to seek services from a psychologist (23.9%) or counsellor (20.7%) than a social worker (9.3%), psychiatrist (7.1%), occupational therapist (7.9%), or nurse (2.5%); and approximately 30 per cent sought the services of a general practitioner (GP) in conjunction with a counselling practitioner (Johnson et al., 2016). This suggests that parents may more readily identify psychologists and counsellors as providers of mental health counselling compared with the other professional and occupational groups.

2.2.3 Medicare subsidies

When Medicare was introduced in 1984, it subsidised only mental health counselling provided by psychiatrists (Doessel & Williams, 2011). This changed in 2006 when Medicare introduced its Better Access scheme which included psychologists, mental health social workers, mental health occupational therapists, and mental health nurses as additional professions that could be subsidised to provide mental health counselling to people with a diagnosed mental health disorder covered under the scheme. Given that a person can only access Medicare-funded mental health counselling if a GP has assessed them as having a mental health disorder and if the GP has developed a mental health treatment plan for them, GPs play an integral role in the scheme (Politis & Knowles, 2013).

The 2006 Better Access scheme has significantly transformed the mental health counselling workforce in Australia. It has resulted in a changed workforce in that many more mental health counsellors are working in private practice (Doessel & Williams, 2011), particularly psychologists (Mathews, Stokes, Crea, & Grenyer, 2010). The scheme has also increased tensions and competition between and among professions (Di Mattia & Grant, 2016). The professions that are funded under Medicare are not funded equally, that is, the rebates and number of sessions covered by Medicare are not the same for all professions. For example, as outlined in the Medicare Benefits Schedule (Department of Health, 2017) there is a reimbursement sliding scale: psychiatrists receive the highest rebate, followed by clinical psychologists, then general (registered) psychologists, then mental health social workers and occupational therapists (both on the same rate), and lastly mental health nurses.

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5 Clinical psychologists typically undergo an extra two years of education and supervision in clinical psychology in addition to the minimum requirements to practise as a registered psychologist.
offer the greatest number of sessions to clients per calendar year (up to 50); clinical psychologists, general psychologists, mental health social workers, and mental health occupational therapists can offer up to 10 sessions per calendar year; and mental health nurses only three sessions per year.

Despite lobbying the government extensively for over 10 years for inclusion in the Medicare scheme, counsellors and psychotherapists continue to be excluded from receiving Medicare subsidies. Since the inception of the scheme, counsellors and psychotherapists working in private practice have experienced a dramatic decrease in their referrals due to people seeking Medicare-funded counselling (Schofield, 2013). The argument made by those opposed to Medicare's hierarchical subsidy system is that mental health counsellors, regardless of their profession, provide the same or similar services yet do not receive equal reimbursement and recognition. The different subsidy levels for different professions and the increased competition and acrimony amongst mental health counsellors in Australia is an important contextual factor to consider when exploring CMHPT counselling phenomena as it is a significant factor influencing the mental health counselling workplace and competition for scarce resources. Additionally, the cap of 10 sessions per calendar year for psychologists, mental health social workers, and mental health occupational therapists is particularly pertinent as it undermines the ability for CMHPT counsellors working under Medicare to produce effective outcomes. Meta-analyses of the efficacy of play therapy interventions have found that efficacy increases with the number of sessions provided, up to approximately 35 sessions (Bratton et al., 2005), with the optimal number of sessions being 30 to 35 (Leblanc & Ritchie, 2001). Thus, Medicare subsidises less than a third of the sessions needed to produce effective outcomes for clients. This is an overt example of a social structure impacting on and shaping practice. Returning to my metaphor of providing a landscape for the backdrop of CMHPT counselling practice, Medicare protrudes as a prominent landmark in the landscape.

2.2.4 Theoretical orientations

Mental health counsellors differ considerably in their theoretical orientation and overall ontological and epistemological stance regarding mental health issues and their treatment (O’Hara & O’Hara, 2015). Unlike other health services, the mental health counselling field is characterised by a vast number of different and competing theoretical orientations, with estimates of 300 different approaches (Feltham, 1995).
Mental health counselling textbooks typically group the vast array of approaches under broader categories such as depth therapies, existential therapies, humanistic therapies, cognitive behaviour therapies, and systems therapies. Some commonly used theoretical orientations in Australia include cognitive behaviour therapy, solution-focused therapy, client-centred therapy, psychodynamic therapy, psychoanalytic therapy, systemic therapy, narrative therapy, and transpersonal therapy (Schofield, 2013). The various theoretical orientations that inform mental health counselling policy and practice have different ontological and epistemological foundations, resulting in a lack of consensus in the mental health counselling field regarding the nature, cause, and treatment of mental health conditions. The longstanding and ongoing lack of consensus regarding the best treatment approach remains a highly contentious area, with some describing it as “warring factions” (Harris, 2009, p. 20) and “therapy wars” (Saltzman & Norcross, 1990, p. xv).

The lack of consensus between mental health counsellors regarding how to best treat mental health issues is perhaps one of the most complex aspects of mental health counselling. Although theoretical diversity is often celebrated and credited for stimulating productive research and providing a more enriched and complete understanding of human behaviour (Weiten, 2017), it is generally not so celebrated regarding counselling practice due to competition for resources and key funding bodies such as Medicare only funding selected theoretical approaches and their associated interventions. This raises similar issues outlined previously regarding naming practice and practitioners, and implications for both practice and education. It undermines potential clients’ ability to make informed decisions and choices about the service, particularly their ability to provide informed consent. It also takes the focus off identifying common factors and capabilities required of all mental health counsellors regardless of their theoretical orientation, which in turn impacts on achieving congruence in the education, supervision, and research of counselling practice. The overwhelming majority of studies in CMHPT counselling have approached counsellors’ theoretical orientation simply as an intervention rather than a sociocultural influence. I contend that theoretical orientations are subcultures within the field and therefore are an important consideration when exploring sociocultural influences on relational phenomena, particularly the various orientations’ conceptual and epistemological treatment of professional relationships.
2.2.5 Workplace diversity

In addition to the varying and numerous theoretical orientations that characterise the mental health counselling field, there is substantial heterogeneity in the workplaces where mental health counsellors practise. Mental health counsellors work in the government, nongovernment, and private sectors (Whiteford & Buckingham, 2005), and their workplaces include inpatient hospital facilities, custodial settings, community-based centres, schools, and private practices (Di Mattia & Grant, 2016). Mental health counsellors work in diverse geographical locations including urban, rural, and remote settings (Pelling & Butler, 2015) as well as virtual workplaces such as internet-supported psychological interventions (Bruno & Abbott, 2015) and telephone counselling (Coman, Burrows, & Evans, 2001).

Adding to the diversity of workplace settings is the broad and rich range of cultural and linguistic backgrounds found among Australians. The Australian Bureau of Statistics (ABS) 2016 Census data reveals that 1 in 3 Australians were born overseas, with nearly 1 in 5 having arrived since the beginning of 2012, and that there are over 300 separately identified languages spoken in Australian homes, with more than 1 in 5 Australians speaking a language other than English at home. Despite policies that promote culturally responsive and sensitive practice, the Australian health system has not been able to effectively meet the needs of a population with such a broad range of cultural and linguistic backgrounds, resulting in health inequalities for many people from culturally and linguistically diverse (CALD) backgrounds (National Health and Medical Research Council, 2005). The failure to meet the unique needs associated with cultural and linguistic diversity is most pronounced for Aboriginal and Torres Strait Islander (ATSI) people. ATSI people have suffered tremendous mental health issues due to the longstanding impact of colonisation as well as government-sanctioned abuse such as the forced removal of children (Parker & Milroy, 2014). For example, a recent study by Twizeyemariya, Guy, Furber, and Segal (2017) found that nearly 1 in 2 ATSI children aged 6 to 10 years were exposed to six or more risks associated with mental illness and 1 in 5 children experienced high psychological distress.

The diversity of Australia’s population is variably reflected in mental health counsellors’ CALD background and country of birth. The ABS 2016 Census data reveals considerable variability regarding mental health counsellors’ country of origin and their linguistic diversity. As illustrated in Table 2.2, approximately 18 to 53 per cent
were born overseas and approximately 10 to 30 per cent of mental health counsellors speak a language other than English at home. Less than 1 per cent of psychiatrists, psychologists, occupational therapists, and nurses identify as ATSI, and 3 per cent of social workers and counsellors. These figures indicate not only a varying level of cultural and linguistic diversity among professional groups that make up the mental health counselling field but also that mental health counsellors who identify as ATSI are grossly underrepresented across all professional groups and are disproportionately represented compared to the high number of ATSI people with mental health issues.

Table 2.2
Demographic diversity among professional groups delivering mental health counselling in Australia (ABS, 2016)

<table>
<thead>
<tr>
<th>Professional group</th>
<th>Female</th>
<th>Male</th>
<th>Born overseas</th>
<th>Non-English speaking at home</th>
<th>ATSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatrists</td>
<td>44%</td>
<td>55%</td>
<td>53%</td>
<td>30%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Psychologists</td>
<td>80%</td>
<td>20%</td>
<td>27%</td>
<td>13%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Occupational therapists(^a)</td>
<td>92%</td>
<td>8%</td>
<td>19%</td>
<td>10%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Nurses(^a)</td>
<td>89%</td>
<td>11%</td>
<td>40%</td>
<td>25%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Social workers(^a)</td>
<td>84%</td>
<td>16%</td>
<td>29%</td>
<td>17%</td>
<td>3%</td>
</tr>
<tr>
<td>Counsellors and psychotherapists</td>
<td>77%</td>
<td>23%</td>
<td>18%</td>
<td>16%</td>
<td>3%</td>
</tr>
</tbody>
</table>

\(^a\) = ABS census data not available for those who have a specialisation in mental health

The ABS census data also reveals how gender is represented across the professional groups. As depicted in Table 2.2, females are overwhelming overrepresented amongst most of the professional groups, with psychiatrists being the only group with fewer females than males. Although many critical theorists argue that mental health counselling is based predominantly on the values and interests of white, middle-class men (e.g., Fox, Prilleltensky, & Austin, 2009), in Australia, it is practised predominantly by women of varying sociocultural backgrounds.
2.3 Dominant ideologies, movements, and debates in mental health counselling

In addition to the issues pertaining to discrepancies in government subsidies, competing theoretical orientations, and workplace diversity, there are other central, and for the most part conflicting ideologies, movements, and debates that take place in the mental health counselling field. On the one hand, a positivist ideology dominates much of the field’s research and policy making. This ideology is used in the campaign to economise and rationalise mental health care, represented predominantly by the evidence-based practice (EBP) movement and its proponents’ incessant call for practitioners to demonstrate accountability via measurable outcomes and the implementation of empirically based treatments (Walker, 2003; Wall, 2008). On the other hand, there is the common factors movement which highlights research outcomes that have found no evidence for the superiority of one theoretical approach over others and provides empirical support for the central role of the client–counsellor relationship in achieving the best outcomes for clients. The common factors movement also calls for research to study mental health counselling as a situated, contextualised, and socially embedded practice rather than a de-contextualised and apolitical practice.

2.3.1 Positivism

Despite the richness, diversity, and complexity of the mental health counselling field, research on mental health counselling practice has predominantly focused on de-contextualised practice. This is largely a result of mental health counselling research being situated in the positivist paradigm. Although there are many variants of positivism, I am broadly referring to the tenet that “there is always a single externally determined law underlying any set of phenomena” (Miller, 1999, p. 6), which in turn neglects the situated, contextual nature of phenomena and the interconnected relationship between phenomena and their sociocultural context. Critical theorists contend that the neglect of the contextualised exploration of phenomena is a result of the mental health counselling field adopting a largely atomistic, reductionist, and mechanistic view of mental health issues (Teo, 2009) that it has emulated from the natural sciences and medicine (Wampold & Imel, 2015). The natural sciences and medicine’s influence on the mental health counselling field can be traced to its early beginnings in the United States where mental health counselling was in the exclusive domain of medicine (Wampold & Imel, 2015).
The positivist orientation that characterises mental health counselling research, and is traced to medicine’s influence, has resulted in the field adopting predominantly quantitative methodologies to explore mental health counselling and practice issues. The chief focus on quantifying and studying individual variables and factors has resulted in mental health counselling research neglecting contextual and process aspects of practice such as professional relationships (Gelso, 2011). When professional relationships are explored, they are primarily explored as dyadic relationships that are separated from sociocultural contexts (e.g., Gelso, 2011; Gelso & Carter, 1994; Norcross & Lambert, 2011a). A contextualised perspective on dyadic relationships such as the parent–counsellor relationship holds that the dyad cannot be separated from its contexts as it is embedded within them. In contrast to the positivist perspective, researchers working from a social constructivist perspective view relationships as “dynamic, changing and culturally bound” (Davis, 2003, p. 225). Other critics such as Cushman (1996) stress that mental health counselling is not apolitical or transhistorical and is itself a cultural artefact and, as such, it too needs to be considered as part of its sociocultural context. Despite the calls for more contextualised research of mental health counselling practice (e.g., Bracken & Thomas, 2001; Cushman, 1996; Davis, 2003), non-quantifiable phenomena such as professional relationships continue to be largely neglected in research. This neglect can be further understood by highlighting other related movements and debates that dominate policy, practice, and research in the mental health counselling field, such as those associated with the EBP movement, evidence-based treatment (EBT) movement, and the common factors movement.

2.3.2 Evidence-based practice (EBP) movement

EBP is a movement that has dominated health care policy and practice in Australia since the late 1990s (Australian Health Ministers’ Advisory Council, 2013). Historically, EBP stems from evidence-based medicine, and was pioneered by epidemiologist Archie Cochrane’s seminal Effectiveness and efficiency: Random reflections on health services published in 1972. Most professional boards and associations representing counselling clinicians endorse the American Psychological Association’s (APA) “inclusive, neutral definition” of EBP, which defines it as the “integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (APA, 2006, p. 273). This definition is often referred to as the “three-legged stool” as it requires counsellors to integrate three types of knowledge in their
decision-making: research evidence (where it is available), clinical experience, and client preferences (Spring, 2007, p. 613). Despite the often-quoted APA definition of EBP, it is often exclusively referred to as the empirico-analytical approach to research on treatments. That is, EBP is largely confused with EBT (Crocket, 2013) or empirically supported treatments (EST), as it is also referred to.

### 2.3.3 Evidenced-based treatment (EBT) movement

Some contend that EBT is a movement in and of itself and, although it shares similarities with EBP, is not synonymous with it (Wampold & Bhati, 2004). EBT essentially involves the exclusive focus on one leg of the three-legged stool – empirical research supporting specific treatment approaches. Like EBP, proponents of EBT uphold knowledge generated by experimental design studies as one of the main tenets for clinical decision-making and view systematic reviews of randomised controlled trials (RCTs) where specific treatments are compared with placebos as the “gold standard” of evidence gathering (Wampold & Bhati, 2004; Westen & Bradley, 2005). This technical, manualised approach is reinforced by policies such as Medicare’s Better Access scheme discussed in Section 2.2.3. Namely, Medicare funds only “approved psychological strategies” for addressing specific mental health issues. These approved psychological strategies under Medicare are those that are supported by evidence according to the evidence hierarchy outlined by the National Health and Medical Research Council’s (1999) clinical practice guidelines, where systematic reviews of RTCs are considered the method producing the highest quality of evidence. Mental health counsellors offering treatment under Medicare must use the approved psychological strategies and are not at liberty to consider the other legs of the EBP stool, that is, clinical experience and client preferences. EBT has fuelled the “theoretical wars” and associated acrimony amongst mental health counsellors as it encourages the notion of a superior treatment approach (Beitman, 2004). What is fundamentally unacknowledged by proponents of EBT is the positivist research paradigm in which it operates and generates its evidence (Reed & Eisman, 2006). The omission to highlight the paradigm at the same time neglects to recognise other paradigms that generate evidence and knowledge based on different worldviews. For instance, two additional research paradigms that also generate evidence are the constructivist and critical paradigms, each with differing ontological, epistemological, and methodological assumptions (Teo, 2009). The most compelling research that undermines the EBT
movement is the meta-analyses that reveal that no one theoretical orientation is superior, as they produce much of the same results (Wampold & Imel, 2015).

The EBT movement has had a significant impact on CMHPT counselling research. Even though CMHPT counselling has a 100-year plus history and is one of the most popular approaches adopted by mental health counsellors when working with children, it has largely been marginalised within the broader mental health counselling field for not producing enough “evidence” of the effectiveness of its practice (Bratton & Ray, 2000; Phillips, 2010) as defined by the EBT movement. As a response to this marginalisation, the last decade or so has witnessed CMHPT counselling research predominantly being undertaken in the positivist paradigm using quantitative methodologies. The focus is primarily on determining the efficacy of specific play therapy approaches, that is, those associated with specific theoretical orientations. Although this is clearly an important endeavour for CMHPT research, as discussed in Chapter 1, there is currently a paucity of research undertaken to explore relational phenomena associated with CMHPT counselling, including contextual conditions for how professional relationships are developed, maintained and understood by CMHPT counsellors. Additionally, I argue that the influence of the EBT movement on CMHPT counselling research relates to issues pertaining to the field’s professional identity within the broader mental health counselling field. As Fawkes (2015) suggests, many professions or fields that struggle for legitimacy tend to focus on highlighting their achievements and efficacy rather than exploring aspects of practice that may undermine efficacy and in turn undermine the profession’s image. In this respect, challenges CMHPT counsellors face with parents and ensuing dropout rate issues could be perceived as a shadow aspect of the field and one that may threaten the imperative to provide empirical support of play therapy’s efficacy.

2.3.4 Common factors movement

An increasing number of researchers and practitioners have led a charge against the ideology and methodology spawned by positivism and the subsequent EBP and EBT movements (Wampold & Imel, 2015). Running parallel with numerous studies concluding that there are no significant differences between various theoretical orientations and their respective psychological strategies and treatments is the common factors movement. Adherents of the common factors movement propose that research should focus on factors common to all theoretical orientations. The movement
was stimulated by decades of research indicating “that the provision of therapy is an interpersonal process in which a main curative component is the nature of the therapeutic relationship” (Lambert & Barley, 2001, p. 357), also referred to as the therapeutic alliance (Budd & Hughes, 2009).

As a response to the EBT and common factors movements and subsequent debates between the two, in 1999, the APA Division of Psychotherapy commissioned a taskforce to identify, operationalise, and publish information on “empirically supported therapy relationships” (Norcross, 2002, p. 3). The main conclusion of the taskforce was that specific techniques account for only 5 to 15 per cent of outcome variance and that individual therapist differences and the therapeutic relationship between client and therapist (regardless of technique or school of therapy) accounts for most of the treatment outcomes (Norcross, 2002). Around the same time, in 2001, Wampold published his seminal book *The great psychotherapy debate: The evidence for what makes psychotherapy work*, where he first outlined his contextual model which he pitted against the EBT model:

The Contextual Model conceptualizes psychotherapy as a socially imbedded healing practice, utilizing social pathways to assist clients in alleviating various forms of psychological distress. In the Contextual Model, the influence of the relationship between the therapist and the client is central – the relationship works through direct means as well as indirect means. (Wampold & Imel, 2015, p. 258)

Despite research and taskforces supporting the notion that there is no significant difference between the outcome of treatments and that the most significant effect stems from the therapeutic relationship between client and counsellor, fierce debates described as the “culture wars” continue, where treatment approaches are pitted against the therapeutic relationship (Norcross & Lambert, 2011b, p. 4). In 2009, the APA’s Division of Psychotherapy and the Division of Clinical Psychology together commissioned a second taskforce to provide an update on the findings of the first taskforce. The second taskforce’s main conclusion was that the therapeutic relationship is not separate from techniques and strategies, and the interpersonal and the instrumental are not separate categories, but rather treatment strategies and techniques are “relational acts”.

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The relationship does not exist apart from what the therapist does in terms of method, and we cannot imagine any treatment methods that would not have some relational impact. Put differently, treatment methods are relational acts. (Norcross & Lambert, 2011b, p. 5)

This was a significant outcome in terms of positioning relational phenomena at the centre of best practice. However, the term relational acts here is still in keeping with a narrow conceptualisation of the term relational. That is, it signifies building relationships between two people (namely, the counsellor and client rather than other parties) in a largely instrumental fashion. It does not encompass relational in the spirit of relationalism, where relational acts are interconnected with and embedded in personal, sociocultural, and collective contexts.

2.4 Towards relationalism

The term relational has markedly different meanings and uses across different disciplines. In CMHPT counselling the term relational is typically used to refer to the relationship between people and is often used synonymously with relationship. Within the philosophical doctrine of relationalism, relational does not refer to the relationship between people, but rather the relationship between various aspects of social space or social context. For example, in Bourdieu's (1990b) sociological relationalism, relational refers to the relationship between a person's agency and social structures. Broadly, relationalism emphasises that phenomena are embedded within their varied social contexts and therefore challenges the substantialist notion of approaching interpersonal relationships as bounded, distinguishable entities (Kaipayil, 2009). The substantialist approach defines positivism and dominates the health and social sciences, including psychology and mental health counselling (Nelson, 2009), and for this reason it is important to reconsider relationalism in the context of my research. Substantialism (also referred to as substantivalism) is a philosophical doctrine that considers the fundamental unit of enquiry as bounded things and substances (reification) or entities that possess intrinsic properties (Tsekeris, 2010). Emirbayer (1997, p. 286) argues that substantialism focuses on individuals or social agents interacting with one another in a linear, causal fashion like “billiard balls” thrust against each other by entities (variables) such as gender, ethnicity, race, income, and age. Substantialist epistemology approaches these entities or variables independently of their context (Crossley, 2005). If context is considered, it is often approached as
another variable rather than embedded within the phenomena being studied (Eacott, 2018).

Given one of the central premises of my research was that phenomena are contextually embedded, I considered it important to draw on relational theories that emphasise social context. Many relational theorists place central importance on social contexts with varying focus. For instance, in relational psychoanalysis, Mitchell (1988) considers a person’s mind (and its mental processes) to be both the product as well as “the interactive participant in the cultural, linguistic matrix within which it comes into being” (p. 19). A person’s relational matrix is regarded as the foundation on which ensuing relationships are built, and therefore is the focus of exploration and change with clients to assist them to shape more positive relationships with others. In the context of professional practice education and development, Edwards (2010) approaches the meaningful relational engagement with clients and other professionals as a specialist capability or expertise that needs to be strategically developed (alongside the core specialist knowledge that defines various professions) in order to maximise outcomes for clients. Edwards draws on sociocultural theorists such as Vygotsky to conceptualise this relational expertise practice and development as embedded in and mediated by sociocultural contexts.

Considering my research questions were concerned with exploring CMHPT counsellors’ understandings of contextual and unconscious influences on their relational practices with parents, I focused on relational theory that emphasised the social embeddedness of relational practices and the pertinent role of unconscious influences in shaping relational practices. I did this by mining the principal relational thoughts from social constructionist and practice theorists, as they offered guidance and nuanced conceptualisations of the terms relational and practices that were most congruent with my research phenomenon, research questions, paradigmatic positioning, and the overall aim of my study. Specifically, social constructionist theorists offered guidance regarding what the focus of inquiry should be when studying relationships between people (that is, the focus should be on relational practices), and practice theorists offered a focus on exploring embedded, unconscious structural influences on practices.
2.4.1 Gergen’s social constructionism

In conceptualising the term *relational*, I began by drawing on relational theory based on social constructionism, also referred to as relational constructionism (McNamee & Hosking, 2012). The main proponent of social constructionism is social psychologist Kenneth Gergen. Social constructionism is a variant of constructivism. Where constructivism emphasises that individuals’ views of reality are socially constructed and are all equally valid, social constructionism emphasises that these social realities are constructed via relational practices: “where constructivism places the origin of knowledge in the head of the individual, social constructionism places the origin in social process [emphasis in original]” (Gergen, 2015, p. 30). Gergen (2009) challenges the notion of relationship entities and argues that relational practices come prior to the concept of the relationship entity and that relational practices form and inform relationships between people. Hosking and McNamee (2006) echo this notion, stating that it is relational practices that create, maintain, and transform social realities and therefore they should be the focus of inquiry. Thus, in relation to my study, exploring the parent–counsellor relationship required a focus on CMHPT counsellors’ relational practices or what Kemmis (2009a, p. 464) refers to as “sayings, doings and relatings”.

In the context of my research, relational practices is a different yet related phenomenon to the parent–counsellor relationship. The parent–counsellor relationship is more of a reductionist entity that pertains to substantialist ideology, whereas a focus on CMHPT counsellors’ relational practices emphasises processes, which is a core feature of relationalism.

Although social constructionist theory provides useful conceptualisations of relational practices as the building blocks that form relationships, it is limited in that it does not adequately incorporate considerations concerning the unconscious influences of social structures. I adopt the general sociological (as opposed to linguistic or anthropological) definition of social structures as “a more or less enduring pattern of social arrangements within a particular society, group, or social organization” (Hunt, 2010, p. 578). These structures are considered to exert their influence at an unconscious level as they permeate social life and act as the preconditions that allow practices to develop. Kemmis and Grootenboer (2008) refer to these preconditions as practice architectures. Practice architectures are considered to identify “pre-existing cultural-discursive, material-economic and social-political orders and arrangements
that enable and constrain practice, respectively, in semantic space, physical space-time and social space” (Kemmis & Mutton, 2012, p. 188).

Social structures or practice architectures form part of the macrosocial perspective and include social stratification such as class, race, ethnicity, and gender as well as social institutions such as the family (Kohn, 1989). I share Kohn’s (1989) view that social psychology (as evident in social constructionism) tends to focus on the microsocial, treating “the immediately impinging environment as if this were all there were to social structure” (p. 27).

2.4.2 Bourdieu’s sociological relationalism

To incorporate considerations of social structures from a sociological relationalism perspective, I turned to Pierre Bourdieu’s practice theory. Bourdieu was a twentieth-century French sociologist who proposed that practice is a result of a complex dialectic between a person’s agency and the structures of society and that one cannot be understood without the other (Webb, Schirato, & Danaher, 2002). In sociological theory, agency and structure are typically juxtaposed, where agency indicates a person’s intentionality and their ability to understand and change their actions, as opposed to social structures which are considered to unconsciously determine a person’s actions (Scott & Marshall, 2009; Webb et al., 2002). Bourdieu draws heavily on sociological relationalism, where relational refers to the dialectic relationship between agency and structure rather than the relationship between people.⁶

“Interpersonal” relations are only apparently person-to-person relations and . . . the truth of the interaction never lies entirely in the interaction. This is forgotten when the objective structure of the relationship between the assembled individuals or the group they belong to . . . is reduced to the momentary structure of their interaction in a particular situation or group. (Bourdieu, 1990b, p. 291)

Bourdieu describes the relationship people have with social structures as “objective relations” (Bourdieu & Wacquant, 1992, p. 97), which refers to the notion that making

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⁶ When discussing sociological theory, I use terms such as person, people, actor, and agent to highlight the conceptualisation of human beings as members of society, as opposed to the term individual, which is a more “psychologistic” term (Harris, 1989, p. 599) that conceptualises human beings as the main focus of enquiry, rather than beings who are situated and embedded in social contexts, and whose practices are intimately related to social structures.
sense of a phenomenon requires the phenomenon to be understood in relation to other phenomena it is contrasted against. This relational sociological perspective relates largely to positioning in social space, in that something only makes sense in contrast to something else in the same field or an intersecting field. Bourdieu (1998) explains that he conceptualises the social world as social fields (as opposed to society), with an emphasis on the social space within social fields, in order to move away from substantialist notions of the nature of the social world and instead stress the relational nature of it. Crossley (2013) uses the example of jazz to illustrate Bourdieu’s relational approach:

To understand “jazz” relationally, for Bourdieu, for example, is to understand it as “middle brow”; as located below “high brow” musical forms such as avant-garde art music but above others, such as music-hall standards. Crucially, however, he also insists, again in the name of relationalism, that positions may shift and that no social practice is inherently low or high brow. What is high can become low and vice versa . . . Likewise, across different national societies, “the same” practice may occupy a different position. The position of tastes and dispositions varies both across (historical) time and across national contexts, Bourdieu insists, and we should not, therefore, succumb to the substantialist error of interpreting and explaining positions in terms of inherent properties. There is nothing inherently “middle brow” about jazz. It just happens to occupy that position in social space at this historical conjuncture – and of course it began life, in the United States, at the very “bottom” of social space. (p. 133)

Bourdieu’s relationality is in fact social embeddedness. Practices, like jazz, are embedded in the field at a particular time and place in relation to other practices in the field, in other words, the sociocultural context they are found in. Thus, CMHPT counsellors’ relational practices need to be considered within the historical sociocultural milieu of the CMHPT counselling field, both past and present. In Chapter 3 I revisit Bourdieu’s practice theory by discussing several of his relational thinking tools. In this chapter, I focus primarily on the overarching tenets of relationalism and practice theory and how practices are conceptualised. To further conceptualise my research phenomenon, in the next section I discuss three main features of how practice theorists conceptualise practices.
2.5 Practice theory and core practice features

As with the term *relational*, the term *practices* is used by different theorists with varying conceptual (ontological and epistemological) underpinnings. In the CMHPT counselling literature, like the broader mental health counselling field, practices are typically considered in the context of a substantialist frame in that they are distinguishable behavioural *acts* that are considered in a de-contextualised fashion. To conceptualise practices within a relational and contextualised frame, I consider the term practices from a practice theory perspective as it offers socially embedded, normative, unconscious, routinised, temporal, material, and spatial considerations of practice. Although there is no definable “practice theory”, a practice approach is generally considered a “distinct genre of social theory” (Rouse, 2007, p. 641) consisting of a “family of theories” derived primarily from the works of Bourdieu, Giddens, late Foucault, Garfinkel, Latour, Taylor, and Schatzki (Reckwitz, 2002, p. 244). Different practice theorists emphasise different aspects of practice and the social construction of reality. In my conceptualisation of practices, I do not draw on a particular practice theorist, but rather on commonalities shared by practice theorists as highlighted by practice theory commentators such as Reckwitz (2002), Rouse (2007), and Nicolini (2012). In the following sections, I discuss six main features and influences of practices emphasised by practice theorists that relate to my research phenomenon: (1) the social unconscious, (2) communities of practice and practices of the community, (3) temporality, (4) materiality, (5) spatiality, and (6) structure and agency.

2.5.1 The social unconscious

Reckwitz (2002) argues that one of the distinguishing features of practice theory is that it gives centrality to unconscious processes. Although practice theorists do not typically provide nuanced explanations of what they mean by “unconscious” and how their understanding of the term may differ from other fields, such as psychology, the unconscious aspect of practice refers primarily to two elements: the routinisation of practice and the socialisation of practice. In terms of routinisation, practice theorists emphasise processes of everyday life, where the social world is created via ongoing, recurrent, routinised practices. The routinisation of practices is learnt via socialisation. In practice theory, socialisation is considered a largely unconscious process and, as Bourdieu (1977) highlights, “the unconscious is never anything other than the
forgetting of history” (p. 78) and it is history that socialises individuals to embody society’s objective structures as second nature practices.

In practice theory the unconscious refers specifically to a social treatment of the unconscious that differs markedly to the conceptualisation of the unconscious in mental health counselling, which primarily relates to the individual’s personal unconscious, that is, the individual’s personal history rather than social history and socialisation. Conceptualising the unconscious as social rather than just personal provides a fresh perspective for professional practice and specifically CMHPT counselling practice, where unconscious influences, when explored, are primarily explored in connection to counsellors’ personal unconscious rather than the social unconscious (e.g., Gil & Rubin, 2005). In the CMHPT counselling field, this notion of the unconscious may include influences pertaining to the counsellor’s socialisation in the field. For example, counsellors may be socialised to be more likely to make child protection notifications when the parent is unemployed and living in social housing than when the parent is a professional living in an affluent suburb.

2.5.2 Communities of practice and practices of the community

The socialisation of practice is an important feature of practice theory, in which practices are considered to be developed (learnt), carried out, and sustained in the context of a specific community of practice (Nicolini, 2012). Wenger, McDermott, and Snyder (2002) define communities of practice as “groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis” (p. 4). From this perspective, practices are always social (and relational), not just because they are influenced by social structures and ideologies, but also because they are situated in the tradition of a community of other professionals. In its most basic form, community in this sense is considered a result of practices by a group of professionals that share something in common and have formal or informal, face-to-face or virtual contact with one another.

The concept of community of practice has been debated for over 20 years due to variability in uses and conceptualisations of the term. Some scholars suggest that one of the misconceptions of using this term is that it implies that communities create practices rather than the practices creating communities. For instance, Nicolini (2012)
argues that “it is practice which performs community and not the other way around” (p. 94). Some practice theorists have called for a reversal in terminology, that is, rather than using the term “community of practice”, “practices of the community” should be used instead. They argue that a change to the latter moves the focus away from where learning takes place (that is, in communities of practice) to a focus on “how situated and repeated actions create a context in which social relations among people, and between people and the material and cultural world, stabilize and become normatively sustained” (Corradi, Gherardi, & Verzelloni, 2010, p. 268).

Although the notion and exploration of community of practice and practices of the community is absent in the CMHPT counselling literature, both concepts resonate with CMHPT counselling practice in a way that reinforces their relational nature. Firstly, my definition of CMHPT counsellor entails counsellors gaining play therapy qualifications from an accredited education or training institution. This implies that counsellors have developed (consciously and unconsciously learnt) their initial practice in a relatively definable community of practice, that is, their educational institution as well as the practice settings where their workplace placements took place. Secondly, my definition of CMHPT counsellor includes actively working in a workplace setting and belonging to a clinical board/association, both of which typically include compulsory clinical supervision, all of which indicates that counsellors are engaged in practices with others (regardless of how big or small their workplace is), further indicating they are involved in practices of a community. Thirdly, in addition to participating in individual clinical supervision, many CMHPT counsellors participate in group supervision, which may involve other counsellors they directly work with or counsellors from other teams or organisations. Thus, group supervision could be considered a community of practice as well as practices of a community.

2.5.3 Temporality

From a practice theory perspective, practices are situated and organised in and through time. Social structures are not seen to exist outside of time but rather they are reproduced through the repetition of routinised practices that take place in the sequence of time (Reckwitz, 2002). Shove, Pantzar, and Watson (2012) describe the routinised aspect of practices as performances and it is the repeated doing of these practices/performances (plural) which make up the broader concept of practice (singular): “it is only through the successive moments of performance that the
interdependencies between elements which constitute the practice as entity are sustained over time” (p. 7). Thus, I conceptualise CMHPT counsellors’ relational practices (plural) as a series of sequentially ordered performances that make up the broader concept of CMHPT counselling practice (singular).

The sequential ordering of practices is fundamental to how practices are performed and in turn how practices are changed. The temporal nature of practices is central to changing practices in that practices are typically changed by agents when there is a “surprise” or a practice “breakdown” that takes places in the sequence of time (Yanow & Tsoukas, 2009, p. 1342). These breakdowns need to be responded to with temporal deliberation, that is, they need to take place in the moment and/or in a timely fashion for the practice to continue effectively. For example, in the CMHPT counselling context, if a parent explicitly or implicitly communicates that they are not happy with some aspect of the service, the counsellor needs to effectively respond in the moment otherwise it is likely the parent will discontinue treatment for their child. Thus, temporality is also related to reflexivity. The timing of the counsellor’s reflexivity and ensuing practice is an important consideration to ensure effective practice. That is, whether they reflect during or after a practice breakdown.

2.5.4 Materiality

In practice theory, the material environment, material objects, and the body are considered interconnected with practices and play a central role in the creation and maintenance of the social world: “Practices with no things and no bodies involved are thus simply inconceivable . . . Objects, in fact, both make practices durable and connect practices with each other across space and time” (Nicolini, 2012, p. 4). Materiality is considered interwoven in all practices rather than used merely in instrumental actions. In the CMHPT counselling field, this infers that the material environment, material objects, and the body are not adjuncts or extensions of counsellors’ practices (as they are overwhelmingly depicted in the CMHPT counselling literature), but are fundamentally part of their practices; that is, they are interwoven and intertwined and cannot be separated from practices. In the CMHPT counselling context, the material environment may include the counselling room, the waiting room, and the building where the counsellor’s rooms are located; and material objects may include office furnishings as well as transient objects such as brochures, information packs, and business cards given to parents. In terms of the body, on a surface level this includes
the body being a “carrier” of practices (Reckwitz, 2002, p. 250) but in the CMHPT counselling context, it also implies that the body is a carrier of somatic responses to interactions with parents, or what is typically referred to as “somatic countertransference” (e.g., Athanasiadou & Halewood, 2011; Gubb, 2014; Ross, 2000; Vulcan, 2009). For example, in the process of a review session with a parent where the CMHPT counsellor provides feedback regarding the counselling progress of the child, the parent may respond to the counsellor’s evaluation with aggression. This aggression is registered not just in the counsellor’s mind but also in the counsellor’s body. For instance, they may experience the parent’s hostility as a “knot” in their stomach. In this light, the body is not simply a contained carrier of practices but an absorber and conduit of affective states emanating from the parent (and vice versa).

2.5.5 Spatiality

Practice theorists conceptualise practice as situated not only in time and place but also in space (Nicolini, 2012) and that time, place, and space are intricately fused (Kemmis, 2009b). Although there are different conceptualisations of spatiality, I am referring to material space (rather than social space). Material space is relational in that it positions people, objects, and time in relation to one another:

Whereas absolute space is space construed as a container or arena in which events occur and entities exist, relational space is a collection of relations among entities (longer than, inside, etc.) and of properties based on those relations (length, position, etc.) (Schatzki, 2009, p. 35).

Material spatiality is particularly pertinent to CMHPT counselling practice as different practices take place in different spaces, which are furnished in different ways. For example, counselling children typically takes place in a “special playroom” which is arranged with specific props, from specific therapeutic categories, arranged in a specific way. The playroom is characteristically separated from adult (parent) spaces (e.g., waiting room and consulting room) with enough distance so the parent cannot hear what is taking place, assisting the CMHPT counsellor maintain the child’s confidentiality. When the counsellor conducts parent sessions (e.g., initial intake assessment and review sessions) they do so in a separate consulting room which is furnished for adults rather than children. Additionally, the CMHPT counsellor’s movements and seating arrangements are different with children compared with parents. In the playroom with children, the counsellor is typically seated on the floor
and moves around as the child moves (maintaining eye level), whereas in spaces with parents such as the consulting room, the counsellor is generally seated in a chair or sofa. Reckwitz (2012) stresses that spaces are also affective spaces in that they elicit different affective states through the positioning of people and objects in space.

### 2.5.6 Structure and agency

Although the social world is largely created and maintained by the unconscious, routinised carrying out of practices by agents (mostly influenced by social structures), practice theorists contend that practices can also be changed. That is, practices are not blindly determined by social structures but also determined by agency. In this context, I conceptualise agency as a person’s intentionality, the ability to understand and change their actions, as well as how they “inhabit, negotiate, or elude” social structures (Webb et al., 2002, p. 36). In practice theory, agency and social structures (and ideologies) are each considered to play a role in that a person’s practices are regarded as “neither mindless repetition nor complete invention” and “that the system can be made and unmade” by practices (Nicolini, 2012, p. 5). Although practice theorists generally share the notion of dynamic interplay between structure and agency, there is considerable variability in the degree of agency they afford (Rouse, 2007). Regardless of where on the continuum they fall, they generally all consider practices as dynamic and changeable.

The agentic nature of practices was important to my study as I not only explored CMHPT counsellors’ understandings of unconscious influences on their relational practices with parents, I also explored the nature of their critical reflexivity regarding these unconscious influences. That is, to exercise agency, the person (or practice community) needs to first be critically reflexive of the nature of the unconscious influences on their practices. This infers that social structures influence but do not determine CMHPT counsellors’ practices and that counsellors may counteract the unconscious influence of social structures by engaging in critical reflexivity on these influences, which in turn provides the foundations for agentic capabilities. Thus, in the context of my study I conceptualise reflexivity as a forerunner of agency. To provide a more robust conceptual frame for the agentic nature of practice, I turned to the professional practice literature.
2.6 Core dimensions of professional practice

Although practice theory encapsulates all kinds of practices, including everyday practices, my research phenomenon of relational practices falls specifically in the domain of professional practice. The term professional may assume little conceptualisation; however, I wish to avoid the use of the word professional as a “stop word”, that is, “a word that draws a close to reflection or explanation” (Macklin, 2009, p. 85). In other words, I do not intend it to merely mean the practice of members of a profession. Green (2009) points out there are different “senses” in which professional practice might be understood. Indeed, professional practice theorists emphasise and illuminate many different facets of professional practice. In terms of my study's phenomenon of relational practices, I consider the term profession as not just implying belonging to a legally and/or industry recognised group (e.g., psychologists, social workers) but I define professional in contrast to non-professional (not formally educated and not belonging to a profession) by emphasising three core dimensions of professional practice: (1) critical reflexivity, (2) ethics and values in climates of uncertainty, and (3) notions of professional becoming. By arranging and focusing on these dimensions of professional practice, I emphasise the agentic aspect of relational practices and in turn contribute to and deepen relationalism’s agent–structure dialectic.

2.6.1 Critical reflexivity

Reflective practice is often cited as a defining feature of contemporary professional practice and is founded primarily in the work of Dewey and Schön (Fook et al., 2006) and utilised across disciplines such as education, psychology, philosophy, and sociology with varied conceptualisations and applications to professional practice (Moon, 2013). In the field of counselling, Dallos and Stedmon (2009) distinguish between reflection and reflexivity, where reflection refers to the practice of reflecting in action, often dominated by “self-awareness of bodily sensations and emotions and the attentional focus on memories, experiences and cognitions as evoked during in-the-moment reflective episodes [emphasis in original]” (p. 4). Dallos and Stedmon state that reflexivity, on the other hand, refers to the practice of reflecting on action to make sense of remembered episodes. Dallos and Stedmon (2009) stress that reflexivity can include creative activities that draw on “a person’s selfhood and agency beyond declarative and procedural knowledge of how to do therapy” (p. 5). In the CMHPT
counselling context, this can include counsellors utilising play therapy and other expressive modalities and mediums in clinical supervision to represent and then work through practice episodes they are struggling to make sense of. It is important to note that reflection and reflexivity are not two distinct processes, but rather the latter builds on the former and they often overlap.

Some such as Brookfield (1998) extend the notion of reflective practice to critical reflective practice to emphasise “a process of inquiry involving practitioners in trying to discover, and research, the assumptions that frame how they work” (p. 197). Brookfield (2012) refers to this process as “hunting assumptions” (p. 7). For Brookfield, critical reflective practice relates primarily to hunting paradigmatic assumptions and involves considering the influences of power, social structures, and ideologies on practice. I extend critical reflective practice further via the concept of critical reflexivity, which emphasises unearthing personal, social, and collective unconscious influences on practices. My conceptualisation of critical reflexivity emphasises that practices are not only related to unconscious social influences but personal and collective unconscious influences as well. Given that so much of what counsellors do is experiential and implicit (Irving & Williams, 1995), without critically reflexivity counsellors could routinely and automatically attribute the difficulty they experience with a parent to the parent “being” difficult (substantialism) rather than the situation or encounter being difficult due to any of a range of unconscious contextual influences (relationalism). Additionally, this increased awareness garnered via the process of critical reflexivity can lead to action, or more specifically “good action” or ethical practice, which I discuss in the following section.

2.6.2 Ethics, values, and uncertainty

A central concern with ethics and values sets professional practice apart from general social practices (Kemmis, 2012). In principle, professional practice is driven by a general notion of the common good, that is, “serving or contributing to society” (Higgs, McAllister, & Whiteford, 2009, p. 102). However, serving the greater good and being driven by ethics and values is not formulaic, but rather is characterised by uncertainty and ambiguity. In the context of professional practice, it is important to distinguish between morals and ethics as they are frequently used interchangeably without sufficient conceptual clarity. In making my distinction between the two, I explored the origins of these terms. Morals comes from the Latin word mos meaning custom, and
ethics comes from the Greek work *ethos* meaning character. Consequently, I conceptualise morals as based on social and cultural customs of a group of people and concerned with “right and wrong” practice, and what generally forms the foundation of legislation. Ethics, on the other hand, defines the character of a person (“good or bad”) which is formed not solely by whether the person does the right or wrong thing (e.g., whether they follow laws) but how they respond to situations where there is significant complexity and uncertainty and no right or wrong doctrine to guide practice. Thus, moral issues indicate a clear path to “right action” and are less context dependent than ethical issues. Ethical issues are context dependent, and infer “good action” based on the character a person develops by having to navigate murky terrain without a doctrine to guide them. To further highlight ethics as a function of uncertainty and positioned outside “right or wrong” doctrine, I explored Aristotle’s concept of *aporia*.

**Aporia**

Aporia refers to the encounter of seemingly unresolvable issues and paradoxes. Derrida (2005) describes aporia as “an impasse of the undecidable” (p. 92). In the climate of evidence-based practice agendas, aporia is a reminder that not all practice is instrumental, quantifiable, and predictable. Rather, there are many aspects of professional practice that are characterised by uncertainty and ambiguity, where there are no clear solutions or a clear course of action (Green, 2009). In the context of working with parents, the concept of aporia is important as it acknowledges and succinctly names frequent experiences CMHPT counsellors encounter where there appears to be no clear course of action as each course has undesirable consequences. For example, a common aporic situation CMHPT counsellors encounter is when a child discloses to the counsellor that their parent is abusing them. As a mandatory reporter, the counsellor notifies the Department of Family and Community Services; however, they are informed by the department that departmental resources are stretched and therefore they are unable to make the case a priority for investigation at this stage. The counsellor is now in a position in which if they confront the parent about their abusive behaviour they risk the parent taking the child out of counselling. If the counsellor does not confront the parent, the parent will continue to abuse the child. In sum, it appears that there is no clear “right” action.
Macklin (2009) argues that practical reasoning cannot help to solve aporic situations, “to somehow mysteriously clear the mists and reveal the answer to moral conundrums [emphasis in original]” (p. 94). Drawing on Derrida, Macklin (2009) concludes that we must live with uncertainty and accept that aporic dilemmas cannot be solved by practical reasoning alone and that they “will most often involve leaps of faith” (p. 96) as we make decisions without having the certainty that we are making the right decision. Although I agree with Macklin’s contention that practical reasoning cannot solve aporic dilemmas, I do not agree that a leap of faith is the best we can hope for. The professional practice literature primarily focuses on professional judgments and decision-making with respect to ethical issues, which positions change or the addressing of issues at a largely cognitive level without adequately reflecting on unconscious influences. In contrast, I argue that change and addressing of issues most effectively occurs by bringing unconscious influences to light. Consequently, I conceptualise aporia as fundamentally influenced by unconscious influences and I argue that dilemmas can be adequately resolved when these unconscious influences are considered and made conscious through the process of critical reflexivity. For example, in terms of unconscious social influences in the scenario outlined above, the aporia may not be based on what the counsellor consciously and rationally thinks the dilemma is about (that is, the risk to the child regardless of which path they take). Rather, the decision whether to confront the abusing parent may be unconsciously influenced by the parent’s social class and whether the counsellor anticipates (mostly unconsciously) a retaliation that would result in a detrimental outcome for the counsellor. The counsellor may be less inclined to confront an abusing parent who is a lawyer compared to an abusing parent who is unemployed and receiving welfare benefits. Thus, through critical reflexivity, it may be revealed that the dilemma is not really or only about the risk to the child but the risk to the counsellor. Any action taken based on this identification of the underlying influence is more likely to be “good” action as it is based on a deeper and more relationally aware reason for the aporia or, metaphorically, it involves addressing the issue at the root rather than the surface.

### 2.6.3 Professional becoming

A third interrelated dimension of my conceptualisation of professional practice draws on Scanlon’s (2011) notion of “becoming a professional” (p. 14). The notion of becoming is associated with what Scanlon (2011) describes as an “ongoingness” of developing a professional self and a professional identity, which emphasises lifelong
learning rather than arriving at a static endpoint called “expert” (p. 13). Scanlon (2011) stresses that lifelong learning involves professionals’ ongoing engagement with change – change in “knowledges, skills and practices” needed to meet “ever-changing contexts” (p. 28). Uncertainty and ambiguity are defining features of the knowledge and practice associated with aporia, which further implies that learning is ongoing as there is no finite knowledge to acquire. The need for professionals to adapt their practices to increasingly changing contexts challenges the notion of mastery in the static sense of the word, that is, arriving at an “expert” destination.

Although the notion of continuous, lifelong learning is an important and central feature of professional becoming, I argue that it needs to encompass personal development rather than simply professional development as the two are intricately related. That is, continuous learning’s relationship to and with ethics does not simply relate to committing oneself to learning how to navigate the ever-changing contexts that practices take place in. It also relates to the notion that our self-development is intricately related to how we treat other people. I return to this notion in the following chapter when I discuss Jung’s approach to developing an ethical attitude via the process of individuation.

The notion of professional becoming is congruent with some CMHPT counselling approaches to learning and offers to extend and deepen current approaches to learning in the CMHPT counselling field. For instance, the CMHPT counselling field and the broader mental health counselling field is steeped in the tradition of lifelong learning. The ongoing engagement, demonstration, and monitoring of professional development rejects the notion that one can arrive at a static “expert” status, but rather espouses the notion of continuous learning and the continuous becoming of a professional. To maintain registration or membership with their clinical body or association (e.g., Psychology Board of Australia, Australian Association of Social Workers), mental health counsellors are required to engage in a minimum amount of professional development activities per year. Most boards and associations require mental health counsellors to engage in a combination of professional development training (e.g., workshops and courses) and clinical supervision.\footnote{In the mental health counselling field, clinical supervision (also frequently referred to as professional supervision) is not seen as a professional development activity solely for intern counsellors as is the case in other health fields, but one that is carried out for the entirety of one’s professional life.} One of the main foci

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of clinical supervision is to develop and engage in reflexive practice (Dallos & Stedmon, 2009). Professional development and learning hours are recorded in a log and may be audited by the board or association for compliance. For mental health counsellors who wish to maintain registration or membership with play therapy–specific associations, these associations may also require counsellors to engage in play therapy–specific training and clinical supervision. Although the field places an emphasis on professional development and knowledge acquisition rather than continuous professional learning (CPL), my conceptualisation of CPL offers a different perspective to what is currently in place in that the learning is based on critical reflexivity, specifically unearthing and making explicit hidden personal, social, and collective unconscious influences on practices.

Conceptualising professional practice within the frame of the three interrelated dimensions of critical reflexivity, ethics, and professional becoming offers not only to place relational practices in a professional context (as opposed to everyday practices) but also offers conceptual guidance regarding agency. That is, to counteract personal, social, and collective unconscious influences, the three dimensions of professional practice need to be considered and engaged. Figure 2.1 illustrates the three dimensions of professional practice as a triadic interconnection that is enacted within and shaped by personal, social, and collective unconscious contexts.
Although the personal, social, and collective unconscious are depicted somewhat separately, they are in fact interrelated and weave their influence through all dimensions of professional practice. The following chapter explores theoretical thinking tools that specifically focus on reflexively unearthing the unconscious influences on practices.
CHAPTER

3

Theoretical thinking tools

I showed my masterpiece to the grown-ups, and asked them whether the drawing frightened them. But they answered: “Frighten? Why should anyone be frightened by a hat?” My drawing was not a picture of a hat. It was a picture of a boa constrictor digesting an elephant.

– Antoine de Saint-Exupéry, The little prince

In Chapter 2 I drew broadly from relationalism and practice theory in defining and conceptualising relational practices, particularly in a professional practice context. In this chapter I focus on developing a tool kit of theoretical concepts to use in the exploration of unconscious influences on CMHPT counsellors’ relational practices with parents. I approach the use of theory by adopting Bourdieu’s notion of theoretical “thinking tools” rather than the notion of “theoretical lens”. As illustrated by the Little Prince and the different ways in which his drawing is viewed, adopting a lens determines what we can see (or are limited in seeing). The notion of thinking tools, on the other hand, indicates how we think about what we see, suggesting a more active and reflexive notion than a lens.

Having defined unconscious influences as encompassing personal, sociocultural, and collective dimensions, I chose to draw on theoretical thinking tools that focused on exposing these specific aspects of the unconscious. Specifically, I drew on Bourdieu’s practice theory as it offers thinking tools that can be used to expose sociocultural unconscious influences on practices and Jung’s psychological theory as it offers tools to reveal personal and collective unconscious influences on practices. I approached the creation of my tool kit as a means of facilitating a thought partnership between Bourdieu and Jung, where I not only drew on their respective theoretical thinking tools separately to uncover their respective unconscious focus, but I also used them together as collaborative, relational tools to achieve a more enhanced understanding of my research phenomenon. I commence the chapter with a discussion of a family of concepts I drew from Bourdieu’s practice theory. I then discuss some limitations in
Bourdieu's thinking tools and how I subsequently drew on a suite of concepts from Jung’s psychological theory as additional tools to enrich the exploration of my research phenomenon. I conclude the chapter by signposting how I employed the thought partnership offered by these Bourdieusian and Jungian theoretical thinking tools in my methodology.

3.1 Theory as “thinking tools”

There is considerable confusion and neglect regarding the definition, relevance, and use of theoretical and conceptual frameworks in research studies (Green, 2014). I adopt Bourdieu’s notion of theory as a set of “thinking tools”. Bourdieu argues that theory does not exist outside empirical work, but rather theory exists in relation to empirical work and it is evidenced by empirical research:

[Theory is] a set of thinking tools visible through the results they yield, but it is not built as such . . . It is a temporary construct which takes shape for and by empirical work [emphasis in original]. (Bourdieu in Wacquant, 1989, p. 50)

The concept of thinking tools suggests that the tools themselves are flexible and may be changed depending on their application to the practice (data or texts) being explored. This perspective on theory is a relational one in the sense that theory is in a dialectic relationship with practice. It also reflects Bourdieu's epistemic premise that knowledge is not generated from de-contextualised empirical analysis, but instead is garnered via a contextual empiricism where theoretical tools are “put to work” by the researcher (Webb et al., 2002, p. 81). Thus, for Bourdieu, “data are collected first, and only then is theory developed, after immersion in their analysis” (Grenfell, 2014, p. 214). Indeed, Bourdieu's theoretical thinking tools emerged from his detailed practical research involving many different fields including education, economics, science, media, and the arts. Commentating on Bourdieu's approach to theory, Jenkins (2002) states that theory is about “doing” as much as it is about “knowing” (p. 69). I add that it is about thinking as much as it is about seeing.

3.2 Bourdieu’s practice theory

Bourdieu developed his practice theory in the climate of two main intellectual contexts: classical social theory (Marx, Durkheim, and Weber) and the opposing theories
dominant in the post–World War II French intellectual field of structuralism (particularly Lévi-Strauss) and existentialism/phenomenology (Sartre) or what has been described as the “antithetical poles of a basic opposition between subjectivism and objectivism” (Brubaker, 1985, p. 746). Bourdieu (1989, p. 14) describes his approach as “constructivist structuralism” or “structuralist constructivism” to emphasise the amalgamation of both subjective and objective approaches in his general theory of practice and his overall methodological approach. Bourdieu rejects the exclusive use of subjective approaches such as constructivism as he contends they fail to recognise the influence of society’s structures on people’s practices. Conversely, he also rejects the sole use of objective approaches such as structuralism as they do not account for individual agency. Indeed, a core feature of Bourdieu’s theory is his efforts to do away with or surpass binary oppositions such as agency and structure, subjective and objective, individual and society, and conscious and unconscious; and instead encompass a dialectic relationship between these opposites.

Bourdieu’s practice theory shares the central feature of the family of practice theories discussed in Chapter 2, namely, the view that practices are socially embedded, normative, unconscious, routinised, temporal, material and spatial in nature. What makes Bourdieu’s brand of practice theory so unique and attractive is his family of relational concepts: field, habitus, capital, doxa, symbolic violence, misrecognition, and reflexivity. As outlined in Chapter 2, Bourdieu’s practice theory is a relational theory in that he “understands the nature and meaning of ‘things’ in terms of their relatedness to other ‘things’” (Veenstra & Burnett, 2014, p. 188). Having a toolbox of concepts to use that are all related to one another is attractive as it allows “the dots to be connected” between various aspects of the social world, offering a rich tapestry of conceptual understanding.

Of the seven concepts that make up the Bourdieusian conceptual toolbox for my study, field, habitus, and capital are considered a conceptual triad which Bourdieu insists need to be considered together (Wacquant, 2007). Doxa, symbolic violence, and misrecognition are another triad that are typically considered together as well as with the other threesome (field, habitus, and capital). Reflexivity is both a tool and a researcher disposition. On the one hand, reflexivity is interrelated with the other six concepts and as such is considered another thinking tool and is used relationally with the others. On the other hand, it is a kind of disposition that Bourdieu maintains
researchers should adopt as a way of positioning themselves in relation to their research phenomena, their methodological approach, and academia in general.

3.2.1 Fields

Bourdieu does not refer to the macro social world as “society”, but rather as a “field of power” which consists of a multitude of subfields (Bourdieu, 1984, 1989). Bourdieu uses the term field to describe the context in which practice takes place (Thompson, 1991). Bourdieu refers to fields as sociocultural fields to emphasise they are not static entities, but rather are fluid and dynamic – they “are made up not simply of institutions and rules, but of the interactions between institutions, rules and practices” (Mahar, Harker, & Wilkes, 1990, p. 8). There are different fields as there are different types of work and social interests (Bourdieu, 1990a). For example, on a broader scale, there is the intellectual (academic) field, the political field, the fashion field, the healthcare field, and the scientific field. There are also fields within fields. For instance, the CMHPT counselling field could be considered a field; however, so could the different theoretical orientations that counsellors adopt (e.g., the psychoanalytic field) and counsellors’ different professions (e.g., the social work field).

Bourdieu (1990a) stipulates that at the core of any given field is interest, which is both a condition and a function of the field in that it is what motivates people in the field to compete with each other for various types of capital (to be discussed further in Section 3.2.3), as well as a product of the way in which the field operates. In other words, interests create and are created by the field in a dialectical fashion. Due to the interests that govern fields, Bourdieu (2002) views fields as fundamentally competitive and as such characterised by tensions and conflict. Despite the tensions and conflict, a fundamental feature of what Bourdieu refers to as “the game” is that agents are committed to it, they are invested in it and recognise it is a game “worth playing” (Bourdieu, 1991, p. 180). Bourdieu (1984) also frequently refers to this as illusio – “belief in the game” (p. 54).

It is useful to note that, unlike in English, in French the word field (champ) has a strong connotation of playing field. Contemplating the metaphor of a playing field assists in an overall understanding (albeit rudimentary) of Bourdieu’s theory. For instance, much like a game on a soccer field where players compete for the ball, and their access and vicinity to the ball is determined largely by the positions they occupy
on the field, so too is the case in sociocultural fields – agents compete for resources (or what Bourdieu specifically refers to as capital) and their access to these resources is determined by the position they hold in the field. In soccer, someone who is playing centre is more likely to access the ball and score than, say, someone playing fullback. Although soccer is a team sport and the final score a team outcome, it is accepted that there is unequal access to the ball and unequal ability to score, and that those who score ultimately receive the most accolades. Despite this, all players are committed to the game and deem it “worth playing”. In the context of the CMHPT counselling field, as discussed in Chapter 2, the field is comprised of several mental health professions and occupational groups that differ in terms of status, resources, and access to government subsidies, despite offering the same or similar services. Regardless of these differences, the respective professions and occupational groups are committed to participating in the field or “playing the game”. They also rally together to compete against other teams (e.g., the general mental health counselling field).

In addition to fighting for and over capital, Bourdieu stipulates that fields also fight for their autonomy, that is, a field strives to “insulate itself from external influences and to uphold its own criteria of evaluation over and against those neighbouring or intruding fields” (Wacquant, 2007, p. 269). An indication of the autonomy of a field is the presence of people and/or institutions with authoritative power to select and sanctify members and to partly (or fully) protect this process from external influences (Hilgers & Mangez, 2015). The more autonomous a field, the more autonomous the language and overall practices it produces, which have logic and understanding specific to the field and therefore are best understood by those within rather than outside of the field (Hilgers & Mangez, 2015). In the case of the CMHPT counselling field, the establishment of an international member association (Association for Play Therapy) that publishes its own international journal (International Journal of Play Therapy) and organises its own international conference (Association for Play Therapy International Conference) assists in the quest to develop and maintain an autonomous and specialised field. In doing so, it distinguishes itself from neighbouring fields such as the general child mental health counselling field by emphasising its play therapy interventions as the main point of difference.

In his conceptualisation of struggles and conflicts in the field, Bourdieu avoids referring to social class in the Marxist sense, which he contends implies a reification of
class as a fixed entity. Instead, Bourdieu (1998) focuses on social space: “Social classes do not exist . . . What exists is a social space, a space of differences, in which classes exist in some sense in a state of virtuality, not as something given but as something to be done [emphasis in original]” (p. 12). By “something to be done” Bourdieu is emphasising the generative nature of social spaces – they are constantly created, fought over, conserved and transformed. Bourdieu (1998) also stresses that social differences and differentiation are not the same “at all times and in all places” (p. 32), and for this reason social class is an arbitrary concept. That is, a person’s differentiation and sense (or not) of struggle depends on the given field they are in at the time, who in the field they are interacting with, and the nature of the power they possess and wield in the respective field. For example, in the CMHPT counselling field, struggles can take place between a counsellor and parent and, regardless of the social class they may occupy in the classic Marxist sense, the outcome of such a struggle is largely unpredictable. A CMHPT counsellor with a PhD in psychology, working in private practice, and earning a six-figure salary may have more economic, physical, and social resources than a single parent with no qualifications, receiving social security benefits, and living in government-funded housing. However, these resources or class markers do not necessarily translate into power as both the counsellor and parent can be in positions of more or less power at different times and in different situations. For instance, the parent can be seen to have more discernible power than the counsellor in that they can terminate the counselling with their child at any time. The parent also has the power to submit a complaint to the counsellor’s clinical board/association and, regardless of whether the complaint is found to be substantiated or not, it remains on the counsellor’s record and is something they must disclose when applying for professional insurance as well as in job applications. Perhaps less discernible but also powerful is the parent’s power to discredit the counsellor via word of mouth. Any of these actions can significantly impact on a counsellor’s finances, morale, reputation, professional standing, and even jurisdiction to practice.

Although Bourdieu views all action in fields as motivated by interest, he stresses that this motivation is largely unconscious. Bourdieu states that his conceptualisation of interest is different to conscious goal-orientated interests found in rational actor model theory, as he sees practice as tacit, implicit, and occurring at a “prereflective level of awareness that occurs through time” (Swartz, 2012, p. 67). This largely unconscious
process where social agents are socialised about interests and “playing the game” is captured by Bourdieu's concept of habitus.

### 3.2.2 Habitus

Habitus is the concept Bourdieu uses to describe the unconscious embodiment and translation of the field’s structures and interests into the dispositions of people (Wagner & McLaughlin, 2015). Bourdieu (1984, p. 28) describes habitus as a form of “unintentional learning” which takes place via the socialisation of people by social structures such as home and school. The socialisation process forms dispositions which Bourdieu (2002) describes as “manners of being, seeing, acting and thinking, or a system of long-lasting (rather than permanent) schemes or schemata or structures of perception, conception and action [emphasis in original]” (p. 27). In light of the deep-seated nature of habitus, it may be more accurate to describe habitus as a predisposition to act, rather than simply a disposition, as predisposition suggests a more inherent, unconscious process than disposition.

Highlighting the relational foundation of his practice theory, Bourdieu (2002) argues that habitus must not be explored in isolation, but rather must be explored in relation to the field. Bourdieu contends that, because habitus is a set of largely unconsciously characteristics acquired through interaction in the field, one person’s habitus may resemble that of others who have been socialised in the same field. As discussed in the previous section, Bourdieu conceives of fields as dynamic rather than static entities with fluid boundaries that interact between other fields and, as such, a person’s habitus may also resemble that of others from similar fields as they occupy a similar social space due to similar socialisation (Bourdieu, 1984, 2002). For example, a CMHPT counsellor’s habitus may be very similar to that of a counsellor in the general child mental health counselling field. Each field, regardless of how big or small, has its own habitus, which intersects with other neighbouring fields. One of the functions of habitus is to determine who gets on better with whom:

proximity in social space predisposes to closer relations: people who are inscribed in a restricted sector of the space will be both closer (in their properties and in their dispositions, their tastes), and more disposed to get closer, as well as being easier to bring together, to mobilize . . . This does not mean that, inversely, proximity in social space automatically engenders
unity. It defines an objective potentiality of unity [emphasis in original].
(Bourdieu, 1998, pp. 10–11)

It is important to note that habitus is not the same as practice. Habitus is a *predisposition* that enables particular kinds of practices in particular fields. The field’s structures and interest are infused in people by the way of habitus, which results in practice, and this is a generative process. Bourdieu (1998) describes this as “the two-way relationship between objective structures (those of social fields) and incorporated structures (those of the habitus)” (p. vii). Bourdieu (1990b) contends that habitus is not consciously remembered as history (that is, being socialised by structures over the course of time), but rather as “spontaneity without consciousness or will” (p. 56). The word spontaneous implies that practice derived from habitus’ interaction with the field appears natural and free, but according to Bourdieu it is anything but. It is the product of unconscious historical socialisation by various structures in and of the field and continues to be reproduced and regenerated precisely because agents conceive of their practice as belonging to themselves, a product of their will and choice, rather than to structures and fields.

Despite the influence of social structures on practices, Bourdieu stresses that social structures do not determine practices per se. Habitus dissolves the dichotomy between agency and structure in that practices are not the result of either but a combination of both; that is, habitus represents the intersection between these various dichotomies. In keeping with his relational dialecticism, Bourdieu stipulates that habitus is both structured by social fields and its practices as well as structuring the fields and its practices; that is, habitus is a “structuring and structured structure” (Bourdieu in Bourdieu & Wacquant, 1992, p. 139). In this way, the concept of habitus challenges dualistic notions such as structure versus agency and objective versus subjective, which dominate much of western philosophy. Habitus has become an attractive concept due to this “integrative power” (Steinmetz, 2006, p. 457).

Similarly, another defining feature of habitus is that it is not prescriptive or determining. Although there is a durable and possibly lifelong aspect to a person’s habitus, Bourdieu (2002) argues that it can be changed, particularly through a person’s reflexivity and consciousness raising. Furthermore, a person’s predispositions and overall habitus are tempered by personal history, which indicates the subjective,
personal agency component of the concept (Webb et al., 2002). Because people belong to many fields, the interaction of these fields and their influence on a person’s habitus is also unique, subjective, and complex. This supports the notion that practice needs to be studied relationally and in context rather than attempting to extrapolate individual variables and study them separately.

**Hysteresis**

When habitus and field meet in a seamless fashion, practice appears as the natural order of things; however, when it does not, *hysteresis* takes places. Hysteresis is the concept Bourdieu uses to describe the disparity that can occur between habitus and the field. It is a temporal issue in that the habitus fails to keep up with the changes in the field’s structures and what Bourdieu (2005) describes as “a lag in adaptation and counter-adaptive mismatch” (p. 214). Thus, habitus functions as a form of social continuity and discontinuity (Wacquant, 2007). It is important to emphasise that hysteresis is an unconscious lag in habitus’ adaptation to new circumstances in the field. That is, it is nonreflexive. An example of the hysteresis effect in the CMHPT counselling field is the mismatch between the length of treatment counsellors have been trained to provide (habitus acquired via pedagogical socialisation) and the number of counselling sessions they are funded to provide by bodies such as Medicare (the field’s structures). That is, most CMHPT counsellors are trained and accustomed to providing medium- to long-term counselling for children (approximately 20–40 counselling sessions); however, recent changes to funding for mental health counselling brought on by neoliberal policies has resulted in a decrease in the number of sessions funded (on average, between 6 and 10 sessions per calendar year). In other words, counsellors’ habitus predicated on medium- to long-term counselling is at odds with the changes in the field’s structures that demand short-term counselling. This mismatch between the habitus and the field’s structures not only impacts on counsellors’ direct work with children but also how they approach relationship building with parents. If the field’s structures have reduced counsellors’ funded time, time previously spent on building relationships with parents may be dismissed in favour of allocating the short amount of time available just to the child. Thus, hysteresis not only describes the lag between habitus and the field’s structures but also a rupture in practice that was previously relatively integrated.
3.2.3 Capital

The nature of people’s habitus depends on the position they occupy in the field, which is in turn determined by the amount of capital they have (Wacquant, 2007). Bourdieu considers the nature of practice as inherently competitive, albeit latently expressed, and explains that this competition is over people’s position in the field and consequently the amount of capital these positions allow them to acquire (Webb et al., 2002). Bourdieu (1986, p. 16) posits that there are three types of capital or three “fundamental guises” that capital can be found in: economic, social, and cultural capital. Economic capital refers to capital that can be immediately converted into money. Social capital consists mainly of social “connections” and membership with a group, and these social relationships are institutionalised or durable in nature (e.g., family name, school). Social capital is reproduced and maintained through ongoing reinforcement of the connections – “through an unceasing effort of sociability, a continuous series of exchanges in which recognition is endlessly affirmed and reaffirmed” (Bourdieu, 1986, p. 22). Social capital does not simply refer to whom a person knows, but rather how they use their connections to their advantage (Burke, 2016). What makes social capital worthy is that the social connections provide the person with the backing and support of the “collectively owned capital”, a kind of collective credential “which entitles them to credit, in the various senses of the word” (Bourdieu, 1986, p. 21). An example of social capital in the CMHPT counselling field is client referrals that are generated for a counsellor through their social connections.

Cultural capital refers to the means people use to appropriate symbolic wealth (Bourdieu, 2003). Cultural capital can exist in three main forms: embodied, objectified, and institutionalised. Embodied cultural capital is manifested through a person’s habitus and is something that cannot be acquired immediately but over time, and can include linguistic capital such as mastery of language. For instance, when someone is referred to as “cultured” or “cultivated”, the person’s embodied cultural capital is being referenced, which is something that they have acquired (largely unconsciously) over time via the socialisation of various structures, particularly family and school. Objectified cultural capital consists of “cultural goods” that represent the person’s cultural capital in physical objects; for example, books, dictionaries, and work instruments. Institutionalised cultural capital refers to institutional recognition, mostly in the form of educational qualifications (Bourdieu, 1986). Thus, from a Bourdieusian perspective, the material environment and its artefacts (including the body) are
conceptualised largely as cultural capital. They may be functional and assist the person to conduct their practices, but they also represent the person’s tastes, positioning in the field, and their values. In relation to the CMHPT counselling field, embodied cultural capital may be evidenced in the jargon the counsellor uses, particularly language that pertains to play therapy interventions. Objectified cultural capital may include the CMHPT counsellor’s designated play therapy room (that is, a different room from that used with their adult clients and when meeting with parents), as it represents the counsellor’s play therapy specialisation in a distinct material form. From a symbolic wealth perspective, CMHPT counsellors who have a permanent, separate play therapy room would have more wealth than counsellors who do not; for example, compared with counsellors who have only one room that they use for both children and adults, or counsellors who do not have any permanent space and instead have to share counselling rooms with colleagues. Institutionalised cultural capital may include the counsellor’s mental health qualifications (e.g., Masters in Psychology) as well as their play therapy qualifications. These qualifications may be displayed in the form of artefacts in their material environment and/or highlighted in their correspondence with others (e.g., business card and email signature). Counsellors who have a permanent work space that they are not required to share with others have more symbolic wealth than those who do not, and are able to display their institutionalised cultural capital more prominently than those using space on a sessional basis. For instance, counsellors who share their space with colleagues are typically unable to display their qualifications or other artefacts that represent their cultural capital. This would be evident to stakeholders such as parents when meeting with the counsellor and in turn affect their assessment of the counsellor’s capital/power in the field.

What constitutes social and cultural capital and the practices associated with them is derived from contrasts or binary oppositions such as positive–negative, distinguished–vulgar, and pure–impure (Swartz, 2012, p. 63). This links to Bourdieu’s relationalism where practices are socially embedded and their meaning (value) is derived in relation to other practices in the field, particularly opposing or contrasting practices. Capital is intrinsically linked in a dialectic relationship with habitus, as the types of capital a person values, acquires, and in turn exchanges, are a function of their habitus and vice versa. Values in Bourdieu’s theory are synonymous with taste. Taste in the Bourdieusian sense refers to the immediate and intuitive judgment of value (Bourdieu, 1984, p. 99). Taste is a term Bourdieu employs frequently and which he
uses in a sociological context, referring not specifically to gastronomy (although it might include it), but rather to signify both “an aesthetic and moral category” (Gronow, 2002, p. 12). That is, what is considered beautiful and aesthetically pleasing is woven in with what is considered “good and proper”. Tastes are defined in contrast to their opposites – “taste is first and foremost the distaste of the tastes of others” (Wacquant, 2007, p. 271). A person acquires taste via a usually lengthy period of socialisation, which in turn forms part of their habitus. The person's ability to demonstrate “good taste” (in contrast to “bad taste”) is a function of their habitus and plays a leading role in determining the nature and amount of social and cultural capital they acquire. It is those with power in the field who typically determine what is considered good and bad taste; that is, what is considered valuable social capital, and this is always contrasted with those from the opposing space in the field. These “group-specific taste cultures” also function as “symbolic forms of social group identity” (Honneth, 1986, p. 65). In Bourdieu’s tautological words, “taste classifies, and it classifies the classifier” (Bourdieu, 1984, p. 6).

In the climate of neoliberal health policies influenced by evidence-based treatment (EBT) research, discussed in Chapter 2, an example of “good taste” in the CMHPT counselling field is one’s ability to accept, articulate, and generate EBT research. Accepting EBT research refers to understanding the hierarchy of evidence, whereby systematic reviews of randomised controlled trials (RCTs) are considered the gold standard for evidence gathering, and accepting this definition of evidence. Articulating EBT includes effectively communicating evidence-based play therapy research to stakeholders (e.g., via clients’ counselling plans, funding proposals, and conference presentations). Generating EBT research includes conducting and publishing research that aligns with the EBT hierarchy. I argue that those in the CMHPT counselling field that hold the most power are those who demonstrate all three.

Bourdieu (1986) highlights that, unlike economic capital, the way in which social and cultural capital are acquired and used is largely disguised. They are mostly unrecognised as capital, and therefore not identified as having legitimate power and authority in the social world in and of themselves. Economic, social, and cultural capital become legitimised and effective through the function of symbolic capital. Symbolic capital is not a different kind of capital per se, but rather is the legitimised and recognised form of economic, social, and cultural capital in the eyes of others.
(Bourdieu, 1998). It includes things such as prestige, distinction, and status. Symbolic capital is achieved by the successful conversion of other capitals to currency that is useful to the person in question. This suggests that economic, social, and cultural capital have no real value in and of themselves, but rather through the recognition by others that they can legitimately be used for exchange (Lawler, 2011). Bourdieu (1986) stresses that capital is only effective insofar as it is used by agents “as a weapon and a stake in the struggles which go on in the fields” (p. 20). However, the use of capital is typically not overt and conscious, but rather disguised and unconscious (Bourdieu, 1998).

### 3.2.4 Doxa, symbolic violence, and misrecognition

The interrelated and interpenetrating nature of field, habitus, and capital is what shapes practice. However, the resultant practice is one that suggests the natural order of things and unquestioned beliefs (Wacquant, 2007), or what Bourdieu refers to as doxa. Doxa is when the social world appears as “a self-evident and natural order which goes without saying and therefore goes unquestioned, [and thus] the agents’ aspirations have the same limits as the objective conditions of which they are the product” (Bourdieu, 1977, p. 166). Thus, “doxic submission” is when power becomes legitimised, not by conscious means, but rather by unconscious means (Bourdieu, 1998, p. 56). This definition suggests that doxa acts like a type of glass ceiling. CMHPT counsellors conceptualising and treating children as their primary client rather than or including the children’s parents is an example of doxic submission, where the counsellor and parent both accept this as the natural order of things. An example of the doxic control of parents over counsellors may include situations where the counsellor does not notify child protection authorities of an abusing parent if the parent has more social and cultural capital than the counsellor. In other words, it is an unspoken rule that parents with more social and cultural capital are not to be challenged in the same way as those with less social and cultural capital.

Doxa prepares the conditions for social domination, which Bourdieu argues takes place largely in subtle, unconscious ways rather than through overt, direct force. The disguised nature of symbolic capital allows it to act as a key ingredient in this subtle domination or what Bourdieu (1989) calls *symbolic violence* or “world-making power”, as it is enacted through having “obtained sufficient recognition to be in a position to impose recognition” (pp. 22–23). In other words, those with power in the field, due to
their accumulated capital, determine what is recognised as valuable. This provides them with symbolic power over those who have less capital, which in turn leads those with more symbolic power to commit symbolic violence against those with less (Bourdieu, 1991). Like virtually all of Bourdieu's concepts, symbolic violence is largely governed by unconscious forces rather than conscious ones – it is not a direct form of violence, but rather is primarily insidious such as treating others as inferior and denying them access to services in a way which both parties consider is “natural”. One of the primary features of symbolic violence is that those committing it and those who are the victims of it do not perceive it in this way, but rather they see it as natural, accepted, and expected (Snook, 1990).

*Misrecognition* is the concept that Bourdieu (1991) uses to refer to the failure of people on both sides of an inequality to recognise that the symbolic violence is not a natural order of things, but rather they recognise it as legitimate. Misrecognition is analogous to Marx’s concept of false consciousness in that it implies the denial or inability to see the economic and other hidden interests in people’s practices (Swartz, 2012). Misrecognition is not achieved through calculating means on behalf of those who have power, but rather through unconscious structural ones. The mechanism and impact of misrecognition is unveiled through the process of reflexivity, which I discuss in the following section.

### 3.2.5 Reflexivity

In addition to his set of relational thinking tools, another important dimension of Bourdieu’s theory is what Wacquant (2007) refers to as an “obsessive insistence on reflexivity” (p. 271). Bourdieu conceptualises *reflexivity* in a few different ways. The first type of reflexivity is what Bourdieu (1984, p. 11) initially refers to as “social psychoanalysis” and later as “socioanalysis” (Bourdieu in Bourdieu & Wacquant, 1992, p. 49), which involves illuminating the social aspect of the unconscious or unconsciousness and making the misrecognised conscious (Bourdieu, 1984). Bourdieu sees this as one of the primary tasks of the social researcher, that is, to expose symbolic power as well as to reveal how social structures are embedded in habitus. Indeed, this is one of the aims of my study. Reflexivity in a Bourdieusian sense also includes an epistemic reflexivity, which calls on the researcher to reflect on the academic field of practice they belong to, their positioning in it, and how this academic field and its epistemology impacts on their research in unconscious ways (Webb et al., 2002).
Swartz (2012) refers to this as social science having “a ‘reflexive return’ upon itself” (p. 11).

Figure 3.1 illustrates the main Bourdieusian theoretical thinking tools I have discussed in this chapter. The two triadic concepts (field, habitus, and capital; and doxa, symbolic violence, and misrecognition) are superimposed to depict their interdependent relationship with one another. Positioned in the centre of the two triads is Bourdieu’s concept of reflexivity, which is a pivotal function in terms of being both a thinking tool interrelated with all the other six concepts and a researcher disposition.

![Figure 3.1. Bourdieusian theoretical thinking tools.](image)

### 3.2.6 Bourdieu and the unconscious

Bourdieu uses the term *unconscious* both as an adjective and as a noun, which he draws exclusively from Freud’s psychoanalytic theory (Steinmetz, 2006). As with most practice theorists, Bourdieu’s use of the term unconscious refers not to a personal
unconscious, but rather a social unconscious or social unconsciousness. Despite his writing including a number of psychoanalytic terms associated with the Freudian tradition, Bourdieu frequently criticises and at times condemns psychoanalysis for being essentialist and de-historicised and espousing a form of biological reductionism (Steinmetz, 2006). As Fourny and Emery (2000) observe, “Bourdieu does not seem able to refrain from borrowing certain of its concepts while repudiating the discipline altogether” (p. 104). In his later writing, Bourdieu (1999a) states:

Sociology does not claim to substitute its mode of explanation for that of psychoanalysis; it is concerned only to construct differently certain givens that psychoanalysis also takes as its object, and to do so by focusing on aspects of reality that psychoanalysis pushes aside as secondary or insignificant. (p. 512)

According to Bourdieu, psychoanalysis primarily sees history as secondary or insignificant, and in turn he attempts to historicise what Freud sees as natural phenomena; for example, the differences between the sexes (Fourny & Emery, 2000). However, for Bourdieu, history is not a personal history but a social one, and as such he conceptualises the unconscious as fundamentally social in nature.

There are two main limitations to Bourdieu’s conceptualisation of the unconscious. First, Bourdieu’s focus on the social nature of the unconscious ignores other interrelated dimensions of unconsciousness such as personal and collective (universal) dimensions. Second, Bourdieu’s approach focuses primarily on social power relations as the main feature of the social unconscious. However, as Hopper and Weinberg (2011) point out, although social power relations are an important feature of the unconscious, they are not the only aspect of social life that is embodied – shared “anxieties, defences, fantasies, myths, and collective memories” (p. xxxviii) are also important. These other aspects are important as they acknowledge the affective nature of the unconscious, a somewhat neglected feature of Bourdieu’s theory. As outlined in his seminal Weight of the world: Social suffering in contemporary society, Bourdieu (1999b) relegates suffering as a function of hysteresis or symbolic violence and neglects the possibility that exploring one’s affect could reveal other unconscious processes and influences at play, such as those associated with the personal and/or collective unconscious.
In many respects, Bourdieu’s neglect of personal and collective dimensions of unconsciousness as well as the affective nature of unconsciousness reflects “the familiar split” between sociology and psychology, which hinders the study of both (Clarke & Hoggett, 2009, p. 1). Although Bourdieu was clearly a sociologist and not a psychologist, it is curious that he did not include the sociological–psychological dichotomy in the group of binary opposites he endeavoured to surpass through dialectical integration, particularly because psychology offers rich conceptualisations of individual agency and reflexivity. Bourdieu’s concept of socioanalysis has the semblance of such integration; however, this concept is more of an analogy than a serious attempt at dialectic interconnection. That is, Bourdieu is saying that in exposing symbolic power and revealing how social structures are embedded in habitus, the sociologist’s work is analogous to the psychoanalyst exposing the workings and drives of the individual’s unconscious.

Rather than use psychotherapeutic processes as an analogy, I argue that they should be considered in conjunction with social theories of the unconscious, as they offer a more enhanced understanding of unconscious influences on practices. I contend that several concepts found in Carl Jung’s psychological theory can address key aspects of the unconscious that Bourdieu neglects. Conversely, I argue that Bourdieu’s thinking tools offer to enrich Jungian thinking tools by emphasising considerations of social power and its influence on practices. A “thought partnership” between Bourdieu and Jung is one that has only recently begun to be explored (Fawkes, 2015, p. 167); however, proposals to date are scant in nature and mainly involve the observation that Bourdieu’s concept of habitus is similar to Jung’s concept of the collective unconscious (e.g., Gray, 2008). Placing this thought partnership on a relational axis has the potential to be richer and more dynamic than simply identifying congruence between two concepts. Although Jung has an extensive opus with a rich ecosystem of concepts addressing unconscious and conscious processes, I have focused specifically on his concepts that relate to structured unconscious processes, as these are most pertinent to enriching Bourdieu’s approach to exposing unconscious influences on practices. I have

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As with Bourdieu, Jung’s unconscious concepts relate primarily to structural influences on unconscious processes, which is the primary focus of my study. This is not to be confused with other concepts that address the unseen or “the invisible”, such as tacit awareness, information processing, and how judgments are made. Jung (1971/2014) addresses these other aspects of awareness in his theory of psychological types, which outlines different functions and attitudes of consciousness: sensory, intuitive, thinking, and cognitive. Although these aspects of awareness are no doubt also important aspects of professional practice, they are not the focus of my study; therefore I have not included them in my theoretical thinking tool kit.
selectively chosen a total of nine Jungian concepts to form three conceptual triads. I argue that these Jungian concepts complement and enhance Bourdieu’s practice theory and serve to deepen the understanding of unconscious influences on professional practices by offering personal and collective unconscious considerations.

### 3.3 Jung and the unconscious

Jung was a psychiatrist and psychotherapist practising in the first half of the twentieth century, and his thinking was influenced by a broad range of disciplines including literature, anthropology, religion, and eastern and western philosophy. Despite his predominant philosophical leanings, Jung considered himself a scientist with “mantra-like insistence” (Lachman, 2012, p. 205). Jung referred to his science as “depth psychology” as he was primarily focused on exploring the workings of the unconscious mind, as opposed to the academic psychology of his time that “looked only at what was rationally explicable” (Tacey, 2006, p. 1).

Jung’s conceptualisation of the unconscious is often contrasted with Freud’s theory of the unconscious. This contrast is important to consider in the context of my thesis mainly because sociologists such as Bourdieu who reference psychoanalytical conceptualisations of the unconscious overwhelmingly reference Freud without acknowledging there are other often divergent conceptualisations found in psychology’s analytic traditions. For example, unlike Freud, Jung does not attribute the formation of the personal unconscious primarily to sexual drives, but rather conceptualises the personal unconscious as organised and driven by any number of different psychological complexes. Also, Jung does not view the personal unconscious as the only dimension of the unconscious. He conceptualises the personal unconscious as one of two unconscious dimensions, the other being the collective unconscious, which is organised by primordial images called archetypes. The first triad of Jungian thinking tools I explore are psychological complexes, the collective unconscious, and archetypes. I start by providing a brief outline of this conceptual triad as it relates to individuals, and then in the subsequent section I discuss cultural complex theory and its application to groups of individuals such as professions, and how this theory offers to enrich Bourdieu’s sociological conceptualisation of the unconscious.

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9 I primarily use the term *the unconscious* rather than *unconsciousness* but do so not with the intention to reify it, but rather, as Samuels (2003) points out in the tradition of Jung, simply as an analogy.
3.3.1 Psychological complex

One of the first concepts Jung developed was the psychological complex. Jung (1960/2014) describes psychological complexes as “constellations of psychic elements grouped around feeling-toned contents” (pp. 10–11). Jung (1960/2014) argues that we all have complexes and states that most complexes arise from unresolved and often painful experiences which leave “lasting psychic wounds behind them” (p. 313). Jung (1960/2014) explains that, given the emotional charge which characterises a complex, we might expect this “would automatically force the complex into consciousness, that the power of attraction inherent within it would compel conscious attention” (p. 11); however, this is typically not the case as complexes remain largely unconscious. Jung (1960/2014) further explains that complexes remain largely unconscious for two main reasons: either the contents of the complex are not acceptable to the conscious mind and therefore repressed, or the contents of the complex are so strange or foreign to consciousness that they are not capable of readily reaching consciousness. For example, a person with a parent complex sees most of life’s experiences as somehow associated with parenting, and this association is derived from both their personal experiences of being parented as well as collective symbols of parents and parenting (e.g., as found in the media). A person with a parent complex may manifest this psychic splinter in one of many ways. For instance, they may play out either of two extreme ends of a parental behaviour continuum: either an overdevelopment of parenting sensibility and behaviour (e.g., nurturance and protection of children) or “a weakening of them to the point of complete extinction” (Jung, 1982, p. 114). This is not to say that behaviours associated with either end of the continuum indicate the presence of a parent complex. A complex is indicated by the emotional charge generated by the topic: “This is how Jung first came to identify personal complexes – the emotional reactivity of a trigger word caused disturbance in responses” (Singer & Kaplinsky, 2010, p. 20). Thus, if a person’s behaviour is indicative of either end of the parental continuum and they are emotionally triggered by words such as “parent”, then this combination suggests a parent complex is present.

In the context of CMHPT counselling, a counsellor with a parent complex based on their own unresolved issues associated with their parents may identify with the nurturance and protection of children end of the parenting sensibility, and in turn develop a parental complex pertaining to parents whom they consider represent the opposite end of the continuum, that is non-nurturing and non-protective. Bringing and
projecting their parental complex in the CMHPT counselling work with parents is likely to facilitate oppositional and accusatorial practices with parents. The nature of complexes can be further understood by considering two interrelated concepts: the collective unconscious and archetypes.

3.3.2 The collective unconscious

Jung conceptualises the personal unconscious as only one dimension of the unconscious, existing alongside and interconnected with the collective unconscious. Jung (1968/2014) contends that, unlike the personal unconscious, the collective unconscious does not owe its existence to personal experience, but rather it is universally inherited and shared by all people. In other words, it is a layer or dimension of the unconscious that surpasses the individual, society, and culture. The inherited nature of the collective unconscious is perhaps one of its most distinguishing features:

The existence of the collective unconscious means that individual consciousness is anything but a *tabula rasa* and is not immune to predetermining influences. On the contrary, it is in the highest degree influenced by inherited presuppositions, quite apart from the unavoidable influences exerted upon it by the environment. (Jung, 1960/2014, p. 112)

A central feature of the collective unconscious is that it is organised by “primordial images”, which Jung (1966/2014) describes as “the most ancient and the most universal ‘thought-forms’ of humanity” (p. 66). Jung refers to these primordial images as archetypes, and they are found at the core of all complexes (Singer & Kaplinsky, 2010).

3.3.3 Archetypes

Whereas the personal unconscious is organised by psychological complexes, the collective unconscious is organised by archetypes – universal predispositions that “have existed since the remotest times” (Jung, 1968/2014, p. 5). Archetypes function much like prototypes in that they are the original pattern or structure that forms the basis for our thinking, behaviour, and emotions (Bologna, 2010). Stories, myths, and legends can provide good illustrations of the core features and functioning of archetypes. For example, on the surface, stories such as Harry Potter, Snow White, and The Wizard of Oz appear significantly different. The protagonists of each of these stories and their respective settings and plots are unique; however, at the beginning of the story they all
embody the same archetype – the orphan. The orphan archetype is not only indicated by the fact that the protagonist’s mother is dead or absent in some way, but by the presence of other key archetypes that form the archetypal constellation. For example, regarding the characters embodying the orphan archetype, in addition to having an absent mother, they are also used or abused in some way (by a villain archetype) and assisted by friends (helper archetype) to escape from the villain and find happiness (higher self archetype). Thus, Jung’s archetypal theory is relational in that an archetype never exists on its own but is defined by other archetypes within its particular constellation (Bologna, 2010). In terms of the workplace, different industries and professions tend to be structured by particular clusters of archetypes. For example, a common cluster in the counselling industry is the orphan, villain, martyr, and warrior archetypes; and common in the corporate sector are archetypes associated with kingdoms, such as the king/queen, advisor, servant, spy, and court jester archetypes (Bologna, 2010).

Jung proposed that archetypes are not simply universal images but also include universal feelings, experiences, and patterns of behaviour (Stevens, 2006). Different archetypes are driven by different primary emotions, and these emotions are relational or congruent with the corresponding archetypes which they engage with (Bologna, 2010). For example, the orphan’s primary emotion is abandonment and feelings associated with rejection. The orphan feels good when they are rescued. Typically, this can be in the form of receiving emotional or physical support. The orphan's view of the world is dualistic in that others either will rescue or abuse them. From an archetypal perspective, the world is made up of martyrs or villains. The martyr archetype’s primary emotion is feeling useful and needed. The martyr feels good when they give to those who have been exploited (orphans) by others (villains) and feels particularly good when the help they give is received with gratitude. The martyr’s view of the world is that people are either grateful for their help or are ungrateful. The villain’s primary feeling is self-importance and sense of entitlement and they feel good when they take or profit from others’ resources without consent and/or without fair exchange. This is typically from people who are not able to protect themselves (orphans). Their dualistic view of the world is that others are either able to be exploited or not able to be exploited. This simple triad of the orphan, martyr, and villain demonstrates not only the affective dimension of archetypes but also how affect is relational. This affective dimension of archetypes provides a further depth to the understanding of influences.
on counsellors’ relational practices with parents, as it contextualises affect (e.g., counsellors’ frustration with parents) as a function of unconscious structures (archetypes) rather than something that is inherent to the counsellor, the parent, or the situation; and that consequently, through the process of reflexivity, these structures can be changed.\(^\text{10}\)

Like Bourdieu, Jung is sometimes charged with determinism (e.g., Walters, 2004). I argue against this charge. Although archetypes provide a basic and fundamental structure for our behaviour, emotions, and thoughts, they can be shifted via conscious awareness and reflexive action. The structural feature of archetypes does not suggest that they produce the same stories or scripts in people who embody the same archetype, but rather only the fundamental structures for them – “archetypes of the collective unconscious provided the basic themes of human life on which each individual worked out his or her own set of variations” (Stevens, 2006, p. 75). Additionally, it is important to note that Jung makes a distinction between an archetypal image (commonly referred to as an archetype) and the “archetype-as-such”. The archetype-as-such is the original prototype or structure found deep in the collective unconscious. It cannot be known directly in its pure form, only what it produces, as “it takes its colour from the individual consciousness in which it happens to appear” (Jung, 1968/2014, p. 5). As well as being coloured or flavoured by the individual and their idiosyncrasies, archetypes are also produced with the assistance of society and culture:

The archetype itself cannot be experienced directly; it needs the context of a particular culture in which to “clothe” the archetypal form, thereby creating an archetypal image, which can be experienced directly. It is the cultural layer of the unconscious that actually provides the necessary “clothing”. Although universal patterns may exist in all cultures, each has its own particular contextualization. Despite his keen interest in diverse cultures and their sacred traditions, however, Jung focused on the archetypal level in his study of group life, and left such development to the “second generation” pioneers [emphasis in original]. (Fariss, 2011, p. 304)

Jung’s primary focus was on the study of the presence and nature of the archetype-as-such, rather than the way in which the archetype-as-such is contextualised and shaped by various sociocultural contexts. Given that the structures of the collective unconscious (archetype-as-such) are forged by society and culture to produce

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\(^{10}\) I discuss Jungian reflexivity in more detail in Section 3.5.
archetypes (archetypal images), the collective unconscious has an interrelated relationship and function with the social unconscious, and thus, I argue, needs to be considered when exploring unconscious influences on practices.

3.3.4 The social unconscious and cultural complexes

Jung’s neglect of the sociocultural “clothing” of archetypes, as inferred by Fariss (2011, p. 304), has in recent years been explored by a number of post-Jungian writers. The post-Jungian writers I will discuss in the context of sociocultural clothing are those who have developed and conceptualised a layer of the unconscious that sits between the personal and collective unconscious, which they primarily refer to as the social unconscious—“that vast realm of human experience which inhabits the psychic space between our most personal and our most archetypal levels of being in the world” (Singer & Kaplinsky, 2010, p. 6). Foulkes (1990) argues that the social unconscious as a concept is fundamentally redundant as the unconscious mind of a person is always socially shaped and influenced and as such is both a personal and social unconscious. I agree with this notion that the personal unconscious is socially shaped; however, I also concur with Weinberg (2007) that it is co-constructed: “the social unconscious is the co-constructed shared unconscious of members of a certain social system such as community, society, nation or culture. It includes shared anxieties, fantasies, defenses, myths, and memories” (p. 312).

At the heart of Weinberg’s (2007) conceptualisation of the social unconscious is that it is not simply comprised of hidden cultural norms, but rather it is characterised by “a defence, or a deep conflict” (p. 316) that is shared by others. Based on this notion of the social unconscious, some post-Jungian writers have developed and explored the concept of cultural complex. A cultural complex is a concept spawned from Jung’s individual psychological complex theory but, rather than a complex forming within a personal unconscious, it is formed in the social unconscious and is shared by a group of

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11 I draw on Casement’s (1998) definition of post-Jungian: “The term ‘post-Jungian’ is used here not simply to refer to those who have come after Jung, but to differentiate ‘post-Jungians’ from ‘Jungians’. Post-Jungians are committed to developing further the original insights of Jung himself and include those who have moved away from a total emphasis on psychic reality to an approach that also considers the reality of the outer world” (p. 1).

12 Some refer to it as the cultural unconscious; however, I refer to it as the social unconscious as there is little if any difference in their conceptualisations of the cultural and the social and because most post-Jungian literature refers to it as the social unconscious.
Like individual psychological complexes, a cultural complex always has an archetype at its core.

Cultural complexes often go unnoticed as they manifest in the individual and therefore can be misinterpreted as simply an individual complex (Beebe, 2004). One way to detect the presence of a cultural complex is “the emotional reactivity of a trigger word” in a group (Singer & Kaplinsky, 2010, p. 20). For example, CMHPT counsellors who display a strong emotional reaction to the word “parents”. However, as with an individual psychological complex, the high emotional charge that accompanies a cultural complex is not typically sufficient to alert us to its presence. What makes a cultural complex difficult to detect without conscious reflection is that it is not just individuals but a whole group of individuals that share the same complex; in other words, the complex is normalised.

### 3.4 Synergy between Bourdieu’s habitus and Jung’s complex and archetypes

The concept of cultural complex is highly congruent with Bourdieu's concept of habitus, which is also dispositional in nature and represents the embodiment of structures. Where Bourdieu argues that society’s structures create predispositions in people (habitus), Jung argues that collective unconscious structures (archetypes-as-such) create dispositions in people (archetypal images) typically evidenced in their behaviour, thinking, and emotions, including individual and cultural complexes. Where Bourdieu's habitus emphasises the influence of unconscious social power relations, and in turn the unconscious embodiment of society's structures, Jungian cultural complex theory emphasises the influence of unconscious social anxieties and how these anxieties are structured by archetypes of the collective unconscious, which are in turn embodied in groups of individuals. Both concepts of habitus and cultural complex provide different yet complementary emphases on the social unconscious. I argue that cultural complex theory extends its complementary function by addressing a fundamental missing piece in Bourdieu's theory, that is, it includes a deeper layer of the unconscious – the collective unconscious dimension. In this way, cultural complex theory offers a deeper, richer understanding of unconscious life by including the

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13 Given that cultural complexes are formed in the social unconscious, in many respects it would be more congruent to refer to them as social complexes or sociocultural complexes; however, considering the term cultural complex is so widely used in the literature, I too use this term.
collective unconscious and its archetypal structure as part of understanding unconscious sociocultural influences. Namely, it provides a conceptual bridge between the personal (individual), social (societal), and collective (universal) unconscious.

Additionally, I also contend that the affective relational nature of archetypes, discussed earlier, addresses another gap that has been identified in Bourdieu's work; namely, Bourdieu has been charged with neglecting the intersubjective nature of social relations, particularly the affective dimension between people (e.g., Bottero, 2010; Reay, 2004; Skeggs, 2004). Cultural complex theory addresses this gap by proposing that dispositions that emerge from collective unconscious structures (archetypes) include a specific affective aspect and that these emotions are relational in nature in that they correspond to other archetypes in the archetypal cluster. Thus, considering cultural complex theory in tandem with Bourdieu's habitus maintains the structural integrity of Bourdieu's overall practice theory, in that it addresses affect as a function of structure rather than a function of intrapsychic dynamics, which is often the case with intersubjectivity theories.

3.5 Jung, reflexivity, individuation, and ethics

At the centre of Jung's voluminous opus is his theory of individuation. For Jung (1939), individuation is the ultimate goal of human psychological development and is made possible by making the unconscious conscious. This is achieved by a reflexive process involving the ego, persona, and shadow aspects of one's psyche. Jung first developed these concepts in the context of the individual psyche; however, some post-Jungians such as Fawkes (2015) have applied these concepts to the professional practice of groups of individuals such as professions. I briefly discuss Jung's conceptualisation of these terms as they relate to the individual psyche and their role in achieving individuation. I then discuss post-Jungian applications of these concepts to social groups such as professions.

3.5.1 Ego

Ego is the concept Jung used to represent our conscious understanding of ourselves – who we think we are. As Stevens (2001) highlights, “it is what we refer to when we use the terms ‘I’ or ‘me’” (p. 62). However, it is important to note that in Jung's conceptualisation and use of the term, he writes the German term das ich with a small
“i” which simply means “I” and does not have the English language connotations of egotism or egocentricity (Crowley, 1998). In many respects, Jung’s concept of ego can be considered our conscious private understanding of ourselves, which is typically not shared publicly and only shared with close people such as family and friends. This awareness of ourselves is based primarily on conscious awareness without considering unconscious influences:

Most people confuse “self-knowledge” with knowledge of their conscious ego-personalities. Anyone who has any ego-consciousness at all takes it for granted that he knows himself. But the ego knows only its own contents, not the unconscious and its contents. People measure their self-knowledge by what the average person in their social environment knows of himself, but not by the real psychic facts\(^{14}\) which are for the most part hidden from them. (Jung, 1957/2010, p. 5)

The ego is typically considered in relation to the persona and the shadow – two additional concepts that I present as forming a conceptual Jungian triad.

3.5.2 Persona

Whereas the ego is who we think we are and this thinking is largely private, the persona is the image of ourselves we project socially into the world; it is whom we want people to think we are. Jung defined the persona as a function of society, explaining that the persona allows us to effectively engage, participate, and relate to the social world: “[it] is oriented on the one hand by the expectations and demands of society, and on the other by the social aims and aspirations of the individual” (Jung, 1971/2014, p. 464). Given that Jung (1971/2014) states that the persona is the Latin name for masks “worn by actors in antiquity” (p. 465), Jungian commentators frequently highlight how the persona is associated with pretending or putting on an act. However, I argue that some have mistaken Jung’s use of mask as a metaphor for the social aspect of the psyche to mean that the persona is solely about concealing and pretending. For example, Crowley (1998) states: “The Ego is who we think we are, as opposed to the persona which is who we pretend to be” (p. 21). This notion of pretence is misleading. As social beings, we need a healthy persona that accommodates the number of social roles that we use

\(^{14}\) By psychic facts Jung (1958/2014, p. 6) is referring to the empirical nature of the psyche; however, his empiricism is derived from a phenomenological standpoint where he defines facts as “occurrences, events, experiences” and states that these facts are considered “objective” when they are shared by a society.
to engage with and relate to the social world. Johnson (1993, p. 3) refers to the persona as our “psychological clothing”, which I contend offers a metaphor less prone to confusion. Extending this metaphor further, I view the persona as a closet full of different outfits that correspond to different social roles we play. It only becomes problematic if we overidentify with our persona, in other words, if we mistake our garb for our core sense of self:

When the ego is completely identical with the persona, individuality is wholly repressed, and the entire conscious psyche becomes collective. This represents the maximum adaptation to society and the minimum adaptation to one’s own individuality. (Jung, 1966/2014, p. 303)

An overidentification with the persona is problematic because it cuts us off from reflexivity and unconscious processing. In particular, if we over-identify with the persona, we are unwilling to look at our shadow.

3.5.3 Shadow

The shadow is the concept that Jung (1966/2014) uses to refer to the part of the personal unconscious that contains repressed thoughts, feelings, and experiences. At times he uses it interchangeably with the personal unconscious. To clarify the distinction, albeit subtle, between these two terms, I suggest a metaphor – the shadow is like a locked room in the basement of a house (the personal unconscious being the basement). In other words, the shadow is part of the basement (personal unconscious) but only the part that is actively repressed rather than simply suppressed. The shadow is inextricably linked to the persona and ego in that what gets repressed is what is not compatible with the image we wish to project to the world (persona) and how we like to think of ourselves (ego). However, the shadow is not comprised exclusively of negative, dark content; it is comprised of any thoughts, feelings, experiences and memories we do not wish to own or integrate into our conscious mind. For example, the shadow of a CMHPT counsellor who specialises in child abuse and is predominantly exposed to abusive parenting practices could contain positive parenting; in other words, they may be suppressing the existence and possibility of healthy parenting.

Jung (1953/2014) states that, unless we consciously recognise and integrate our shadow into our conscious sense of self, then we will project our shadow onto other people. For example, if we have unresolved issues regarding being parented, then as
counsellors we may project these unresolved feelings, memories, and experiences onto parents we work with. Jung (1979) conceptualises the integration of the shadow into who we understand ourselves to be as an ethical enterprise. This notion is based on the premise that we cannot act ethically if we are prone to projecting our shadows onto others. Thus, ethical practice is augmented by the integration of our shadows. For Jung, integration of our shadows is achieved through the lifelong process of individuation.

For Jung, individuation primarily involves facing and integrating one’s shadow into one’s consciousness, and consequently preventing the ego or the persona from dominating one’s identity or sense of self. The integration results or rather leads one to connect with one’s “Self” with a capital S. This is translated from the German das Selbst, which, as Crowley (1998) points out, is more impersonal than “self” in English and refers to the essence of something or, borrowing from the Hindu translation, the divine within. Because the word “self” is such a loaded, multi-meaning term in English, I use the term “higher self” when referring to Jung’s concept of the Self (Bologna, 2002). The higher self represents a person’s fullest potential and is timeless, and for this reason is also congruent with some people’s notions of “soul”. The higher self sits at the centre of the psyche and encompasses, integrates, and harmonises both conscious and unconscious realms. The notion of balance is central to Jung’s psychology where the psyche is seen as a “self-regulating system”, which constantly strives to achieve harmony and balance (Jung, 1933/2001, p. 17). This involves being able to balance our focus and attention on various aspects of our psyche, making the unconscious conscious, and in turn developing our higher self. For Jung, this balance is achieved through the lifelong process of individuation which forms the foundation for our ethical attitude in the world.

3.5.4 Ethics and group individuation

Individuation primarily involves a person, group, or society becoming aware of unconscious influences in their life, which in turn renders them more whole. From a Jungian perspective, wholeness is not seen as the same as “good” in a perfectionist sense often associated with a “religious ethic”, but rather the notion of wholeness is founded in a “therapeutic ethic”, which is primarily characterised by facing, accepting, owning, and integrating one’s shadow (Tacey, 2006, p. 56). This shadow work is considered an ethical enterprise because the more we accept, own, and integrate our shadow the less likely we are to project it onto others – “using and abusing the other as
a vehicle for holding the bad aspects of the self” (Solomon, 2001, p. 446). For example, CMHPT counsellors who do their shadow work are less likely to project their shadow (including possible parent complexes) onto parents they work with, and in turn are less likely to undermine congenial relational practices with them.

Some post-Jungians have explored the ethical features of Jung’s reflexivity, particularly integrating the shadow into consciousness, in the context of groups of individuals such as professions. For example, Fawkes (2015) argues that Jung’s individual concepts such as the ego, persona, and shadow can be effectively applied to professions. Fawkes mostly applies these concepts to the profession of public relations but argues that all professions have complexes and issues, much like individuals:

professions could be viewed as psychic entities, containing the same components Jung ascribed to the individual psyche, namely ego, persona, shadow, and other archetypes that have the potential to be brought into conscious relationship with each other during the process of individuation. As with individuals, the first stage of group individuation is recognizing the shadow elements that were previously attributed to others, followed by engagements with this shadow material and finally the reconceptualising of the whole as the sum of many, often contradictory, parts contained in a greater entity or field, often called the transcendent, which may or may not be secular. (Fawkes, 2015, p. 194)

Fawkes (2015) goes on to argue that professions, particularly newly established ones, often have underdeveloped egos; that is, they do not have a coherent sense of identity, which in turn causes them to be defensive and to overidentify with their personas. These professional group personas typically emphasise excellence and service to society and consequently neglect to face their shadow. Post-Jungians frequently refer to this as the “collective shadow” (e.g., Bowles, 1991; Kremer & Rothberg, 1999; Von Franz, 1974/1995). The collective shadow is considered particularly insidious because “people support each other in their blindness” (Von Franz, 1974/1995, p. 7). Newly established professions’ overidentification with their professional persona is evident in the CMHPT counselling field. As discussed in Chapter 2, despite play therapy having a history that spans more than 100 years, the field has only presented itself as a distinct, recognisable field in the past 25–35 years (with the establishment of the International Association for Play Therapy in the early 1980s and the International Play Therapy Journal in the early 1990s). The field’s relative youth, as well as its marginalisation by the broader mental health counselling field for not
producing enough “evidence” of its practices as defined by the EBT movement, has resulted in the field focusing its research as well as public profile efforts on the promotion of the efficacy of various play therapy approaches (developing its persona), and in turn neglecting to explore and discuss the shadow aspects of the field such as high dropout rates and the often challenging relationship between counsellors and parents.

3.6 Synergy between Bourdieu’s reflexivity and Jung’s individuation

I propose that applying Jung’s concepts of ego, persona, and shadow to professions as entities, as well as the ensuing process of individuation, enriches a Bourdieusian approach to reflexivity in two main ways. First, Bourdieu's reflexivity is primarily an individual enterprise. A post-Jungian approach shifts the sole reflexive responsibility from individuals and shares it with the profession at large. Second, I argue that Jung’s understanding of “self as an ethical entity” (Solomon, 2007, p. 229) offers to coax Bourdieu's gestating ethical possibilities into maturation. Bourdieu's reflexivity is predominantly concerned with uncovering power relations rather than offering guidance for “good” or ethical practice. Indeed, in Vandenberghe's (1999) critique of Bourdieu, he goads him and other critical sociologists to provide more guidance on ethics:

Why not go further, all the way from critical theory of domination to a political theory of emancipation, and from there to a normative theory of ethics? If a critical sociology presupposes not only an analysis of the forces of social domination, but also an analysis of the social forces of emancipation and the possibility of a transformative politics of emancipation, then it also presupposes an ethics, or at least some formulation of normative criteria of moral judgement and some indication of the “good life”. Bourdieu has already given us his critique of pure reason and his critique of judgement, what we now would like to see is his critique of practical reason. (p. 62)

Although Bourdieu’s reflexivity is useful for revealing social domination, and his reflexivity offers possibilities for emancipation, I agree with Vandenberghe (1999) that his theory could and should go further in terms of practical reason, specifically ethics. I contend that Bourdieu's theory has the basis for ethical considerations. For example, aporic dilemmas can be viewed as a form of hysteresis where the person's habitus is not in synch with the field, and this rupture between habitus and field causes a stalemate.
Bourdieu does not specifically offer a solution to aporic situations. A Jungian reflexivity based on individuation offers to mature Bourdieu’s gestating ethical seeds. In Jung’s opus, aporia is congruent with his concept of tension of opposites. For Jung, the world is made up of opposites, particularly the conscious and unconscious, and the tension between opposites causes a “blockage” (Jung, 1971/2014, p. 479). However, Jung does not consider such blockages as problematic. Jung contends that such impasses portend the possibility of positive change and embraces the aporic situation that arises from this tension between opposites, stipulating it is necessary in order to develop and grow: “Life is born only of the spark of opposites” (Jung, 1966/2014, p. 54).

3.7 Deepening reflexivity

Jung’s psychological theory includes a suite of concepts that provide guidance regarding how to deal with aporic impasses and general stuckness; namely, the transcendent function, union of opposites, and synchronicity. I propose that these concepts (associated with individuation) enrich Bourdieu’s reflexive approach (concerned primarily with exposing unconscious social power relations) by offering guidance on how we can develop and emerge past these power relations as empowered beings and deepen our reflexivity to achieve individuation.

3.7.1 The transcendent function

Jung (1971/2014) describes the transcendent function as what emerges when we hold the tension of opposites:

Since life cannot tolerate a standstill, a damming up of vital energy results, and this would lead to an insupportable condition did not the tension of opposites produce a new, uniting function that transcends them. (p. 479)

If we can hold the tension of opposites without giving in to one or the other, the transcendent function emerges and usually consists of “a series of fantasy-occurrences which appear spontaneously in dreams and visions” (Jung, 1966/2014, p. 80). There are a few things to note regarding this quotation and its sentiments. Firstly, a way out of aporic situations is always present, namely, in symbolic utterances such as dreams and fantasies, which suggests that we simply need to be aware of such symbolic guidance emanating from the collective unconscious. Secondly, the transcendent function speaks the language of symbolism rather than literality; therefore, we need to
decode the symbolic language, which in the individual context typically takes place via therapy. I argue that, although the transcendent function can appear in dreams and visions, it could also be induced via any tailored symbolic enterprise such as those used in expressive therapies. For instance, in play therapy the transcendent function can be deliberately coaxed by asking the person to symbolically play out the tension using techniques designed for this purpose (e.g., sandplay therapy). As a collective process, the transcendent function could be facilitated via symbolic representation at dialogically focused conferences, symposiums, and the like.

### 3.7.2 Union of opposites

Ultimately, the transcendent function leads to the union of opposites. Jung is careful to stress that union does not entail compromise or that the unconscious has priority over the conscious, but rather the “unconscious compensation is only effective when it cooperates with an integral consciousness; assimilation is never a question of ‘this or that’, but always of ‘this and that’ [emphasis in original]” (Jung, 1954/2014, p. 156). Jung (1954/2014) draws comparisons between his union of opposites and the dialectical monism found in Taoist philosophy (union of yin and yang) and in ancient alchemical texts with the chymical wedding (union of male and female). The progression from the tension of opposites, to the transcendent function, and then the union of opposites, is typically accompanied by an archetypal shift. Or to put it another way, when the archetypes we embody become stale and no longer serve us, we typically encounter an impasse, an aporic situation that generates a crisis of sorts. From a Jungian perspective, this signals fertile ground for growth. Shifting the archetype/s concerned is achieved through reflexive practice, utilising processes such as the transcendent function to move past the tension of opposites and to achieve a union of the opposites.

In many respects, Jung’s union of opposites is highly congruent with Bourdieu’s overall goal to surpass binary opposites of agency–structure, conscious–unconscious, and objective–subjective. However, the main difference is that Jung does not simply offer concepts to describe the interplay and interconnectedness between dualities, but rather he offers reflexive ways in which to transcend the conflict and disharmony that ultimately results from such interplay, which is particularly applicable to ethical practice and notions of professional becoming. I argue that the reason why a thought partnership between Bourdieu and Jung has not been seriously considered in the literature is not simply because most sociologists such as Bourdieu immediately default
to Freud for psychological (personal) unconscious concepts, but because so much of Jung’s approach is numinous in nature and threatens the rationalistic stance that dominates the social sciences (Main, 2007).

3.7.3 Synchronicity

No concept is more numinous perhaps than Jung’s concept of synchronicity. It refers to the “meaningful coincidences” of an outer and inner event, which are not causally connected but are meaningful to the person experiencing them (Von Franz, 1974/1995, p. 226). Jung (1960/2014) also describes synchronicity as “an acausal connecting principle” (p. 417). That is, because synchronicity involves two events that could not plausibly be caused by each other “by any normal means”, their relationship is considered acausal (Main, 2006, p. 38). Main (2006) states that the theory of synchronicity proposes that “the irrational is as important a factor to accommodate in our scientific account of reality as is the rational” (p. 43). By irrational, Main is primarily referring to the spiritual or numinous aspects of reality. I argue that synchronicity is an additional reflexive process to engage when dealing with aporic situations, but it entails individuals and professions being open and in tune with such events and being prepared to engage with the numinous in their reflexivity.

Figure 3.2 illustrates the main Jungian theoretical thinking tools I have discussed in this chapter and their relationship with one another. The first two sets of triads discussed (complexes, archetypes, and collective unconscious; and ego, persona, and shadow) overlap to depict their symbiotic relationship. In the centre of these two triads is Jung’s conceptualisation of reflexivity, namely individuation, which is further developed by engaging with the third triad in the thinking tool suite (the transcendent function, union of opposites, and synchronicity).
3.8 Applying the Bourdieusian and Jungian thought partnership

Throughout the previous sections, I have highlighted that many of Bourdieu’s and Jung’s theoretical thinking tools are congruent with and harmonise with one another. I have also argued that some of the limitations of Bourdieu’s thinking tools, particularly regarding affect, ethics, and addressing aporic dilemmas, can be addressed by employing selected Jungian thinking tools. Conversely, I have also highlighted how Bourdieu’s thinking tools enrich Jungian thinking tools by emphasising considerations of social power and its influence on practices. Although I concede that a thought partnership between Bourdieu and Jung may on the surface seem incompatible, particularly considering the mystical aspect of some of Jung’s concepts, I argue that the numinous underpinnings, particularly the processes associated with individuation (e.g., the transcendent function and synchronicity) are simply the other half of an important duality neglected in the social sciences, namely, rationalism–irrationalism or rationalism–mysticism.
Although I have presented Bourdieu’s and Jung’s respective theoretical thinking tools as triadic sets, I am not suggesting that all their thinking tools neatly match and align with one another in some sort of superimposition. Instead, I am suggesting that there is an evident congruence with some; however, the nature of the connection, and indeed whether there is further congruence between the thinking tools, primarily emerges from the tools being “put to work” on my texts. Metaphorically, I see the thinking tools as threads on different spindles. Through the weaving process, it emerges that some threads naturally go better together; they weave closer together and form a tighter knit. Others do well standing out on their own. I have put the tools to work by incorporating them in my critical hermeneutic methodology, specifically in the interpretation of my study’s text sets. The thought partnership represented by my Bourdieusian and Jungian theoretical thinking tool kit is one representation of the bricolage approach I discussed in Chapter 1 based on Kincheloe’s (2001, 2005) conceptualisation of bricolage as it applies to rigour in qualitative research. That is, it celebrates and promotes the dialectical possibilities between disciplines, theoretical perspectives, paradigms, methodologies, and methods. I further discuss my synergistic approach in the following chapter where I outline my philosophical framework and methodological approach.
I start this chapter by outlining my study’s research aim and questions, which centre on the social constructivist and critical exploration of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents. I then present my paradigmatic assumptions and research approach that encompass Zarathustra’s notion of hybrid, which I consider an apt analogy for my philosophical and methodological approach, as my approach is concerned with the consideration of different positions (sometimes opposites) to arrive at “something beyond” what each position offers on its own. Zarathustra refers to the fallacy of humans thinking they can be either physical or spiritual beings, as they are neither but both. This liminal sensibility is reflected in my overall bricolage attitude and approach, introduced in Chapter 1. In the context of my thesis, liminality denotes an active regenerative space where we can deliberately and consciously access a source of transformative power (Pelton, 1989) by harnessing two different elements to facilitate Zarathustra’s notion of creating something beyond what either element can offer on its own.

In this chapter, I discuss the location of my philosophical positioning at what I identify as the juncture of social constructivist and critical paradigms, which allows me to develop my qualitative inquiry using both constructivist and critical knowledge claims. I also discuss my choice of critical hermeneutics for my overarching methodological approach and how it facilitates the exploration of both social constructivist and critical aspects of my study’s phenomenon. Specifically, I have drawn from Paul Ricoeur’s critical hermeneutics, which consists of subjective (contextual) and objective (structural) text interpretation and an appropriation of the two. I then discuss my research design which includes my participant recruitment, text construction, and
text interpretation strategies. In light of the relational, bricolage sensibilities of my research, ethical and qualitative quality considerations are woven throughout this chapter and discussed with the aspects of my research they apply to rather than presented separately from their contexts. For instance, when I discuss my text construction strategies, I include ethical and quality considerations that specifically relate to text construction.

4.1 Research aim

The aim of my research was to explore the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents. I undertook this exploration with the overall goal of informing professional practice capabilities required by CMHPT counsellors to create the best outcomes for children. To ensure the overall quality of my research, I focused on achieving optimal alignment among my research aim, research questions, paradigmatic assumptions, research approach, and research design.

4.2 Research questions

Based on my research aim, the main research question to guide my research was:

1. What is the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents?

To assist me to answer the main research question, I developed three sub-questions. As noted by Creswell and Poth (2017), research questions evolve and “change and become more refined during the process of research to reflect an increased understanding of the problem” (p. 52). What became evident to me was that my research participants understood personal, sociocultural, and collective influences on their practices as largely separate influences rather than interconnected, and for this reason my sub-questions reflect the deeper exploration of this separation.

i. How do CMHPT counsellors understand personal influences on their relational practices with parents?

ii. How do CMHPT counsellors understand sociocultural influences on their relational practices with parents?
iii. What is the nature of CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their relational practices with parents?

4.3 Paradigmatic assumptions

Following from Thomas Kuhn’s (1962/2012) seminal work *The structure of scientific revolutions*, where he defined paradigms as “universally recognized scientific achievements that, for a time, provide model problems and solutions for a community of researchers” (p. vii), the paradigmatic assumptions of a researcher’s study have become an important consideration and stipulation. Clearly stating paradigmatic assumptions emphasises the researcher’s “disciplinary matrix” or “the objects of group commitment” their research is aligned with (Kuhn, 1974, p. 463). Paradigmatic assumptions are also referred to as knowledge claims (Schwandt, 2015) and include suppositions about what reality is (ontology), how we know what we know (epistemology), and the values that underpin our inquiry (axiology). Paradigmatic assumptions establish a study’s philosophical framework and provide guidance regarding the kind of knowledge that will be generated and the appropriate methods to be used in the knowledge generation process (Trede & Higgs, 2009).

As discussed in Chapter 1, my engagement with my research phenomenon emerged from identifying the limitations of the positivist paradigm in exploring relational phenomena in the CMHPT counselling field. Given that I identified understanding and critical reflexivity as central to the exploration of my research phenomenon, it was important that I situated my research in a paradigmatic space that facilitated the exploration of multiple ways of knowing, including social constructivist and critical meaning-making. In this section, I first discuss these paradigms as separate spaces and then discuss what I refer to as the juncture of the two paradigms and how and why I have positioned my research at this juncture.

4.3.1 Social constructivist paradigm

The social constructivist paradigm (sometimes referred to as the interpretive paradigm) is anchored in a postmodern relativist ontology where reality is considered individually constructed within a social context. There are as many realities as there are individuals, and all realities are considered equally valid (Scotland, 2012). These realities are constructed contextually and are specific in nature, although aspects of the
realities may be shared among people (Guba & Lincoln, 1994). Social constructivist ontology can be traced back to Kant’s (1881) Critique of pure reason and his contention that we cannot separate objective reality from the person interpreting that reality, which stands in contrast to the ontological position of the positivist paradigm (Ponterotto, 2005). Another influential figure in the development of social constructivism is Dilthey (1894), who, influenced by Kant, highlighted the substantial difference between the natural sciences and human sciences; namely, the goal of the natural sciences is scientific explanation (Erklären) whereas the goal of the social sciences is understanding (Verstehen) social phenomena (Schwandt, 2000).

In the social constructivist paradigm, knowledge construction is considered to occur through the interaction between people, that is, it cannot be objectively observed but must be subjectively interpreted. Due to multiple realities and interpretations of realities, the researcher positioned in this paradigm is primarily concerned with exploring the complexity of participants’ views (Creswell, 2013). The interest is not in universal truths but rather in “local” truths (Kvale, 1992, p. 34). Interaction between people is considered to depend largely on language; therefore, the words used and the interpretations made are the researcher’s central focus (Minichiello, Aroni, & Hays, 2008). The researcher plays a central role in knowledge construction in a social constructivist paradigm. In this paradigm, given that knowledge is considered co-constructed through interaction, emphasis is placed on the researcher–participant relationship achieving substantial depth in the course of the research study, and therefore the relationship typically extends over a period of time (Haverkamp & Young, 2007). Throughout my study, I approached knowledge construction not as an observer of the phenomenon from an “objective” distance, but rather as a co-constructor, by engaging in lengthy in-depth interview dialogues with my participants over a period of months. Consequently, knowledge was constructed via dialogical interaction with participants rather than through observing or extracting information from them.

In this paradigm, the researcher’s values (axiology) are detailed, discussed, and reflected upon as part of the research process. This includes “the impact of the research process on the emotional and intellectual life of the researcher” (Ponterotto, 2005, p. 132). I considered and discussed my axiological position in Chapter 1, where I acknowledged, stipulated, and reflected on my experiences, assumptions, and values regarding my research phenomenon and my positioning in the CMHPT counselling
field. In Chapter 7 I include an exploration of how my own unacknowledged and unexplored shadow precluded me from identifying participants' shadows as influences on the research phenomenon.

4.3.2 Critical paradigm

The critical paradigm is characterised by a critical realist ontology where a distinct reality is considered to exist; however, it is considered to be shaped over time by society into a series of structures that are taken for granted and are ultimately disempowering and hidden from consciousness (Guba & Lincoln, 1994). The critical paradigm emphasises the role of power in constructing reality and what constitutes knowledge, that is, “what counts as worthwhile knowledge is determined by the social and positional power of the advocates of that knowledge” (Cohen, Manion, & Morrison, 2011, p. 32). Thus, in the critical paradigm, knowledge is considered socially constructed and largely influenced by structures within society that are characterised by power and inequality (Scotland, 2012). Uncovering the influence of social structures on people's lives, and in turn facilitating the emancipation of people disempowered by social structures, is of central concern to research positioned in the critical paradigm (Lincoln, Lynham, & Guba, 2018).

Like postmodern theorists, critical theorists challenge positivism's insistence that researchers should avoid acknowledging their values and should exempt their “empirical claims from rigorous self-reflection and self-criticism” (Agger, 1991, p. 111). Researchers are regarded to have more power than their participants and thus, as part of their research, are expected to be reflexive regarding their motivations and influences, and are expected to facilitate the empowerment of participants as much as possible in the knowledge generation process (Scotland, 2012). The central importance of reflexivity is like that found in the social constructivist paradigm; however, in the critical paradigm the researcher is typically required to have a clear “action agenda for reform” (Creswell, 2013, p. 9). Such an agenda is used to facilitate change and transformation of existing structures and to facilitate the empowerment of the powerless in the process of the research study, and this change is in turn considered one of the main outcomes of the research (Guba & Lincoln, 1994). Although my study aligned with the broad sensibilities of critical social sciences, I did not subscribe to typical critical theory conceptualisations of emancipation where an action agenda for reform was the goal. Additionally, as discussed in Chapter 3, I expand unconscious
structural influences to include structures of the personal and collective unconscious rather than solely the social unconscious. In the following section I discuss why and where I position my study in the critical paradigm and how this positioning relates to the social constructivist paradigm.

4.3.3 Juncture of social constructivist and critical paradigms

By adopting a bricoleur approach to my research, it was important that I seek liminal paradigmatic spaces to locate my study. One such space is what I describe as the juncture between the social constructivist and critical paradigms. Rather than viewing them as separate, mutually exclusive paradigms, I view the social constructivist and critical paradigms on an ontological, epistemological, and axiological continuum where purist positions pertaining to each paradigm can be found on either end of the continuum, and in the middle there exists a blurred boundary between the two. I consider that my study is situated at the juncture of the two paradigms. That is, my paradigmatic influences arise from both the social constructivist paradigm and the critical paradigm and, as such, my study is not wholly in either one in the purist sense in which paradigms are typically depicted (e.g., Creswell, 2013; Outhwaite, 1987). Consequently, I contend that CMHPT counsellors’ understandings of the influences on their relational practices with parents are constructed relative to their sociocultural context (social constructivist paradigm), and that their relational practices with parents are influenced by personal, social, and collective unconscious structures, which they have varying awareness of (critical paradigm).

Boundary crossing with Hermes

Essentially, my paradigmatic position is one of boundary crossing and merging between social constructivist and critical territories. To illustrate both and provide a rationale for this position, I explore the symbolism of Hermes, the Greek god of communication, and his emblematic role in both paradigms. I do this because research strategies that feature strongly in the social constructivist and critical paradigms privilege the role of communication in both their ontological and epistemological positions. In Greek mythology, Hermes was considered the god of communication – the messenger between the gods and humans. However, Hermes was a complex character. His personification of communication was multifaceted and did not simply involve language and writing. Hermes was known as the trickster god, frequently
mischievously taunting his fellow gods. He was also known as the patron god of thieves – he stole Apollo’s cattle, Poseidon’s trident, Artemis’ arrows, and Aphrodite’s girdle (Sears, 2014). In addition to his association with overt forms of communication (language and writing), trickery and theft, Hermes was also known as the god of boundaries, boundary crossings, and transitions (Neville, 2003). Hermes was the only god whom Hades, the god of the underworld, permitted to travel between the Earth and the underworld (symbolically, the conscious and unconscious realms), and for this reason he is also referred to as the god of the liminal (Beebe, 1997). This hidden, underworld association with Hermes is reflected in the meaning of the word “hermetic”, which means secret or sealed (Ramsay, 1997). It suggests that the tricky, hidden nature of Hermes needs to be uncovered, decoded, and deciphered. I argue that the multifaceted and trans-territorial nature of Hermes suggests that any research approach that holds communication as its central tenet should authenticate its communicative agenda by including considerations of both conscious, conspicuous facets as well as unconscious, hidden aspects of communication.

**Paradigmatic research and transformative agendas**

Considering the positioning of my research at the juncture of the social constructivist and critical paradigms, I do not share the research objectives stipulated by purist positions found in either paradigm. Social constructivism’s objective is to achieve deeper understanding of a phenomenon through exploring the interpretations of those experiencing the phenomenon; however, my contention is that, although exploring the deep (subjective) understanding of a phenomenon is crucial to the research inquiry, a truly deeper understanding of any phenomenon needs to include the exploration of hidden (objective) unconscious structural influences, as these influences lie at the depths. Or, as Schwandt (1994) points out, we need to avoid a social constructivism “that degenerates into nihilism, where we do nothing but engage in endless parasitical deconstruction and deny the existence of social order” (p. 249). In other words, deeper understanding should ultimately inform a change agenda where the changes in practices no longer reproduce embedded unconscious structural influences.

Critical theory has an emancipation agenda. Although I agree it may be an important goal, I argue that there are degrees of liberation on a continuum where on one end liberation equates to external emancipation (in the form of social action) and, at the other end, liberation equates to internal freedom achieved by increasing our awareness
of the unconscious influences on our lives. Thus, emancipation in the form of social action is one form of liberation (Corradetti, 2012), and is positioned towards one end of the continuum rather than defining the whole critical paradigm agenda. In this way, I conceptualise emancipation as a function of liberation. As Corradetti (2012) points out, although emancipation is the frequently used English translation of the German *Befreiung*, the word in German is much more elastic and encompasses a broader spectrum of meaning, with “liberation” being the most recurrent use in German philosophical works. Although appearing perhaps as a subtle semantic differentiation, the difference between emancipation and liberation is significant in terms of stipulating research outcomes for studies situated in (or at the juncture of) the critical paradigm. Namely, the concept of liberation allows the nature of transformation to be adjusted depending where on the continuum the research is situated. Considering the above, my conceptualisation of liberation in the context of my research, and in terms of its positioning at the juncture of the critical paradigm, involves illuminating the unconscious influences that shape my research phenomenon.

4.4 Research approach

Given my research aim was concerned with both participants’ understandings (social constructions) of the influences on their relational practices with parents and the nature of their critical reflexivity regarding these influences on their practices, in deciding on my research approach, I drew on critical hermeneutics as an approach that offered optimal alignment with my research aim, questions, and paradigmatic assumptions. Broadly, hermeneutics is considered “especially useful for exploring phenomena that have complex, multilayered meanings and can be viewed from a number of different perspectives” (Loftus & Trede, 2009, p. 61). Ricoeur’s critical hermeneutics is a methodological approach that I consider is positioned at the juncture of the social constructivist and critical paradigms as it incorporates both the constructivist tradition and critical theory, or what Ricoeur (1976, p. 73) refers to as “understanding and explanation”, respectively. Additionally, Ricoeur’s critical hermeneutics enhanced my overall bricolage approach to exploring my phenomenon and best represented Hermes’ liminal, hybrid sensibilities. In particular, Ricoeur’s approach metaphorically captures Hermes the trickster rather than simply Hermes the god of communication, as his critical hermeneutical spiral includes a “moment of suspicion” (Stiver, 2003, p. 182) to uncover, decipher, and decode covert, surreptitious, unconscious influences at play. In the following section, I discuss key
aspects of Ricoeur’s critical hermeneutics and my rationale for employing it in my study, and subsequently discuss my research design, which was informed by this critical hermeneutic tradition.

4.4.1 Critical hermeneutics

Paul Ricoeur was a twentieth-century French philosopher whose early career focused largely on hermeneutic phenomenology but, towards the end of his career, he explored the integration of key elements of structuralism and critical theory in his hermeneutic approach. Ricoeur (1976) developed his critical hermeneutic approach, specifically what he referred to as a hermeneutical arc, largely in response to the Gadamer–Habermas debate that took place in the late 1960s. The debate involved Habermas’ highly critical review of Gadamer’s Truth and method, particularly Gadamer’s notion of “rehabilitation” of prejudice, authority, and tradition (which influence a person’s preunderstanding of a phenomenon), and Habermas’ claim that Gadamer neglected the role ideology plays within tradition and its influence on injustice and disempowerment (Ricoeur, 1981/2016a). Habermas argued that distanciation is needed from tradition, that is, a relatively objective critical distancing which “would make space for reflection, question dogmatic forces, and not conflate knowledge with authority” (Bilimoria, 1998, p. 59). For Habermas, domination takes place through communicative action, where language is unconsciously distorted by the dominant ideologies of society.

Ricoeur (1976) responds to the debate firstly by declaring that hermeneutics and critical consciousness are not mutually exclusive, and should “not be treated in dualistic terms, but as a complex and highly mediated dialectic” (p. 74). Ricoeur (1981/2016) states that he does not attempt to put forward “a super-system which would encompass both”, but rather to demonstrate that each can “recognise the other, not as a position which is foreign and purely hostile, but as one which raises in its own way a legitimate claim” (p. 48). Ricoeur considers that a person’s subjective understanding and an explanation of society’s objective inherent structures go hand in hand. Ricoeur’s critical hermeneutic methodology offers a relational approach to phenomena. That is, a phenomenon can be explored subjectively (contextually) as well as objectively (structurally) as a whole, rather than focusing on one or the other. In a series of publications from the 1970s to the 1990s, Ricoeur outlines and elaborates on
what he refers to as his [critical] hermeneutical arc, which defines his critical hermeneutic approach, particularly his theory of text interpretation. The arc consists of three distinct “moments” in Ricoeur’s interpretation process which Ricoeur (1986/1991) states incorporates Gadamer’s “understanding” and Habermas’ “explanation”. Ricoeur refers to it as an arc to describe the back and forth movement between initial understanding of the text and in-depth (structural) explanation of the text (Tan, Wilson, & Olver, 2009).

**The first moment: Initial understanding**

Ricoeur (1976) describes the first moment in his arc as a “naïve grasping of the meaning of the text as a whole”, which he states is the first act of understanding (p. 74). It takes the form of a guess “because the author’s intention is beyond our reach” (p. 74). The guess work in this initial stage involves going through the hermeneutic circle, that is, exploring the parts of the text and constructing the whole and vice versa (Singsuriya, 2015). Some researchers such as Wiklund, Lindholm, and Lindström (2002) have interpreted this moment to include using a relevant theoretical framework and previous research on the phenomenon as a starting point to exploring the text. The initial moment is a subjective moment as it explores the text in a contextualised way. That is, it is situated in the sociocultural and historical context of the phenomenon.

**The second moment: Distanciation**

In contrast to the subjective nature of the first moment, the second moment involves an objective structural analysis of the text, which Ricoeur (1981/2016) refers to as a critical moment or distanciation. Distanciation focuses on the text as semantically autonomous from the intentions of the author and something that can be interpreted outside of its sociocultural context (Kaplan, 2008). The second moment is based on Ricoeur’s concept of a “hermeneutics of suspicion”, where the text is interpreted as meaning something other than what it says on the surface (Bell, 2011, p. 531). Ricoeur (1970, p. 17) articulates this notion in his seminal work *Freud and philosophy*, where he explores what he describes as “the latent meaning” in language from Freud’s psychoanalytic perspective. Ricoeur (1970) considers Freud one of the “three masters of suspicion” along with Nietzsche and Marx, all of whom he states consider

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15 Ricoeur also used the concept of the hermeneutical arc in his writings on phenomenology and narrative analysis. In the context of my study, I use his conceptualisation of the hermeneutical arc to refer to his critical hermeneutic approach to interpretation rather than his phenomenological or narrative approach.
consciousness as “false consciousness” (p. 17). False consciousness refers to exploited people not recognising that they are being exploited due to the process of systematic mystification, that is, the ideology of social systems and structures (Heywood, 2012).

As a way of uncovering false consciousness, Ricoeur incorporates literary structuralism (as opposed to structuralism in the Marxist sense) in his arc, which seeks to illuminate the deeper “codes” that structure a text and are not apparent on the surface and probably not the intention of the author (Stiver, 2001, p. 62). These codes primarily refer to linguistic or narrative systems that stand out in their own right without needing reference to the author of the text or the author’s sociocultural context (Scott-Baumann, 2009). Ricoeur does not stipulate what sort of structural analysis should be conducted in this second moment, only what the analysis should reveal, namely, that it should reveal universal narrative or linguistic structures such as those found in the work of Lévi-Strauss (Singsuriya, 2015). For example, Ricoeur (1981/2016) discusses Lévi-Strauss’ analysis of the Oedipus myth where he examines units he calls “mythemes” and how they function as “bundles of relations” (p. 122) throughout the narrative. Mythemes are organised around binary opposites. For instance, in the case of Adam and Eve, core mythemes are gender (male–female), virtue (good–evil), morality (truth–lie), law (obedience–disobedience), membership (inclusion–exclusion), and judgment (paradise–hell). Although Ricoeur contends that structural analysis is integral to objectifying the text and providing a type of rigour, he believes that structuralism is limited as it “cannot move beyond structures to meaning, from the text to the world [emphasis in original]” (Stiver, 2001, p. 62). To move beyond the text to what it refers to in the world, Ricoeur argues that an additional moment is needed, one that appropriates the first and second moment.

**The third moment: Appropriation**

Ricoeur (1981/2016) refers to the third moment along his arc as appropriation, which is achieved by considering both what has been revealed in the first moment and the second moment to reveal “the mode of being unfolded in front of the text” (p. 53). Ricoeur (1976) also refers to this moment as the referential moment: “To understand a text is to follow its movement from sense to reference: from what it says, to what it talks about” (pp. 87–88). Thus, the appropriation moment moves beyond the specifics of the research phenomenon to a broader, meta-synthesis of what the research findings reveal.
In his later writings, Ricoeur suggests that his critical hermeneutical arc may be better called a hermeneutical spiral as the researcher may repeatedly return to the text and arrive at new meaning (Stiver, 2001). That is, the process of transformation through understanding and critical reflexivity is an ongoing one and new insights and opportunities for developing deeper understanding of the phenomenon are endless. This signifies that a research study presents a snapshot of a deeper understanding of the phenomenon, but that there is always more to understand and more to transform. Ricoeur's critical hermeneutical spiral offers a methodological bricolage approach to understanding as it incorporates a journey through subjective, objective, and appropriation moments. I used Ricoeur's journeying to and from these moments to guide the main elements of my research design.

4.5 Research design

My research design was guided primarily by the nature of my research questions, the positioning of my research in the social constructivist and critical paradigms, and my critical hermeneutic methodological approach that provided the overall philosophical foundation for my qualitative inquiry. Although I present my research design in a somewhat linear sequence, it is important to stress that it was not developed through a predetermined linear process, but rather an ongoing, reflexive one, which is characteristic of sound, rigorous qualitative research (Maxwell, 2013). In this section, I discuss the main elements of my research design which includes participant details with inclusion and exclusion criteria, text construction, and text interpretation strategies.

4.5.1 Participants

To journey through the various moments of understanding my phenomenon, and to develop text sets that were credible, it was important that I recruit participants who had experiences with my research phenomenon.

Selection criteria

To explore the phenomenon of CMHPT counsellors’ understandings of influences on their relational practices with parents and the nature of their critical reflexivity regarding these influences, I sought to recruit qualified CMHPT counsellors with relevant experience of the phenomenon and who met the following criteria:
• held an accredited qualification in play therapy (from a registered training organisation or university)
• held registration/membership with a counselling clinical board in Australia (e.g., Psychology Board of Australia, Australia Association of Social Workers, Australian Register of Counsellors and Psychotherapists, Australian College of Mental Health Nurses, Australian Association of Occupational Therapists as a Mental Health Occupational Therapist, or Royal Australian and New Zealand College of Psychiatrists)
• delivered mental health play therapy counselling to children (aged between 3 and 14 years)
• were based in New South Wales (NSW), Australia.

My study's participant criteria excluded those who did not hold formal qualifications in play therapy and/or did not hold registration or membership with a clinical board/association in Australia. This excluded practitioners who had participated in play therapy training from a non-accredited institution. I determined it was important that participants hold accredited qualifications as it would ensure that participants' capabilities had been formally assessed (non-accredited training programs do not require an assessment component), meet national quality assurance requirements (non-accredited training is not bound by such requirements), and that training and assessment had been conducted by appropriately qualified individuals (non-accredited training can be delivered by individuals with no training and assessment qualifications and therefore their training and assessment capabilities have not been assessed). This selection criterion enhanced the credibility of my text construction and in turn my findings in that appropriate participants were selected to explore the research phenomenon (Jensen, 2008).

I limited my recruitment to Australian participants to contribute to generating knowledge of CMHPT counselling practice in an international context that had not to date been adequately studied. Focusing on recruiting participants from the same country also allowed me to situate my research phenomenon in the sociocultural context it was enacted in. I commenced the recruitment of participants in the state of NSW for practical and budgetary reasons, as NSW is where I was based and this enabled me to conduct face-to-face interviews with participants in their workplaces. It also
enabled me to better manage budgetary allowances by keeping my travel within one State.

**Recruitment**

Recruitment of participants took place via a process of purposive sampling, which involves selecting “fertile exemplars of the experience for the study” (Polkinghorne, 2005, p. 140). In other words, participants were purposefully selected because they were “information-rich” in terms of their experiences with the research phenomenon (Patton, 1990, p. 169). I first approached publicly listed members of the Association for Play Therapy (APT) who were based in NSW, and then asked the members who accepted the invitation to participate in my study to nominate counsellors who met the study’s criteria but who were not members of the APT. Thus, participants were recruited via two processes of purposive identification, one of which was a snowball recruitment technique. I decided to open the recruitment to non-APT members for two main reasons. Firstly, although APT is an international association with over 6000 members, membership in Australia is relatively small, with only 28 members listed at the time of my recruitment, and only seven in NSW. Secondly, because APT membership is not compulsory for those who practise CMHPT counselling, it was likely that many prospective participants who met my study’s criteria were simply not members of APT, but likely known to members as they may have completed the same qualifications at the same educational institution.

I emailed those who were publicly listed on the APT website and based in NSW with an invitation to participate in my study (see Appendix A). To minimise confusion regarding my role, I emailed potential participants from my university email address rather than my personal or business email address. The email included a Participant information sheet, which provided details of the nature of my study, the voluntary nature of participation, and that participants could withdraw from the study at any time (see Appendix B). Because of the in-depth nature of the interviews requiring a substantial amount of participants’ time and because I envisaged that most of my participants would be working in private practice and therefore the time they participated would be unpaid time (in contrast to a salaried employee), I determined it was important to provide participants with a token of appreciation for their time. Thus, my invitation to participate stipulated that those participating in my study would receive a $100 Dymocks bookstore gift voucher.
Table 4.1
Participants’ professional background details

<table>
<thead>
<tr>
<th>Participant pseudonyms</th>
<th>Profession</th>
<th>Overall mental health counselling experience</th>
<th>CMHPT counselling experience</th>
<th>Current workplace</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne</td>
<td>Counsellor</td>
<td>0–5 years</td>
<td>0–5 years</td>
<td>NGO</td>
</tr>
<tr>
<td>Elizabeth</td>
<td>Mental health nurse</td>
<td>25 + years</td>
<td>0–5 years</td>
<td>NGO</td>
</tr>
<tr>
<td>Emily</td>
<td>Psychologist</td>
<td>5–10 years</td>
<td>0–5 years</td>
<td>Private practice (solo + team)</td>
</tr>
<tr>
<td>Josephine</td>
<td>Social worker</td>
<td>20–25 years</td>
<td>5–10 years</td>
<td>Private practice (solo)</td>
</tr>
<tr>
<td>Louise</td>
<td>Social worker</td>
<td>10–15 years</td>
<td>0–5 years</td>
<td>Private practice (solo)</td>
</tr>
<tr>
<td>Luisa</td>
<td>Psychologist</td>
<td>20–25 years</td>
<td>5–10 years</td>
<td>Government department</td>
</tr>
<tr>
<td>Tammy</td>
<td>Psychologist</td>
<td>5–10 years</td>
<td>0–5 years</td>
<td>Private practice (solo)</td>
</tr>
</tbody>
</table>

In total, I recruited seven participants to my study. Four CMHPT counsellors responded to my invitation. At the end of the first interview, I invited these four participants to nominate CMHPT counsellors whom they knew met the study’s participant criteria but who were not members of the APT. Participants provided email contact details for these counsellors and I sent them an invitation to participate in my study. An additional three participants were recruited in this way. All seven participants recruited in my study were female. This reflected the high percentage of females in the CMHPT counselling field and mental health counselling in general, as discussed in Chapter 2. At the time of interviewing, four participants (Emily, Josephine, Louise, and Tammy) worked in solo private practice, one participant (Luisa) worked for a government department, and two participants (Anne and Elizabeth) worked for a nongovernment organisation (NGO). Luisa and Anne had previously worked in private practice settings and compared their past private practice experiences to their current workplaces. All participants’ workplaces were in community settings as opposed to inpatient settings. Table 4.1 provides a summary of participants’ professional backgrounds, including their profession, overall mental health counselling experience, specialised CMHPT counselling experience, and workplace. Names are pseudonyms that all participants chose themselves.
4.5.2 Ethical considerations for participant recruitment and engagement

I gained ethics approval from the Charles Sturt University (CSU) Human Research Ethics Committee (HREC) to conduct my research (see Appendix C). Ethical considerations pertaining to my participant recruitment included obtaining free and voluntary consent, managing any existing relationships with research participants, and maintaining the confidentiality and anonymity of participants.

Consent

As all the participants were qualified mental health counsellors, I made the assumption that they were able to comprehend and retain information provided to support their decision-making processes and thus I did not anticipate that a determination of competence to give informed consent was required. There were two consent processes involved. The first was when participants accepted via email the invitation to participate in the study, and the second at the first interview, when I asked participants to read and sign the Consent form (see Appendix D). Participants were clearly advised that their participation was voluntary and they could withdraw from the research at any time without prejudice or penalty.

Existing professional relationships

A key ethical issue I identified pertaining to my study was my existing relationships with potential participants, as the field of CMHPT counselling in Australia is relatively small and, as a supervisor and educator in the field, it would be highly probable that I would have had some level of past or present professional engagement with participants. To address this issue, I undertook the following measures:

1. I suspended my involvement in delivering training and supervision for ongoing professional development elective units delivered by my training organisation while I constructed texts for my study. This meant that I was not in a position to enter a training, assessor, or supervisory relationship with any participants of my study. In explaining the aim and research questions of my study to participants, I made it clear that there was no assessment or evaluation agenda; instead I emphasised my role as the researcher, particularly a qualitative researcher. This included me sharing with
participants how I came to research the topic, or rather how the topic chose me. I determined that this would assist me to forge my role as the researcher as a “conversation partner” (Kvale & Brinkmann, 2009, p. 123) more so than someone outside the field or someone who did not identify with the phenomenon. Having said this, I was also mindful that I did not want to overshare or self-disclose too much regarding my experiences with the research phenomenon as I wanted the focus to be predominantly on the participants’ experiences and understandings. I also stressed that I did not have a hypothesis that I was testing, and that I really did not know what to expect in terms of participants’ experiences and understandings of the research phenomenon. I felt this was important to emphasise as most of my participants, particularly the psychologists, would have been more familiar with quantitative methodology and research situated in the positivist paradigm where hypothesis testing is the norm. Essentially, as a qualitative researcher, I emphasised my preliminary position as one of “not knowing” as opposed to “knowing” associated with my other roles. In emphasising this aspect of my role, I distanced myself from my supervision, training, and assessment personas.

2. I did not envisage that decisions about participation in my study would impair existing or foreseeable professional relationships between participants and myself. Participants were clearly advised that their participation was voluntary and they could withdraw from the research without prejudice or penalty.

3. Through the text construction phase of my study, I had the option of seeking consultation with my primary and secondary supervisors at CSU as well as consulting my clinical supervisor/consultant (a psychologist external to CSU) regarding managing any ethical issues. However, no significant ethical issues arose during my study.

Confidentiality and anonymity

From the beginning of my study, I used pseudonyms for all participant texts. To empower participants, I asked participants to choose their own pseudonym. I de-identified or withheld details that seemed likely to identify a participant or their
practice. Participant interviews were audio-recorded with the participants’ consent and, consistent with conventions in qualitative research, pseudonyms were utilised in all coding, analysis, and reporting. In discussions with my supervisors regarding my texts, I only referred to de-identified texts. Participants’ confidentiality was maintained at all times. If participants wished to make others aware they were participating in my study, I considered this their prerogative and right; however, on any acquaintance with a participant’s colleagues or employer, I did not make them aware of who was participating in my study.

When I conducted interviews, I kept notes and audio-recorders in my locked vehicle out of sight, or kept them on my person. The study’s texts were stored in paper copies, audio files, and text files. Participants’ pseudonyms were also used in labelling the texts, thus electronic/hard copy texts were not identifiable. Electronic text sets were held in my password-protected computer. Hard copy text sets such as transcripts as well as audio files were kept in a locked filing cabinet in my office. No issues regarding breaches of security arose in the course of the study. In accordance with CSU policy, research data will be preserved for five years, and then destroyed – electronic files will be deleted, and hard copies will be shredded. Until such time, all data will continue to be stored in a password-protected computer and locked filing cabinet.

4.5.3 Text construction strategies

In this section, I discuss my text construction strategies. In the hermeneutic tradition, text refers to “any discourse fixed by writing” (Ricoeur, 1981/2016b, p. 145). In constructing my texts, I adapted Ricoeur's critical hermeneutical spiral to develop what I refer to as a critical imaginal hermeneutic approach to text construction. This approach includes using in-depth interview dialogues teamed with imaginal product-making and imaginal sense-making processes to construct my empirical texts. In this section I discuss the features and processes involved in these strategies including ethical and quality considerations pertaining to various facets of the text construction process.

In-depth interviews

Guided by the hermeneutic tradition, which is concerned with interpreting existing and/or created texts about the phenomena being explored for hidden and deeper meaning (Higgs, Paterson, & Kinsella, 2012), I constructed empirical text sets from a
series of 21 semi-structured in-depth interviews with my seven participants (three interviews per participant). All interviews were recorded and I transcribed each interview recording verbatim. I used these 21 verbatim transcripts to construct my empirical text sets. As my research aim was to explore participants’ understandings of the influences on their relational practices with parents and the nature of their critical reflexivity regarding these influences, I chose in-depth interview dialogues as my main text construction strategy, as in-depth interviews “are particularly well suited for studying people’s understanding of the meanings in their lived world, describing their experiences and self-understanding, and clarifying and elaborating their own perspective on their lived world” (Kvale & Brinkmann, 2009, p. 116). In-depth interviewing also allows the researcher to gain access to participants’ understandings of phenomena which cannot be directly observed by the researcher (Minichiello et al., 2008).\footnote{Although I acknowledge that direct observation of participants and parents would have provided further points for discussion with my participants regarding their understanding of influences on their relational practices, I decided against this as a method because my study was focused on counsellors’ understandings of influences on their relational practices rather than exploring their relational practices ethnographically.}

Returning to Hermes and his role in bricolage, hybridisation, and traversing liminal spaces such as the conscious and unconscious, I considered it imperative that my text construction and text interpretation incorporated a hybrid communication approach. Additionally, given part of my research aim was to explore CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their practice, it was necessary that I include a research strategy that could avail itself of unconscious material as well as involve the participants’ reflexivity. I achieved this by partnering the customary verbal mode of communication characteristic of in-depth interviewing with inviting my participants to produce visual expressions of the research phenomenon.

**Engaging the imaginal**

In my thesis, I refer to visual expressions as products of the imaginal in the tradition of philosopher Henry Corbin (1972), who uses the term to distinguish it from imaginary or imagination, which have connotations of fantasy and triviality. The imaginal is part of a mediatory realm with a mediatory function that links different universes, worlds, or realms with one another (Corbin, 1972). In the context of my thesis, the imaginal is the intermediary between the conscious and unconscious realms. This is congruent
with Jung's use of the imaginal, where the imaginal and the images it produces are considered the threshold between the conscious and unconscious realms (Romanyshyn, 2013).

The use of expressive and visual mediums features in both the social constructivist paradigm and critical paradigm and they are referred to by a variety of names including arts-based, arts-informed, creative, and visual methods/research strategies (e.g., Banks & Zeitlyn, 2015; Cole & Knowles, 2008; Gauntlett & Holzwarth, 2006; Leavy, 2015; Patton, Higgs, & Smith, 2011). However, these visual and expressive methods are used primarily to “record, reveal, elicit, illustrate, demonstrate or evoke meanings” (Felstead, Jewson, & Walters, 2004, p. 118), where images are approached predominantly as ways of facilitating a person’s expression of their thoughts, emotions, and experiences. They are not typically used as a specific, systematic approach to uncover a relational web of unconscious structural influences on practices.

As Romanyshyn (2013) points out, when research traditions such as hermeneutics do “acknowledge the presence and reality of the unconscious . . . they do not develop procedures to make the unconscious as conscious as possible” (p. 317). Specifically, the distanciation function of the imaginal is neglected. It is, however, strongly featured in the practice and research of Jungian psychology (Davidson, 2013). In Jungian psychology, the imaginal is at the centre of understanding unconscious influences, particularly collective unconscious influences. Jung (1964/1978) considered symbolism the language of the unconscious and developed a systematic procedure and principles to unpack and explore the symbolism embedded in imaginal products to reveal hidden aspects of consciousness that verbal dialogue cannot reveal. This systematic approach draws on Jung’s (1935/1997) active imagination method. Before I explore this systematic approach to unpacking imaginal products, I first discuss the imaginal as a hybrid practice-based research strategy in my study.

The imaginal as a hybrid practice-based research strategy

Regardless of theoretical orientation, all play therapy approaches centre around metaphor and symbolism as the primary mode for communicating thoughts, feelings, and experiences (Kottman, 2011). Given that the imaginal plays a central role in play therapy practice, it was important that I considered my and my participants’ pre-existing relationship to the imaginal and its place in my research. Surprisingly, the use
of play therapy techniques and mediums in play therapy research that does not directly involve counselling clients is largely absent from the play therapy literature. That is, when the imaginal features in research, it does so primarily in the context of the imaginal being used with clients in counselling rather than as a research strategy or method. I consider the imaginal tools and processes used in CMHPT counselling as valuable resources in developing a research strategy. Given hybridisation is at the centre of my study’s research sensibility, I take the view espoused in the related field of art therapy, where some researchers have actively embraced what Sinner, Leggo, Irwin, Gouzouasis, and Grauer (2006) refer to as a “hybrid, practice-based form of methodology” (p. 1224). In the field of art therapy, this is referred to as “a/r/tography” where a/r/t denotes artist–researcher–teacher (Leavy, 2015). Leggo and Irwin (2014) state that a/r/tography emphasises the importance of the researcher embracing their multiple identities:

the distinctive focus on a/r/tography is on the intersections of identities of the artist, the researcher, and the teacher as integrally and contiguously connected . . . we acknowledge the holistic nature of our identities as vigorously and vibrantly connected. (p. 151)

I borrowed this concept of a hybrid practice-based strategy and applied it to my participants and myself. CMHPT counsellors are accustomed to thinking and expressing themselves symbolically. Aside from their work with clients, CMHPT counsellors’ reflexive practice and supervision involve the use of a variety of play therapy mediums and techniques. Thus, engaging with the imaginal is an accustomed and comfortable way in which to express themselves. I too am accustomed to using the imaginal in these roles and settings as well as in my role as educator and supervisor. This aligns with the notion of researcher-as-research-instrument as a function of a study’s credibility. Researcher-as-instrument is an established concept in qualitative inquiry literature and relates to “the distinctive function of the researcher’s knowledge, perspective, and subjectivity in data acquisition” (Kvale & Brinkmann, 2009, p. 123). The concept of researcher-as-instrument is based on the premise that, because research data is mediated through the researcher rather than “through some inanimate inventory, questionnaire, or computer” (Merriam, 1998, p. 7), it is important to discuss key aspects of the researcher’s professional or personal background as they influence the quality of the text interpretation. As Thompson (1997) points out, “the quality of the research findings is contingent upon the scope of the background knowledge that
the researcher brings to bear and his or her ability to forge insightful linkages between this background knowledge and the texts at hand” (p. 442). In this context, I highlight that I have over twenty years of experience in facilitating imaginal products and engaging in imaginal sense-making processes guided by a clear systematic and systemic theoretical framework based on Jungian psychology and its emphasis on communing with and revealing unconscious influences. I brought this knowledge and experience to my research and did so with a range of ethical considerations in mind.

**Imaginal product-making and ethical considerations**

There were three aims behind inviting participants to create an imaginal product. First, I wanted to use participants' understandings of their situated, contextual, and temporal interaction with parents as it occurred over time as a basis or springboard to explore my research phenomenon. Second, I wanted to explore participants' understandings of each part of the process and how these understandings related to their overall understanding of the influences on their relational practices with parents. In other words, I engaged a hermeneutic circle of understanding regarding their relational practices—how the parts related to the whole and vice versa. Third, I wanted to use the activity to discuss relational practices that were not captured in the temporal sequence, but nonetheless infused their relational practices. This was based on the Jungian premise that all images contain both our conscious intentions (that is, what we think the images relate or refer to) and unconscious structures (such as archetypes), which we are unaware of until we engage with the imaginal sense-making process (Avens, 1992).

In inviting participants to create imaginal products of their experience of the research phenomenon, I was mindful of pertinent ethical considerations. For example, I was mindful of the need to contain participants' unconscious processes within a structured activity (rather than unstructured) to enable safe expression. In this context, safe expression refers to minimising the risk of participants' unconscious shadow processes dominating or taking over the process. Had I given participants little structure (e.g., invited them to express any aspect of their relational practices with parents they wanted to), it would have increased the likelihood that the unconscious would take the opportunity to express other material not directly related to the research phenomenon (e.g., their own unresolved parenting issues). This is based on the Jungian principle that the unconscious is always seeking to express unhealed
aspects of itself and, when presented with its language of choice (the imaginal) coupled with minimal direction/structure, it can take the opportunity to express shadow content (Bologna, 2002) that could potentially “overpower the conscious mind” (Jung, cited in Miller, 2004, p. 13). In a therapeutic context, a more non-directive approach would have been suitable and aligned with the goal of treating the client’s mental health issues. However, in a research context, the goal is to understand the research phenomenon and thus I considered it unethical to potentially invite shadow material not directly related to understanding the research phenomenon.

In light of the need to provide structure and containment for participants’ unconscious processes to be expressed safely, I invited participants to map out the general sequence of their contact with parents (e.g., initial phone call, intake meeting, bringing the child in for their first session, review meetings) with any play therapy medium of their choice (e.g., image cards, sandplay figurines, collage, drawing) to symbolically represent how they understood and made sense of each part of the process (e.g., the purpose, intention and overall function of each part of the process). I then asked participants to produce a photo of their imaginal product so that we could further discuss it in the following interview. The imaginal products produced by participants were not of identifiable people or places, but rather symbolic imaginal representations of the participants’ relational practices with parents. The images below provide examples of how some participants approached the activity. For example, Louise used image cards (see Figure 4.1), Josephine used collage (see Figure 4.2), and Luisa used sandplay (see Figure 4.3) as their respective mediums.
Figure 4.1. Louise’s imaginal product.
Figure 4.2. Josephine’s imaginal product (3 pages).
Imaginal sense-making process and ethical considerations

To unpack participants’ imaginal products with them, I adopted a Jungian approach to imaginal sense-making which mirrors Ricoeur’s moments of interpretation, that is, the stages of unpacking correspond with the three moments of Ricoeur’s hermeneutical arc. Thus, it is a nested model where I used the critical hermeneutical spiral in the imaginal sense-making process within my wider text construction strategy. In unpacking participants’ imaginal products, I was also mindful of ethical considerations associated with the Jungian tradition that centre around not imposing one’s interpretation on somebody else’s imaginal sense-making, respecting and facilitating the autonomy of imaginal expressions, and not interrogating images (McNiff, 1991, 2004).

Initial understanding

The first step in unpacking participants’ images involved me inviting participants to discuss what they wanted to about the image they produced. This typically involved participants discussing what they thought their imaginal products represented in terms of their relational practices with parents. In discussing participants’ imaginal products,
I was mindful not to assume what I was seeing was what participants saw or understood; that is, I was focused on confirming participants’ individual, self-owned, subjective meaning of the images (including the specific words they used) and being mindful of not projecting my own interpretation of the images. This did not mean I did not use the images to probe the phenomenon, but rather to emphasise that I did not assume to know what a symbol or image stood for until I unpacked it with the participant and drew the individual, subjective meaning from them.

**Distanciation**

Once participants had discussed their initial understandings of their imaginal products, I engaged Jung’s active imagination technique to de-contextualise the image from the context participants had placed them in and to approach the image as an autonomous entity outside its prescribed social context. Hillman (1989, p. 75), a post-Jungian analyst and founder of imaginal psychology (also known as archetypal psychology), is fond of the mantra “stick to the image”; in other words, de-literalise the participants’ previous understandings of it, personify it, and allow the image to speak for itself. I adapted this for the research context by asking participants not to embody the image, but rather to talk on its behalf. This subtle difference was important in that I did not lead participants in a psychic space of embodiment as that could potentially be too psychologically confronting, particularly in a non-therapeutic context. That is, I was still able to achieve distanciation without immersing participants in a deeper psychic space that is more suited to a therapeutic setting rather than a research one. I also distanciated the imaginal products by adopting a gestalt approach to unpacking images commonly found in gestalt therapy traditions (e.g., Rhyne, 1996), where I explored different parts of the image (as separate entities) and then the parts’ relationship with the whole image in a dialectic fashion. The gestalt approach is congruent with the hermeneutic process of “oscillating between the part and the whole, in order to make the whole clarify the parts or vice versa” (Oilman, 2007, p. 118).

** Appropriation**

After distanciating the image, I asked participants if/how the discussions we had had about the image related to aspects of their practices with parents. This was a moment of metaphorically returning from the underworld to reflect on how its messages relate to participants’ current (social) reality and circumstances. It was at this moment of the
image sense-making process that participants typically commented how their imaginal products revealed more than they thought would be revealed; that is, deeper unconscious aspects emerged. Chapter 7 provides examples of the different stages of participants' imaginal sense-making processes.

4.5.4 Quality considerations for text construction

I took several quality measures into consideration in preparing and conducting my interviews. These considerations included critiquing my interview style, temporal considerations such as the time gap between interviews, location of interviews, the general focus for each of the three interviews, and my ongoing reflexivity.

Interview preparation

Before interviewing participants, I arranged for one of my university supervisors and her research assistant to interview me. I gave the research assistant a draft of an interview guide I had prepared, which she used as a guide to interview me while my supervisor took notes. I arranged to be interviewed for a few reasons. I wanted to put myself in the position of the participants and get a sense for the semi-structured questions I had prepared for the first interview and an overall feel of the interview process. This experience allowed me to fine-tune the wording of some of my questions and gave me insight regarding how best to approach establishing a relaxed yet productive interview environment. For example, I noticed that the first question I had drafted: “What is the first thing that you think of when I say the word ‘parents?’” made me hesitate. I felt I wanted to say more than I did and realised I was consciously filtering my response, as I did not think the research assistant and my supervisor had the appropriate context for my uncensored response. Also, I was aware that the word “parents” did not just evoke thoughts but also feelings. In considering my personal experience of the question, I wanted to encourage more candid and visceral responses from my participants, so I changed the question to: “In the context of your work with children, without feeling you need to be politically correct, what is the first thing you think and feel when I say the word ‘parents?’”

Timing of interviews

I conducted a series of 21 in-depth semi-structured interviews in total (three interviews with each participant) over a 3-month period for each participant, that is,
approximately one month between interviews, in order to give participants and myself sufficient time to reflect on our conversations. The schedule for the interview sequence was determined largely by participants’ availability. With the first participant I interviewed, I conducted the sequence of three interviews between July and September 2015. I conducted the three-interview sequence for the other six participants between November 2015 and April 2016.

First interview

The first interviews ranged between 1.5 and 2.5 hours’ duration with each participant. In the Participant information sheet I had previously emailed to participants, I stipulated that interviews would last approximately 1 hour; however, I found that all participants wanted to speak for longer. Some participants had set aside a whole morning or afternoon, anticipating a lengthy discussion. The first interviews were conducted face-to-face in the participants’ workplace, specifically in the room in which they typically see parents. I chose to conduct the first interview at participants’ workplaces so that the interview conversations could be situated in the site where my research phenomenon largely takes place, thus increasing my study’s credibility. It also allowed participants to use their material environment and its artefacts as a reference point in a lot of their discussions. Conducting the interview in participants’ workplaces also gave me a rich opportunity for observation which I recorded in my research journal. I was then able to reflect on these observations and musings between interviews and raise further questions with participants at the following interview. In particular, I was able to observe aspects of the participants’ material environment and ask questions I would not have thought to ask had we been in a non-workplace setting. For example, one participant’s counselling room was located in a church-owned building with a church/charity sign at the front door. I immediately noticed the sign as I walked in the building. In the subsequent interview, when we were discussing the participant’s understanding of the influence of the material environment on her relational practices with parents, I asked whether she felt the sign at the front of the building impacted on any parents’ understandings of her service, given she was not working for the church-run agency, but only leasing space from then. This then led to an insightful discussion of some parents’ negative reactions to the sign, and in turn the role of the material environment in developing first impressions and assumptions about the counsellor’s service. I may have only focused on the inside of the participant’s space had I not
physically walked into her building (as would a parent) and noticed external features such as the sign.

I started all interviews by answering any questions regarding the *Participant information sheet* I had emailed participants previously, and going through the *Consent form*. I then spoke about my positioning in the field, stressing that I was in the role of researcher rather than supervisor, trainer, or assessor and gave a few examples of the difference between the roles. With participants whom I had previously supervised in their workplace, I suggested I sit in a different chair to reinforce the change in my role. The first interview mirrored the initial understanding moment of Ricoeur’s critical hermeneutic spiral. It included discussing participants’ most challenging and most positive parent experiences, the relational practices involved, and how they understood these practices in light of their experience with parents. Although I had prepared an *Interview guide* (see Appendix E), I did not refer to it in the interviews, instead preferring to organically follow the flow of the discussion. What I found, however, was that all the questions I had prepared in the *Interview guide* were covered in the interview, but generally not in the order outlined in the guide. Not referring to the guide or other written notes assisted in setting the atmosphere for me as a conversation partner, that is, I was not stilting or predetermining the flow of our discussions by using a guide or notes. The organic nature of the discussions also allowed other topics to emerge that I had not thought to cover in my guide. At the end of the first interview I explained the imaginal product-making activity discussed in the previous section and gave participants the option of doing the activity in their own time and then simply bringing the imaginal product (or a photo of it) for discussion in the following (second) interview or, if they preferred, to do it in the second interview with me present. At the end of the first interview, I also invited participants to choose their own pseudonyms as I deemed it ethically important that they choose as a way of being empowered by some of the process.

*Second interview*

The second interview was conducted face-to-face where practical or via Skype, and ranged between 1.5 and 2 hours with each participant. With participants to whom I had in the past provided supervision via Skype, I playfully hung in the background (where a painting is usually hung) a promotional bag with my university’s logo to emphasise my role as a researcher rather than supervisor. The second interview
involved a deeper discussion of participants’ understandings of the influences on their relational practices with parents, which mostly centred around participants’ understandings of sociocultural influences on their practices. In terms of Ricoeur’s critical hermeneutical spiral, this indicated that an additional moment emerged as a distinct moment between initial understanding and distanciation. I refer to this as the *deeper understanding moment*. The second interview also involved discussing and exploring participants’ imaginal products they had created since the last interview. Some participants had not created the imaginal product as they wanted to create it in the interview. The second interview involved exploring the participants’ imaginal products via the imaginal sense-making process described earlier. Thus, in addition to the deeper understanding moment, the second interview also aligned with Ricoeur’s distanciation moment as a co-constructed meaning-making process with participants and myself.

*Third interview*

The third interview ranged between 1.5 and 2 hours. The third interview focused on further discussing participants’ understandings of their relational practices with parents, which was informed by questions I had prepared based on reflecting on notes in my research journal and transcribing previous interviews, as well as points participants had reflected on and wanted to further discuss with me. Most participants had engaged in their own self-directed reflexivity (not prompted by me) between interviews which was spurred by their imaginal products and imaginal sense-making processes that took place in the previous interview. The third interview incorporated the appropriation moment of Ricoeur’s critical hermeneutical spiral, where participants discussed what emerged for them as part of the three interviews and their reflexivity in between. Some participants noted that they experienced synchronistic occurrences that had taken place since the second interview, and that they interpreted these events in the context of discussing parents in my research. This in turn inspired them to engage in deeper reflexive practices concerning the phenomenon and, in many cases, to make changes to their practice based on their emerging understandings of the phenomenon. Table 4.2 provides a summary of the three interviews, place of interviews, and the time involved. The names are the pseudonyms participants chose themselves.
Table 4.2
Participant interview details

<table>
<thead>
<tr>
<th>Participant pseudonym</th>
<th>Interview #1</th>
<th>Interview #2</th>
<th>Interview #3</th>
<th>Total interview hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anne</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>4.5 hours</td>
</tr>
<tr>
<td></td>
<td>Workplace</td>
<td>Workplace</td>
<td>Workplace</td>
<td></td>
</tr>
<tr>
<td>Elizabeth</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>4.5 hours</td>
</tr>
<tr>
<td></td>
<td>Workplace</td>
<td>Workplace</td>
<td>Workplace</td>
<td></td>
</tr>
<tr>
<td>Emily</td>
<td>2.5 hours</td>
<td>2 hours</td>
<td>2 hours</td>
<td>6.5 hours</td>
</tr>
<tr>
<td></td>
<td>Workplace</td>
<td>Skype</td>
<td>Skype</td>
<td></td>
</tr>
<tr>
<td>Josephine</td>
<td>2.25 hours</td>
<td>1.75 hours</td>
<td>1.5 hours</td>
<td>5.5 hours</td>
</tr>
<tr>
<td></td>
<td>Workplace</td>
<td>Skype</td>
<td>Skype</td>
<td></td>
</tr>
<tr>
<td>Louise</td>
<td>1.75 hours</td>
<td>1.75 hours</td>
<td>1.5 hours</td>
<td>5 hours</td>
</tr>
<tr>
<td></td>
<td>Workplace</td>
<td>Skype</td>
<td>Workplace</td>
<td></td>
</tr>
<tr>
<td>Luisa</td>
<td>1.75 hours</td>
<td>1.5 hours</td>
<td>1.25 hours</td>
<td>4.5 hours</td>
</tr>
<tr>
<td></td>
<td>Workplace</td>
<td>Workplace</td>
<td>Workplace</td>
<td></td>
</tr>
<tr>
<td>Tammy</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>1.5 hours</td>
<td>4.5 hours</td>
</tr>
<tr>
<td></td>
<td>Workplace</td>
<td>Workplace</td>
<td>Workplace</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total: 35 hours</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sample size**

Although many qualitative approaches use saturation as a guide in terms of sample size for interviews, that is, stopping when the data is not saying anything new (Ezzy, 2002), hermeneutic approaches do not recognise saturation as an objective as the hermeneutic spiral always reveals something new. Smith and Osborne (2008) argue that in interpretive qualitative studies sample size depends largely on the richness of data, which can be obtained from a single participant, a few, half a dozen, or more. As depicted in Table 4.2, I conducted three interviews with each participant, which resulted in 4.5–6.5 hours of interview dialogues with each participant, totalling 35 hours of in-depth interviewing. I stopped recruiting at seven participants due to the richness and depth of the information I had collected at this point.
**Critiquing my interview style**

I used the transcription of my first participant interview as an opportunity to critique my interview style. Although I considered myself an experienced therapeutic interviewer, and that “there are not necessarily hard-and-fast distinctions” between therapeutic interviews and researcher interviews (Kvale & Brinkmann, 2009, p. 2), I was mindful that “classic mistakes” can still be made (Pezalla, Pettigrew, & Miller-Day, 2012, p. 181), and therefore determined it was important that I critique my research interview style. After transcribing my first interview and listening and re-listening to it, I identified two main issues to be mindful of and, where possible, to avoid in subsequent interviews. The first issue I identified was interrupting the participant and not allowing sufficient time between pauses (that is, asking the next question too quickly). The second issue I identified was occasionally using theoretical jargon associated with practice theory and hermeneutics literature that participants were not familiar with but that had slipped into my vocabulary because of the literature I was immersing myself in around the time when I conducted the interview. In other words, I was transplanting language from my academic field, which was not familiar to participants, into the CMHPT counselling field.

**Interview transcription**

I personally transcribed all the interviews verbatim. I re-listened to each interview several times to ensure the accuracy of my transcriptions. On the one hand this process was time consuming; on the other hand, it allowed me to immerse myself in the texts for prolonged periods of time, which in turn facilitated a deeper, enhanced understanding of my research phenomenon. My prolonged engagement with my participants and the subsequent transcribing of all the interviews myself also assisted in strengthening the credibility of my study (Thomas & Magilvy, 2011). I transcribed all interviews immediately after conducting them. This resulted in a few unexpected benefits. It facilitated me carrying my participants’ voices into other participants’ interviews. That is, on occasion, when discussing challenges and positive experiences associated with working with parents, I would bring other participants’ experiences of the phenomenon into my discussion with the participant and ask whether they could directly or indirectly relate. This resulted in an added dimension to our conversational partnership, where the conversation was not just between each participant and myself, but with other participants whose voices I would occasionally metaphorically channel.
to form a larger conversational space and partnership. Although I did not speak of other participants' experiences often, when I did, the response from participants was unanimously positive and they all made remarks that they felt relieved they were not the only ones facing various challenges in terms of working with parents. It seemed to give participants a sense of safety and permissiveness to disclose even more about their experiences and thoughts regarding working with parents. In this way, other participants' voices were used to facilitate an atmosphere of openness, deeper exploration, and reflexivity.

**Research journal**

I maintained a research journal throughout the interview and text construction process, which informed both my interview preparation (e.g., specific questions I wanted to ask participants in the following interview) as well as the text interpretation processes. My research journal included documenting my own imaginal products, which involved creating imaginal products of my impressions of an interview or some other aspect of the research process. The use of visual expression to accompany my written notes assisted in the articulation of my thoughts and exploring aspects of the research process from different perspectives. Appendix F is an extract from my research journal, which illustrates this process.

**4.5.5 Text interpretation**

In the design of my text interpretation, I incorporated and adapted aspects of Ricoeur's critical hermeneutics and Jung's active imagination approach to form four moments of interpretation in my Critical Imaginal Hermeneutic Spiral. I developed the spiral to guide my progressively deeper, more enhanced understanding of the phenomenon by revisiting and reintegrating different moments of understanding. In the tradition of critical hermeneutic interpretation where dialogue between the interpreter and text is central, and is characterised by the interpreter putting questions to the text (Prasad, 2002), I used the different moments to develop relevant text interpretation questions, to provide a focus for each of the three interviews with participants, and to structure the findings chapters in my thesis where each of the moments are presented. Table 4.3 provides a summary of my research design and includes how the four moments of the Critical Imaginal Hermeneutic Spiral correspond to my text construction strategies, text set questions, research questions, and text interpretation.
Table 4.3
Summary of research design

<table>
<thead>
<tr>
<th>Moment of understanding</th>
<th>Research questions</th>
<th>Text construction</th>
<th>Text interpretation questions</th>
<th>Text interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial understanding</td>
<td>How do CMHPT counsellors understand personal influences on their relational practices with parents? (sub-question)</td>
<td>Interview #1</td>
<td>What are participants’ initial understandings of the research phenomenon? What is the tone and mood that characterises participants’ initial understandings of the research phenomenon?</td>
<td>Chapter 5 – participants’ initial understandings of influences on their relational practices with parents</td>
</tr>
<tr>
<td>Deeper understanding</td>
<td>How do CMHPT counsellors understand sociocultural influences on their relational practices with parents? (sub-question)</td>
<td>Interview #2</td>
<td>What are participants’ deeper understandings of the phenomenon? What is the tone and mood that characterises participants’ deeper understandings of the research phenomenon?</td>
<td>Chapter 6 – participants’ and my co-constructed deeper understandings of influences on their relational practices with parents</td>
</tr>
<tr>
<td>Critical and imaginal distanciation</td>
<td>What is the nature of CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their relational practices with parents? (sub-question)</td>
<td>Interviews #2 and #3 and my imaginal product-making and sense-making process</td>
<td>What does the application of Bourdieusian and Jungian thinking tools reveal about the nature of participants’ critical reflexivity? Is there an aspect of participants’ shadow I have overlooked?</td>
<td>Chapter 7 – my distanciation of text sets using Bourdieusian and Jungian thinking tools; identification of participants’ and my shadow via my imaginal product-making and sense-making process</td>
</tr>
<tr>
<td>Imaginal appropriation</td>
<td>What is the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents? (main research question)</td>
<td>My imaginal product-making and sense-making process</td>
<td>What stands in front of the text? What does it refer to?</td>
<td>Chapter 8 – meta-synthesis of the three preceding moments using my imaginal product-making and sense-making process</td>
</tr>
</tbody>
</table>
Below I discuss the four moments I used to create my Critical Imaginal Hermeneutic Spiral and how I used them to guide my interpretation of the texts.

**Initial understanding moment**

The first moment of my Critical Imaginal Hermeneutic Spiral corresponds to the first moment of Ricoeur's critical hermeneutical spiral. I approached the texts with the broad question: *What are the participants' initial understandings of the research phenomenon?* Patton (2015) uses the metaphor of distinguishing a radio station signal from static noise to illustrate the process of text interpretation, highlighting how this process begins with the text construction process rather than simply the text interpretation stage. I extend this metaphor to include not simply what signals or patterns my text sets were emanating but also the tone and mood of the texts. I determined that tone and mood were important to explore as they would assist me to more fully interpret the *nature* of participants' understandings, not simply identify *what* they understood. This formed my second question to the text sets: *What is the tone and mood that characterises participants' initial understandings of the research phenomenon?* I began posing my questions to my texts following each participant interview, and I recorded the answers in my research journal. I continued posing the questions as I was transcribing my interviews (the text construction process), as well as when I immersed myself in my text sets by reading and rereading them to determine emerging patterns and themes (text interpretation process).

To determine patterns and themes emerging from my text sets, I applied the basic principles of the hermeneutic circle, which involves understanding the phenomenon by considering the parts in relation to the whole and the whole to the parts (Gadamer, 1975/2013). I began this process by reading and rereading the first interview transcript and coding each paragraph according to themes associated with the participant's initial understanding of the phenomenon. I engaged in the same process with the next participant's first interview transcript and looked for similarities and differences. I continued this process with all seven first interviews. I then distilled the central themes regarding participants' initial understandings of the research phenomenon. This involved reading parts (each participant's first interview transcript) and comparing the parts to other parts (other participants' first interview transcripts) and with the whole (all participants' first interviews). Participants' initial understandings of the influences shaping their relational practices with parents focused primarily on personal influences.
(in contrast to sociocultural influences) and are presented in the first of my findings chapters, Chapter 5.

**Deeper understanding moment**

For the second moment along my Critical Imaginal Hermeneutic Spiral, I incorporated a deeper understanding moment. This moment does not feature in Ricoeur’s approach. I incorporated this moment for two reasons. Firstly, given that critical hermeneutics is concerned with a progression to deeper understanding through the engagement and re-engagement of the hermeneutic spiral, going from initial understanding to structural understanding (distanciation) was too sudden and did not capture the moment of deeper understanding that followed and overlapped with the initial understanding moment. In this context, I use a depth metaphor to indicate progressively exploring hidden, unconscious influences on practices where an increased level of probing and reflexivity is needed. Secondly, I incorporated this moment to match the organic process of my interview dialogues with participants, whereby participants and I engaged in a distinctly co-constructed moment of understanding the research phenomenon that penetrated past participants’ initial understandings of the phenomenon.

For this moment of my text interpretation process, I approached the text with two questions: *What are participants’ deeper understandings of the research phenomenon?* and: *What is the tone and mood that characterises participants’ deeper understandings of the research phenomenon?* As with the previous moment, I posed these text questions in both the text construction and text interpretation stages and adopted the principles of the hermeneutic circle to determine the central patterns and themes. Participants’ deeper understanding of the phenomenon expanded past participants’ initial understandings (which were focused on personal influences) to one that encompassed understanding sociocultural influences shaping their relational practices with parents. That is, participants’ understandings moved from the micro (initial understanding) to the meso and macro (deeper understanding). Participants’ deeper understandings are presented in second of my findings chapters, Chapter 6.

**Critical and imaginal distanciation moment**

For the third moment along my Critical Imaginal Hermeneutic Spiral, I drew on Ricoeur’s distanciation moment, which incorporates a critical structural interpretation
of the text. For this moment of the text interpretation, I first drew on participants’ own distanciation which was featured in their imaginal sense-making processes. That is, I used participants’ imaginal distanciation as a springboard for my own distanciation interpretation of my text sets. My distanciation of the text sets involved application of the Bourdieusian and Jungian thinking tools (discussed in Chapter 3) to assist in the identification of underlying unconscious structures influencing participants’ relational practices with parents. For this moment of my text interpretation process, I approached the text with the question: *What does the application of Bourdieusian and Jungian thinking tools reveal about the nature of participants’ critical reflexivity?* I answered this question by reading and rereading the text sets with the Bourdieusian and Jungian thinking tools discussed in Chapter 3 in mind. I coded the text with the thinking tools as my categories and noted any overlaps. For instance, some parts of the text corresponded to both Bourdieusian and Jungian thinking tools. This process facilitated the identification of congruence between the thinking tools.

To strengthen the quality of my findings, I included an imaginal technique to determine whether there were any aspects of participants’ shadow I had overlooked due to the influence of my own unexplored shadow. In other words, I asked whether my own unconscious blind spots precluded me from identifying participants’ unconscious blind spots. To do this, I employed the Blind Image Card Technique, which is an imaginal technique I developed for use in CMHPT counselling and supervision with the purpose of engaging with the unconscious more directly. It is an imaginal technique that is particularly suited to asking the unconscious direct questions, and in turn engaging in a dialogue with it (Bologna, 2002). The word “blind” in the title of the technique is used to highlight that the image card is produced without looking and also refers to the technique revealing what our conscious mind cannot see or access. With regard to producing the image card without looking, this is achieved either by turning a set of image cards over so the images cannot be seen and then choosing a card randomly, or by randomly choosing a card from a set of image cards with closed eyes. Much like the hermeneutic approach of posing a question to a text, a question is first formulated before choosing the card. The question I posed before choosing my card was: *Is there an aspect of participants’ shadow I have overlooked?* Once the card was

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17 This technique is recommended for use with people who are accustomed to dialoging with the unconscious in a personified fashion and for this reason I did not use the technique with participants as I reasoned it may be too confronting or awkward for those not accustomed to this approach.
chosen, I unpacked it using the imaginal sense-making process described in Section 4.5.3. The technique is based on Jung’s free association method; however, rather than use a word and then freely associate other words that immediately come to mind, the free association is done with a pre-existing imaginal product (i.e., the image card). The technique is based on the premise that, by producing the imaginal product without involving our conscious mind (i.e., choosing it “blind”), we can engage in free association with the image without our conscious mind contaminating the process because we do not have a predetermined intention for what the image is about.

As I was a sole researcher, I engaged in the imaginal sense-making process on my own. I did this using the non-dominant hand writing method developed by Capacchione (2001). In this method, writing with the dominant hand is considered to connect to the conscious, verbal, analytical part of our psyche and writing with the non-dominant hand to the unconscious, nonverbal (visual/spatial), intuitive part of our psyche. I achieved dialoguing by taking a pen in my dominant right hand (conscious mind) and writing down a question I wanted to pose to the image. I then took the pen in my non-dominant left hand (unconscious mind) and wrote down my response to the question. This process of question-answer dialoguing with both hands can be a lengthy and engrossing process. I continued until I felt I achieved resonance with a response from my non-dominant hand that had not been part of my awareness prior to commencing the process. A section of this dialogue is presented in Chapter 7.

The distanciation moment revealed the nature of CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their relational practices with parents and is presented in the third of my findings chapters, Chapter 7.

**Imaginal appropriation moment**

The fourth moment along the Critical Imaginal Hermeneutic Spiral was guided by Ricoeur’s notion of appropriation, and involved determining what lies in front of the text, that is, not what the text is about, but what it refers to. This referential moment provided a meta-synthesis of the findings derived from the previous moments. To assist with this process, I engaged the unconscious by producing an imaginal product using the Blind Image Card Technique discussed previously. Before choosing the card, I posed the questions: What is in front of my text? What does it refer to? The appropriation moment assisted me in synthesising my findings from the previous moments and
developing my Critical Imaginal Reflexive Model, which I discuss in my concluding chapter, Chapter 8.

Figure 4.4 represents the four moments of my Critical Imaginal Hermeneutic Spiral and how each moment assists in getting closer to the essence of the research phenomenon.

![Figure 4.4](image)

*Figure 4.4. Moments of understanding in the Critical Imaginal Hermeneutic Spiral.*

### 4.5.6 Quality considerations for text interpretation

The main criteria of quality I considered pertaining to my text interpretation were transparency and credibility. Transparency involved including participants' voices in rich, meaningful ways. I did this by providing ample portions of their dialogue (via direct quotations) and, where relevant, the dialogue between participants and myself to demonstrate how I facilitated the interviews. Transparency also involved providing representations of participants' imaginal products accompanied by the associated dialogue between participants and myself in terms of the imaginal sense-making.
process. Additionally, I was mindful to highlight and differentiate when I discussed participants’ understandings of the phenomenon of relational practices with parents, and when I discussed my understanding of participants’ understandings. Smith and Osborne (2008) refer to this as a double hermeneutic. In discussing my text interpretation, I was also mindful of presenting both common themes emerging across participants (across interview texts) as well as distinctive, idiosyncratic interpretations made by specific participants. I did this to provide richness and depth in interpreting my text sets and understanding my research phenomenon.

The transparency of providing participants’ voices via verbatim quotations also enhanced the credibility of my research in that their perspectives were authentically presented (Fossey, Harvey, McDermott, & Davidson, 2002). I did this at the three stages of my interpretation process before arriving at my appropriation moment. That is, participants’ voices were represented in detail and depth in the initial understanding, deeper understanding, and critical and imaginal distanciation moments of interpretation, which I discuss in my findings chapters 5, 6, and 7 respectively.

4.6 Overall quality considerations

Rigour in qualitative research has been hotly debated for over 50 years and has gone through various phases that focus on different conceptualisations and aspects of rigour (Morse, 2018). I concur with recent developments and arguments in qualitative research that a study’s rigour is not confined to discussions or declarations regarding the study’s methodological rigour, but begins at the inception of the research with the research topic and continues throughout to focus on the appraisal of the completed research (e.g., Denzin & Lincoln, 2018; Morse, 2018; Tracy, 2010). Denzin and Lincoln (2018) refer to this as “a focus on ‘webs of relationships’ with the researcher as bricoleur” (p. 760).

In Chapter 1 I discussed the hybrid, bricolage sensibility that guided the overall quality and rigour of my research through all aspects of my study to achieve congruence within and among the different disciplines, theories, paradigms, and methods I drew from. In this chapter, I have discussed how I achieved congruence by aligning my research aim, research questions, paradigmatic assumptions, research approach, and research design. I did this mostly by ensuring each of these elements of my research
included both the social constructivist and critical focus of my research, and that the theorists I drew from facilitated a dialectical interplay between conscious and unconscious influences.
5.1 Introduction to findings chapters

This chapter is the first of four findings chapters. The findings were guided by the four moments of my Critical Imaginal Hermeneutic Spiral: (1) initial understanding, (2) deeper understanding, (3) critical and imaginal distanciation, and (4) imaginal appropriation. The focus of this chapter, the first of the findings chapters, is the sub-question: *How do CMHPT counsellors understand personal influences on their relational practices with parents?* Although answering this sub-question includes outlining what personal influences counsellors understand to shape their relational practices, it also involves highlighting key features of how participants’ understandings were formed. This captures the sentiment of Epictetus’ quotation in that I emphasise that the influences identified are a function of participants’ interpretation of their experiences rather than the experiences as reified entities. I begin this chapter by first outlining participants’ conceptual understandings of relational phenomena such as *parent–counsellor relationship* and *relational practices* as this forms part of participants’ initial understandings. I then discuss the various personal influences participants understood influenced their practices with parents, and the general nature of participants’ understandings of these influences. Participants’ initial understandings of influences on their relational practices with parents were garnered primarily from my first interview with them, and involved minimal probing from me.

In Chapter 6, I answer the sub-question: *How do CMHPT counsellors understand sociocultural influences on their relational practices with parents?* This chapter highlights how participants’ understandings of the research phenomenon evolved and deepened through the process of the interviewing, that is, moving from initial understanding to deeper understanding as a co-constructed knowledge process with me, the interviewer.
As such, this chapter discusses a deeper layer of participants’ understandings of the research phenomenon.

In Chapter 7, I answer the sub-question: *What is the nature of CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their relational practices with parents?* Chapter 7 breaks from the symbiosis between participants’ and my understandings to present findings from my structural interpretation of the text sets as per the critical and imaginal distanciation moment of my Critical Imaginal Hermeneutic Spiral. This involves discussing my understanding of the nature of participants’ reflexivity regarding unconscious structural influences on their relational practices with parents, which I developed by applying the Bourdieusian and Jungian thinking tools to the text sets. Thus, the process of participants moving from initial understanding to deeper understanding of the phenomenon informed my own process of more deeply and critically understanding the research phenomenon.

In Chapter 8, my concluding chapter, I present my imaginal appropriation of the different moments of text interpretation. This includes addressing the main research question: *What is the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents?* Metaphorically, my findings chapters and concluding chapter depict the understanding process between participants and myself as a double helix that commenced at separate points of initial understanding then became tightly bound together through the process of in-depth interviewing and eventually pulled apart in the distanciation and appropriation moments of text interpretation.

5.2 Conceptual understandings of relational phenomena

In this section, I discuss participants’ conceptual understandings of relational phenomena that formed the basis of their initial understandings of the influences on their relational practices with parents. These included participants’ conceptualisation of who their client is, their conceptualisation of the child–counsellor relationship and the parent–counsellor relationship, and how they conceptualise relational practices.
5.2.1 Child as client and parent as stakeholder

Most participants’ initial understandings involved conceptualising the child as their primary client (rather than the parent or the family) and conceptualising the parent as a primary stakeholder. Although participants involved the parent in varying degrees throughout the child’s counselling treatment (e.g., via intake sessions, review sessions, phone calls, and email contact), they primarily delivered the counselling service to the child rather than to the child’s parent or family. Five of the seven participants stated that if they identified that a parent had their own mental health issues to address, they referred or suggested that the parent see a separate (other) counsellor. Two of the seven participants offered to provide individual counselling to the parent if it emerged in the intake stage (before seeing the child) that the parent would benefit from this. However, if it emerged that the parent would benefit from their own counselling once the participant had already commenced seeing the child, the participants referred the parent to a separate counsellor to emphasise that counselling for the child and parent were separate, confidential processes. Participants identified that their conceptualisation of the child as client stemmed mostly from a child-focused framework that they used to inform their practices.

Regardless of their theoretical orientation, all participants stressed the importance of delivering counselling to children individually but working in a systemic way. Thus, although participants identified the child as the client, they still considered the child as part of various social systems, including the child’s family, and identified the need to engage with these different systems to advocate for the child’s needs. Tammy captured the sentiment of most participants regarding the need to provide children with one-on-one counselling where appropriate while still working systemically:

I work individually with the child but still work systemically . . . that’s a big part of the intake process, is understanding the system that the child’s in . . . as long as I’ve been able to highlight what the child’s needs or unmet needs are, and the family has a good understanding of that, I don’t need to see them all to work effectively . . . I think it’s often really nice for the child to have one-on-one counselling. They really, really benefit from that, that special relationship . . . I can still advocate with the family and their needs without working [directly] with the whole family. (Tammy)\(^\text{18}\)

\(^{18}\) Where participants’ direct quotations have been edited, an ellipsis has been used to indicate omission of a section of dialogue without altering its original meaning.
The nature and conceptualisation of working systemically differed among participants. Some participants considered that their role was to highlight the various systemic needs of the child and subsequently recommend the child’s parent/s and other services (e.g., the child’s school, family support services, and the Department of Family and Community Services) get involved in meeting these needs. Some participants went beyond making recommendations by initiating and maintaining ongoing contact with the various social systems involved in the child’s life. This typically involved organising and attending regular case conferences to discuss the child’s needs, the child’s progress in counselling, and any obstacles to their progress. Thus, participants’ conceptualisations of working systemically involved varying degrees of contact with the child’s parents and other social systems, but this came from the position that parents and the various social systems were stakeholders rather than clients. That is, the therapeutic intervention was directed at the child, and the parent was one of many stakeholders.

5.2.2 The child–counsellor relationship versus the parent–counsellor relationship

All participants readily and clearly conceptualised their understanding of the child–counsellor relationship, which was overwhelming uniform in that they described it as a therapeutic relationship built on the principles of unconditional regard and emotional safety, and that they considered this was the foundation for instituting change in the client. Conversely, when discussing the parent–counsellor relationship, most participants paused and deliberated on what to name it and how to conceptualise it. This suggested that the parent–counsellor relationship was not at the forefront of participants’ practice focus and their primary relational focus was the child.

There was considerable variability in participants’ conceptualisation of the nature of their relationship with children’s parents. Mirroring the variance in the literature discussed in Chapter 2, participants used a range of different terms to name the parent–counsellor relationship, including: collaboration, connection, partnership, engagement, teamwork, and professional relationship. The following quotations capture the diversity of participants’ conceptualisations of the parent–counsellor relationship:
I think it’s a collaboration. You’re both working together towards the same goal and both need to be involved. Even though I can’t work with the parent, we can recommend them to do the parenting program we offer, read the books, and that is a collaboration. If they don’t do that, then what’s the point in you working with their child? And I do say that to them at the start of the assessment stage: “If we’re going to do this, we have to work together. I’m going to recommend stuff to you, to see your own counsellor, to do the parenting program, the books, but it’s up to you to do that” . . . Yeah. So collaboration. (Anne)

I have used the term with parents that I like to operate like a team: “It’s not just me telling you what to do or I have this wand and I figure it all out, we need to work together. I’m trusting that you have a greater insight, you’ll always have a greater awareness of your child than I would because you have that history.” What I guess I’ve learnt is that’s sometimes not the case, and that’s when it becomes difficult, because they don’t have a lot of insight into their child’s needs, but I’m still wanting to give them that message that we are a team. (Tammy)

One participant, Emily, stated that naming the relationship was dependent on the parent’s conceptualisation of the counsellor and counselling service, not simply the counsellor’s conceptualisation, and that it was also dependent on the parent’s readiness to contribute to the child’s counselling:

It is a collaboration and a partnership when you identify what the child’s needs are and you agree that’s what they are, and there are parents out there who will take things on . . . I do see it like a collaboration or partnership because they’re more receptive to your feedback to what’s going on, and they have the child’s best interests in mind, and even though it might bring up emotions for them, like they’re ready to accept it. But if it’s the type of parent that just wants to drop off their kid to be fixed, and doesn’t want to see anything, that they have anything to do with that, then I can’t call it a collaboration or partnership because really what they think it is, is that they want to hire me to change their child’s personality. (Emily)

Only one participant initially described it as a professional relationship:

I guess it’s a form of relationship, a professional relationship, because I see them as an extension of what you’re doing that needs to be carried through in their other 23 hours a day, 7 days a week . . . It’s almost like a colleague, almost. But not with the experience or [theoretical] models behind it . . . It’s not a therapeutic client relationship as such because I’m not working with them on their personal
stuf, yeah. Yeah, it’s that professional connection of “trust me so I can show you how to perhaps do it differently”. (Louise)

Despite using terms that suggested mutuality and reciprocity (e.g., collaboration, team, partnership, connection), underlying participants’ conceptualisations of the parent–counsellor relationship was the expectation that parents largely accept the counsellor’s expertise by agreeing to their goals and recommendations. Thus, unlike the child–counsellor relationship, which participants conceptualised as based fundamentally on unconditional regard, the parent–counsellor relationship was based on notions (albeit subtle) of conditional regard.

5.2.3 CMHPT counsellors’ relational practices

None of the participants used the term relational practices. Rather, they referred to “strategies”, “activities”, and “approaches” they used with parents as ways of building the parent–counsellor relationship. Participants understood that most of their relational practices with parents took place at a conscious level in that they were deliberately performed at a particular time, in a particular order, and in a particular place and space. The typical sequence of practices discussed by participants were:

1. Initial phone call with the referring parent.
2. Sending an information package to the parent outlining key features of their CMHPT counselling service (five of the seven participants sent written packages prior to meeting with parents face-to-face).
3. Initial parent meeting (also referred to as an intake session, initial parent consultation, or planning meeting).
4. Once the counsellor commences seeing the child for counselling, contact with the parent takes place mostly over the phone rather than via face-to-face discussions.
5. Review session with the parent without the child present (also referred to as review meeting or parent consultation), which takes place after the counsellor has seen the child for a handful of sessions (this varied amongst participants and ranged from 2 to 6 sessions after seeing the child).

Note: Steps 4 and 5 continue until the CMHPT counsellor deems the child no longer requires treatment.
I refer to these individual steps as practice episodes which make up a practice series. Each practice episode is fleshed out by practices and idiosyncrasies of individual CMHPT counsellors. For example, within each practice episode, participants described various strategies, activities, and approaches they enacted with parents to build the parent–counsellor relationship. Participants explained that their main goal was to have the parent allow the child to complete a full series of counselling sessions. Most participants discussed how they constantly trialled, fine-tuned, and continued to tweak their various relational practices with parents in an attempt to keep the parent engaged in the process, and in turn maximise the likelihood that the child would complete their treatment.

5.3 Personal influences on relational practices

Participants identified six main personal influences on their relational practices with parents. Four of the six influences stemmed from participants' understandings of parents' conceptualisations and actions, and two from the counsellors' practices: (1) parents' conceptualisations of mental health, counselling, and the counsellor's role, (2) parents' responses to the counsellor's boundary setting, (3) parents' willingness to change themselves, (4) parents' conceptualisations of child and parent, (5) the counsellor's emotional health, and (6) the counsellor's psychic health.

5.3.1 Understandings of parents’ conceptualisations of mental health, counselling, and the counsellor's role

All participants highlighted how the most challenging parents they worked with had a different conceptualisation of mental health, counselling, and the counsellor's role to their own conceptualisation. Five main facets of this conceptualisation were identified: (1) the cause of mental health issues, (2) the parent seeing themselves as the primary client rather than the child, (3) the parent expecting the child's mental health issues to be addressed in a significantly shorter time frame than the counsellor expects, (4) the parent expecting the counsellor to provide court support, and (5) the parent expecting the counsellor to focus on instructing the child rather than building a therapeutic relationship based on unconditional regard. I first discuss details of how participants understood parents' conceptualisations and then at the end of the section discuss how parents' conceptualisations influenced participants' relational practices.
Cause of mental health issues

Participants observed that many parents they found challenging to work with had a very different conceptualisation of the cause of mental health issues than their own. Participants stated that many parents considered their child’s mental health issues were based on the child’s personality and/or a biological predisposition, and that parents often did not consider the association between external influences such as significant events in the child’s life and the child’s ensuing mental health issues. For instance, Anne provided an example of an adoptive mother who did not consider (or want to consider) that her child’s mental health issues were connected to the child’s unexplored grief and loss regarding her biological mother who had died:

_The child’s [biological] mum was a heroin addict and ice addict and had passed away. She was pregnant with the child while she was using too. She died of a drug overdose and then the child was adopted by this woman who didn’t ever want to talk about the biological mum . . . When I was doing the play therapy sessions with the child, she used needles a lot in her sandplay and it was all there in her play, there were a lot of themes relating to her [biological] mum . . . she wanted to work through the stuff about her [biological] mum. So when I fed back to this woman [the adoptive mother] what I felt the issues were really about, she had a meltdown. She started getting really quite angry: “Oh, that’s got nothing to do with it, that can’t be affecting her, no, no, no . . . the birth mum’s dead, she didn’t even get to know her.” (Anne)_

Conversely, participants discussed that many parents expected the counsellor’s role was to assist with managing their child’s symptoms via a behavioural management approach, rather than assessing and addressing the primary issue driving the symptoms. This contrasted strongly with participants’ conceptualisations of mental health issues as most participants believed that children’s mental health issues often stem from unresolved trauma or attachment issues. Almost all participants stated that the mental health issues of the children they saw primarily stemmed from trauma or attachment issues deriving from their immediate family, rather than extraneous events or people. Although some participants stated they did occasionally see children who suffered trauma resulting from abuse from a non-family member, the overwhelming

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19 Participants broadly defined trauma to include sexual, physical, and psychological abuse, as well as neglect, abandonment, or sudden loss of a loved one. Attachment issues were defined to include disruption of the child’s early emotional attachment to their primary carer (typically their biological mother). The origin of attachment issues participants commonly cited in the children they saw for CMHPT counselling were issues associated with adoption, foster care, the parent’s own mental health issues when the child was an infant, and abuse from either parent.
The discrepancy between conceptualisations of mental health issues based on personality and/or a biological predisposition versus a trauma or attachment model posed significant challenges for most participants. The main challenge was that parents expected the counsellor to focus on reducing their child’s symptoms and participants typically focused on addressing the primary issue they considered was driving the child’s symptoms. Participants identified how focusing on the primary issue posed two main challenges. Firstly, it required more time before seeing positive outcomes compared to addressing the presenting symptoms. Secondly, because participants assessed that the primary issue was almost always related to the parent in some way, a diagnosis or formulation highlighting the parent’s role in the child’s mental health issues could be challenging and threatening to the parent.

**Parent as client versus child as client**

The participants explained that the parents they found least challenging understood that treatment success was founded on the quality of the client (child)–counsellor relationship, and that this needed time to develop in a safe, confidential environment. Participants observed that these parents respected and trusted the counsellor’s professional judgement about the direction the treatment needed to go in. Participants recounted how parents who did not share this conceptualisation expected the counsellor to adopt a parent-focused approach where they were the primary client or customer rather than the child, and, as such, these parents expected to be able to instruct the counsellor how to provide counselling to their child. Emily used an analogy of painting a house to illustrate this parent expectation:

*They think they’re the client so it’s like if they hire somebody to paint their house, they’re the client, they get to choose which colour the house is, not the other way around. The house isn’t paying, maybe that’s how they see their child. Like, “I’m paying you to do what I want you to do and I get to choose the colour, not the child and not you”.* (Emily)

Tammy expressed a similar sentiment in that, despite explaining to parents at the intake interview what her approach involved, and that she would not necessarily be
focusing on the child’s presenting issues, but rather the primary issues driving the present issues, some of the parents she found the most challenging to work with tried to dictate to her what she should be doing in the counselling sessions:

So even though I’ve explained how I work, they’ll still focus on the presenting issue: “I really think they [the child] needs to get better at sleeping in their own bed. Can you talk about that today?” . . . They keep trying to direct how I work. (Tammy)

Additionally, Tammy highlighted that she was more easily able to build relationships with parents who understood that the child needed to be seen separately to their parent, so that Tammy could build the therapeutic relationship with the child. This contrasted with parents who expected her to see the child with them in the room:

I even had a parent interestingly enough say to me: “Please tell me you do see the child” and I said: “What do you mean?” and she said: “My child’s previous psychologist would talk to her for 10 minutes but the whole time it was with me, and I don’t think that’s what my child really needs”. . . So it was the mother saying: “I think she needs her own space, her own special space.” . . . So I think when the parents really respect that way of working, and they get it, I think that makes my life a lot easier. Even when the child is still difficult, even when they’re not progressing as quickly as everyone else would like them to, the parent is still valuing my relationship with the child as the foundation, as one of the most critical things. (Tammy)

The “quick fix” versus developing the child–counsellor relationship

All participants highlighted that many of the difficult experiences they had had with parents involved the parents’ expectation of a quick fix, rather than understanding that counselling is a process that often requires considerable time, as change is based on developing the child–counsellor relationship (rather than simply administering techniques), and based on the parent making fundamental changes as well. Participants identified that many parents they found challenging to work with expected their child’s issues to be improved in about 2–3 sessions and, if they were not, they would drop out. Participants described how, despite spending a considerable amount of time in the initial meeting with the parent, explaining what progress looks like and the amount of time it would likely take, parents would still drop out if they did not see the results they expected:
It still ASTONISHES me, even when I have the conversation on the phone and intake, you know, about how these things take time, because oftentimes people will refer at a kind of crisis-y point, where these things have been going on for so long and they’re finally at their wits end, and so they kind of want a miracle. You can sense the desperation on the phone. So I always have to check in with them and say: “You know, these are going to be the steps, and the first step is to come in for the parent meeting so we can talk about it and we might have one or two of those, and then if we decide to proceed and I see the child, then we won’t be seeing any changes, like the beginning of the term is going to be all about the assessment and what’s going on and then feeding that back to you so we can then work out the goals and things like that”, and then I explain that AGAIN at the parent review, but it still astonishes me even when I lay it out like that, the number of parents who will just take their kids out after 4–6 sessions if they don’t see a change. (Emily)

Most participants argued that they deemed the parents’ expectations of a quick fix to be unreasonable and unrealistic given the nature of most children’s mental health issues and considering that parents typically bring their child for counselling when the issues have been prolonged and have reached crisis, rather than when the issues first appear. Most participants highlighted that many of their positive experiences with parents involved parents who had had or continued to have their own counselling, and understood that counselling took time and was contingent upon the quality of the client–counsellor relationship. Participants interpreted this as parents knowing what was required in terms of counselling for their child:

She also did her own work previous . . . Long time before but knew counselling. Knew what it was. Had a positive experience from a pretty good counsellor by the sounds of things and understood what needed to happen. (Louise)

Counsellor as report writer for courts versus counsellor as therapeutic agent

Five of the seven participants observed that the intention of a significant number of parents in bringing their child to counselling was not to treat the child’s mental health issues, but rather they wanted to use the counsellor in a current or upcoming child custody case in the Family Law Court. This typically involved parents wanting the counsellor to write a court report in their favour. Participants stressed this was almost always in a covert manner:
I’ve NEVER had a parent ask me: “Do you do court reports? Would you be able to provide this information?” They NEVER say that, they just speak to you on the phone and they hope they can just rope you into it. (Emily)

Luisa provided an example of what she considered was a mother’s hidden agenda, in that the mother intended to use Luisa’s services in an upcoming custody dispute but did not reveal this when first presenting her child for counselling:

I had made that black and white from the beginning. I was very, very clear with her that I did not do court reports, that you know, he [the child] was coming to see me just for therapy. We were really, really clear on that but nevertheless: “Yes, yes, yes”, she said, “yes, yes, yes, that’s fine”. But nevertheless . . . in the end she wanted me to go to court . . . she wanted to, you know, use my knowledge of him to build her case . . . she still always wanted me to get him to talk to me about what had happened, things his dad had done, or all that kind of thing. She wanted him to talk, to talk to me about it, whereas he didn’t want to talk about. In fact, one time he said: “I don’t want to talk about it, I’ve talked about it three times already, I don’t want to talk about it again!” [Laughs]. Like he really wanted to play . . . he acted it out and that was great for him and that’s all he needed to do. (Luisa)

Elizabeth spoke about a father who was not initially involved in his child’s counselling as his ex-wife had organised the counselling, but nonetheless he approached Elizabeth on several occasions trying to persuade Elizabeth to side with him regarding an upcoming custody hearing. Elizabeth recounted how she informed the father this was not her role, which frustrated him and at one point he became aggressive toward Elizabeth:

He yelled at me: “I WANT YOU TO RECOMMEND THAT SHE LIVES WITH ME!!!”
(Elizabeth)

For some participants, the covert nature of some parents’ agenda regarding using counselling for court matters elicited frustration, suspicion, and mistrust in them as they interpreted the action as deceitful, particularly when they had spent time and effort stipulating that this was not part of their role. The impact this had on participants’ practices typically manifested in participants becoming more suspicious about parents’ potential hidden motives and more interrogative in their questioning when they first met parents:
And they haven’t been truthful with you so I think, ‘cause that’s happened to me a few times, yeah, I had that in the back of my mind all of the time: “Are they telling the truth? Is this parent giving me the real story?” You know, I try to trust them as much as I can but you can sort of, yeah, it’s a murky, anxiety sort of feeling around that. So now, after these experiences I have had with parents, I’m really quite vigilant when I get into those questions in assessment [initial parent meeting], and I actually go into the marriage, you know, I usually do. But some of them, the ones that did that to me weren’t telling me the truth, which has made me more vigilant now to find out more around that question. (Anne)

Counsellor as instructor versus counsellor as unconditional therapeutic agent

Most participants discussed experiences with parents who expected them to instruct their child how to behave in a certain way, rather than seeing the counsellor as a therapeutic agent, where the therapeutic relationship with the child was the agent of change. Tammy spoke about how some parents expected her to “put the child to work more” and therefore did not expect the child to enjoy counselling:

If they’re not seeing progress in terms of their own goals, and they’re seeing their child almost be rewarded, a few of them have said: “I almost feel like I’m rewarding their behaviour by coming to you”. That I guess for me would be a reason for it [dropping out], I think I would say. (Tammy)

Similarly, all participants commented that the overwhelming majority of children took to CMHPT counselling like the proverbial ducks to water, and this was not always met positively by all parents, particularly those feeling insecure about their parenting. Tammy shared this sentiment:

My relationship with the parents becomes more strained as a result of my relationship with the child. Especially if I maintain my very, very, strong healthy working alliance with the child, and the parents are unable I think to try to match it, or they think that’s what they should be doing, and they can’t, and then they start to see me almost as an enemy or a threat. (Tammy)

Most participants expressed their frustration with parents’ unwillingness to change their conceptualisations of mental health, counselling, and the counsellor’s role to be more congruent with their own. Consequently, participants discussed that they felt that much of their time with parents was used to explain and re-explain their stance on mental health, the fundamentals of counselling, and the counsellor’s role in an attempt to persuade parents to understand and accept their way of working. In these cases,
participants described their practices with parents as primarily “psycho-education” in nature, that is, the focus of their time and energy with parents was to educate parents about their approach to mental health, counselling, and the counsellor’s role and that this was a repeated exercise rather than once only. Over time, due to repeated issues with parents’ conceptualisations, participants explained how their relational practices took on more of an instructive quality as opposed to a predominantly genial one. For example, some participants described how they increasingly adopted practices which served to identify and cull parents who were not prepared to accept their way of working. Most participants explained that they tried to implement these practices before seeing the child, to minimise the child entering the service and forming an attachment to the counsellor only to be prematurely pulled out of treatment by their parent. Several participants spoke about how, over time, they became firmer in both their written communication (e.g., information packages) and verbal communication when meeting with parents, in an attempt to be clear about the nature and conditions of their services. For example, Josephine described how her information packages that introduced her and her services, and that were sent to parents when they first contacted her, had evolved to be more stern than her earlier versions. Josephine explained that she changed her information packages in this way due to her challenging experiences with parents over time, and her wish to minimise working with parents who did not accept her way of working:

*You should see my packages, Rosa. My first packages were really nice, and now they’re like: “you MUST do this, you WILL NOT . . .” [laughs].* (Josephine)

Conversely, most participants identified that they found parents who had been counselling clients themselves were the least challenging as their conceptualisation of mental health, counselling, and the counsellor’s role was congruent with their own. Participants discussed how they felt more relaxed when interacting with these parents (as opposed to anxious and frustrated) and were generally more genial in their approach with them, which participants felt strengthened the parent–counsellor relationship.
5.3.2 Understandings of parents’ responses to counsellor’s boundary setting

Related to participants’ understandings of parents’ conceptualisations and expectations of counselling and the counsellor is how participants understood parents responded to the counsellor’s counselling policies and procedures. This included how participants expected and requested parents behave, particularly in terms of the nature of contact between them. Participants identified three main issues they encountered frequently with parents regarding setting boundaries: (1) parents speaking about the child in front of the child, (2) parents not remaining in the waiting room and/or on the premises while the child was in session, and (3) parents contacting the counsellor outside scheduled times.

Parents speaking about the child in front of the child

Six of the seven participants had a policy of not giving the parent feedback and discussing any issues pertaining to the child in front of the child. Rather, discussions with the parent typically took place via phone calls after the child’s counselling session (either on the same day or the next business day), and in parent review meetings scheduled on a different day to the child’s counselling (without the child being present). Participants stressed that, despite explaining their contact policy and procedures to parents in their information packages and again at the initial parent meeting, many parents ignore this and ask the counsellor a range of questions in front of the child, and often in front of others in the waiting room. Participants described how they would then take an instructive role with the parent in reminding them of their policy regarding speaking in front of children. Anne described this sentiment:

Some of them start discussing their separation or their court cases and other things, and we have to shut them down really quickly and say: “We can’t talk about that here”, and “not in front of the children”, and then we have to call them afterwards and remind them they can’t do that, so it is very child-centred and we protect that child . . . The parent will be good for a couple of weeks and then it’s all out the window again. (Anne)

Luisa was the one participant who did speak to parents in front of the child when she worked as a private practitioner a few years prior. Luisa highlighted that she was early in her career in terms of CMHPT counselling and found maintaining boundaries very difficult with some parents, and therefore with some parents she would concede
to their request to speak to her for a few minutes after the child’s session had ended. However, Luisa found that speaking to parents directly after the child’s counselling session impacted negatively on her relationship with the child as the child often felt they could not trust her to maintain confidentiality:

*Because she [the mother] would try and spend more time with me talking about it, and I would have to keep restating that she had to leave, but I think that her little boy couldn’t trust me completely . . . he didn’t know if he could completely trust me because I talked to his mum so much. (Luisa)*

Additionally, Luisa reflected that a few minutes never seemed to be enough for many parents so, invariably, she found herself trying to get parents to leave so she would not be late for her next appointment. This experience was echoed by other participants who described frequently feeling anxious and frustrated when parents repeatedly disregarded their policy about not speaking about the child in front of the child, and having to constantly set boundaries with parents. Participants felt this undermined their capacity to adopt a more relaxed and warmer demeanour with parents, which they felt was important in building the parent–counsellor relationship.

**Parents not remaining in the waiting room or on the premises**

Most participants talked about having a policy requesting that parents remain in the waiting room or on the premises while their child was in their counselling session. The two main reasons for this policy were in case the counsellor needed to end the session due to the child’s safety, and to ensure the child was picked up on time and not left waiting for their parents. Despite this policy, most participants discussed encountering situations where the parent was not in the waiting room and not on the premises, therefore leaving the counsellor waiting with the child until the parent arrived. These situations typically left participants feeling angry and frustrated with the parent and anxious about being late for their next appointment. Anne talked about an incident where she had finished a session with a child and the father was not there to pick the child up. The child was the last client for the day and Anne was there on her own, so there was no receptionist to assist with the situation. Anne attempted to call the father several times but he did not answer his phone. Anne described herself being forced into the role of babysitter, minding the child until the father returned:
I was FUMING [laughs]. He was about 25 minutes late . . . he was really, you know, as if it doesn’t really matter, and I said: “Well look, I really need parents to be sitting in the waiting room when I come out with the client”. He knew I was quite irritated about it . . . so yeah, they’ve just got to remember that it’s not about them, you know. They think we’re a babysitting service, we’re not a babysitting service. It’s therapy. The child needs their parent there when they walk out of the session. Parents just have to get that, you know. So yeah, just trying to get through to these parents . . . some think they’re just dropping them off for a play date . . . He’s not taking it seriously to me. He’s not taking it seriously . . . And you can see how frustrated I get when I’m talking about it [laughs]. It was so frustrating. (Anne)

Luisa described a similar situation where a parent was late picking up her son and indifferent to the anxiety it had caused the child and inconvenience it caused Luisa:

She was a little bit late a couple of times. Once she was quite a bit late, about 15 minutes and he [the child] was beside himself, and I was ringing her and she wasn’t answering, and she finally came, and she never really apologised for that, and I said: “Do you realise how worried about you he was? He just didn’t know what was happening, he was really quite frightened”, and she could care less. (Luisa)

Parents contacting the counsellor outside scheduled times

Several participants discussed that many parents attempted to contact them after hours or outside scheduled appointment times as a response to a crisis that did not always involve their child, that is, sometimes it concerned their own mental health issues. For example, Anne cited that she experienced a dropout directly after setting boundaries with a parent regarding contacting her outside scheduled times:

She came in here and she just had a meltdown and that’s OK. I was here, I kept her safe and all that sort of stuff, but at that same time, she wanted me to help her as well, and this is when the dropout happened because I wasn’t going to help her . . . I’m only here two days a week. I’d come back to all these phone calls during the week, and all the other therapists were even saying to her: “You can’t, Anne’s only here to look after your daughter. You’re going to have to get your own therapist”, and that’s when the dropout happened. She obviously thought: “Well, they’re not going to look after me”, so she pulled her daughter out. (Anne)

Josephine described an example of one mother who felt disappointed and abandoned after Josephine did not provide court support for her at a court hearing.
involving her daughter being sexually assaulted by a teacher at school. When Josephine stated it was outside her counselling role to provide court support, the mother pulled her child out of counselling:

So when I then had to say to mum: “Look, I can’t do this, I do not have the resources to spend a day at the court house, you know, I can’t do this”. Then I became a part of that system that wasn’t helping her, and up until then it was going quite well . . . and it’s quite sad in a way because she built trust with me and then I could only take her so far, and when I said “no”, that just undid everything. I think that for her, it was very significant to have another person let her down. Which is I’d say was the way she would have seen it. (Josephine)

All participants recounted how they needed to constantly reiterate, remind, and reinforce boundaries with parents, and how frustrating and draining they found this. This was cited by most participants as an influence on their relational practices, and in turn an influence on the quality of the parent–counsellor relationship. Participants stated that they had little time, energy, or willingness to engage meaningfully with parents who constantly ignored their terms of practice. Additionally, participants noted that many of their dropout experiences with parents occurred directly after they had set boundaries regarding some aspect of their policies and procedures.

There was one notable participant anomaly regarding boundary setting with parents. Louise felt that boundary setting was an integral part of working with parents, and considered it an opportunity to role model the setting and maintaining of healthy boundaries. Louise believed this was beneficial to the parent and ultimately the child, as she felt many family issues were characterised by parents’ unhealthy boundaries. Although, like the other participants, Louise stated she found working with children was much more taxing on her time and resources than working with adults, she did not perceive boundary setting to be an undesirable aspect of working with parents, but rather an integral part of a counsellor’s role:

I think a lot of the time you’re role modelling to them what you’re role modelling to the child . . . I’m role modelling a lot of the time what boundaries look like . . . “This is what safety and protection looks like. This is what I’m talking about when I’m keeping your child safe. It is really hard, it’s exhausting, it’s tiring, and you know, emotionally intuned parenting is, it’s not easy, and it is going to be really confronting and challenging, and you’re going to hate people and
become defensive, and all the rest of it, but that’s also ok, because the child’s still protected." (Louise)

Louise also considered boundary setting as a way of building trust and safety with the parent in that it demonstrated she was a reliable person who followed through on what she said she would do. In other words, Louise saw healthy boundary setting as a way in which to develop the parent–counsellor relationship, rather than a challenge to it:

The intention is to build trust with parents, that I will follow through with what I’ve said . . . I think when I hear parents not respecting boundaries, I think, well, the therapist is not very good at putting them in place. Because my experience has been that parents will respond really well to boundaries as long as you’re very clear and transparent from the very beginning, and you just uphold them, you don’t move them for anyone . . . I don’t think I would be able to work as long as I have in this field if I had pretty loose ones. (Louise)

Louise’s conceptualisation of boundary setting with parents highlights that boundary violation, like other influences, is not an influence in and of itself, but rather it influences counsellors’ relational practices depending on how counsellors conceptualise and interpret it.

### 5.3.3 Understandings of parents’ willingness to change themselves

As discussed in Section 5.3.1, all participants cited that they considered that children’s presenting mental health issues overwhelmingly stemmed from issues originating with children’s parents and the family system. Participants identified that parents who were willing to reflect and work on changing aspects of themselves were less challenging to work with and assisted in the effectiveness and speed of the child’s treatment. Conversely, participants identified that parents who were not ready and willing to change aspects of themselves invariably undermined their child’s progress in counselling. Participants talked about a range of recommendations they made to parents regarding addressing their own issues; for example, undergoing their own personal counselling for mental health issues, participating in a parenting program, or engaging with parenting support services offered by other agencies. Emily provided an example of a parent’s willingness to change herself through Emily’s recommendation to have her own counselling, and how Emily viewed this as a positive influence on how she approached the parent:
I have to say that the parents I enjoy working with the most are really the ones that are willing to come in mostly for their own personal therapy, and they’re not insisting that I see [only] their child. So for example, I've been working with one woman on and off for three years, and she’s challenging, she doesn’t always see everything my way or agree with what I’m saying . . . she’s not a perfect parent, like you know, she still yells a lot at the kids and uses a lot of these parenting strategies that wouldn’t be good for the kids, or wouldn’t be good for her, but she WANTS to change . . . it’s the type of parent where you can bring it up with them and say: “Can you see how this might be affecting your parenting now?” So, it’s an openness, a willingness. A willingness to address their own stuff, to be a client themselves and have a desire to change. (Emily)

Tammy described a common scenario observed by most participants in which parents drop out when they receive the counsellor’s assessment of the child’s primary issues, and the counsellor’s recommendation that the parent makes changes to their parenting:

So putting it back onto the parent and actually wanting them to do something that doesn’t just require money and dropping off and picking up the child from counselling is beyond the scope of how they see their role. And I’m challenging how they see their role, so then they’re rejecting me . . . For me, the parent has to be really, really open to a level of criticism . . . Because I’m often communicating some things that they don’t really want to hear or they don’t want to process. And that can either strengthen the relationship I have with the parent in terms of what I’m advocating for, and doing everything I said I would do, or the relationship will start to deteriorate because of my feedback and recommendations. (Tammy)

Participants explained how the parent’s willingness to change aspects of themselves, which participants considered were adversely impacting on their child, determined whether the counsellor could work systemically. Participants stressed that, if the parent was not willing to change key aspects of themselves, the counselling outcomes would predictably be undermined, as the child was living in a family system that was not changing alongside them, and this invariably undermined the child’s progress. As with the previous influences discussed, participants highlighted how their typical response to the parent’s resistance was to spend most of their time and energy attempting to change the parent’s understanding of the situation to be more congruent with their own. The more participants spent energy and time in attempting to achieve this
objective, the more frustrated they became, which in turn undermined the more congenial aspects of their relational practices with parents.

5.3.4 Understandings of parents’ conceptualisations of child and parent

All participants highlighted that the parents they found particularly challenging to work with were those who had a different conceptualisation of child and parent to their own, particularly in terms of what the role of a child is in relation to their parents and vice versa. Conversely, participants observed that parents whom they had positive experiences with had similar conceptualisations of child and parent to their own. The conceptualisation of child and parent as relational constructs to one another were found on a continuum. At one end of the continuum were parents whom participants considered were child-focused and saw their children as unique individuals with unique needs (often different to that of their parents), and believed that the role of the parent was to nurture and protect the child and assist them to grow and develop their unique qualities and talents. In the middle of this continuum were parents who were not wholly child-focused, and instead felt that part of the child’s role in the parent’s life was to meet some of the parent’s needs. Participants argued that these parents may not attract the attention of child protection authorities, but they nonetheless use the child to meet their own various needs; for example, using the child as a pawn in child custody disputes, seeing and using the child as a status symbol, using the child as a possession to mould and control in the likeness of themselves, and seeing the child as a burden if the child did not meet their needs. At the other end of the continuum were parents who believed that the child’s primary role was to meet the parent’s various needs. These parents were described by participants as perpetrators of child abuse. They saw the child’s role was to meet the parent’s emotional, physical, and/or sexual needs.

Emily highlighted the difference between two parents she worked with and how differently she understood they saw the role of the child, particularly in terms of their own role as a parent:

*Even though sometimes she’ll say they [her children] drive her absolutely crazy, she’s not trying to fit them into some particular kind of mould, like she’s trying to get to know them each individually, as different as they all are, see what they would like, and she’s very sensitive and understanding of what’s going on in their life. She knows who their little friends are and what’s going on for them at*
school, so like really getting to know your child and really being interested in them. The other mother, she doesn’t care about what her son is interested in at all. It’s all about what she wants . . . I realised just how resentful she was towards him, that he was just this massive burden to her and that she just didn’t actually want to do anything to help him. She just wanted somebody to make him into a different person so that she didn’t have to deal with him anymore. (Emily)

Participants explained how parents who demonstrated a similar conceptualisation of child and parent to their own were less taxing on their time, as they did not have to spend time and energy on psycho-education or boundary setting in the same way they did with parents who did not. As a result, the nature of participants’ relational practices was more relaxed and amiable, which in turn positively impacted on building the parent–counsellor relationship. However, participants highlighted that this experience was not the norm. Four of the seven participants stated that 80–90 per cent of the children they saw for counselling had mental health issues associated with trauma, and they considered the trauma related to the children’s parents in some way, often with the parents being direct perpetrators of abuse.

All participants discussed how some of their most difficult parent experiences involved parents who abused their children and had not yet been investigated by the Department of Family and Community Services (FaCS). These parents represented the extreme end of the continuum in terms of possessing all the qualities outlined in the previous sections; that is, they saw counselling as a place to bring a problem child who needed “fixing”; they attempted to dictate to the counsellor the methods and approach to take in counselling the child; they did not respect the counsellor’s boundaries, indeed, they frequently engaged in abusive and threatening behaviour toward the counsellor; and they had many unresolved emotional and mental health issues of their own, but were not interested in changing or addressing any of these issues.

Participants’ approaches to parents who abuse their children varied, which in turn impacted differently on their relational goals and practices with parents. Some participants discussed that they effectively cease to make the parent–counsellor relationship a primary goal when they discover the parent’s abuse of his/her child, but rather they put their time and energy into advocating for the child’s rights and need to be safe. This typically involves reporting the parents to FaCS and for FaCS to determine a child protection plan, which would ideally include mandated counselling for the child.
(that is, the parent does not have the option or capacity to terminate counselling). In other words, these participants took the view that the child was not safe, and therefore their primary goal was to notify child protection authorities rather than to attempt to engage the parent in the counselling process. Although these participants predicted the parent would drop out of counselling, this did not concern them in terms of perceiving their dropout as a negative outcome per se. It was only negative if FACS was unable to intervene to ensure the child’s safety and to mandate the child continue counselling. These participants also identified that parents who abuse their children invariably attempt to control and intimidate the counsellor, which in many cases involves verbally abusing and threatening the counsellor. In these cases, relational practices with parents were considered redundant, as participants were not aiming to build a relationship with the parent. Additionally, these participants identified these parents as a risk to their own (the counsellor’s) occupational health and safety, which they responded to from a legal framework (e.g., calling the police) rather than a therapeutic one. Louise and Emily’s discussions illustrate this approach:

*I’m comfortable with swearing in the room but I will not be comfortable with them calling ME names or becoming aggressive with me, and I tell them: “This is the boundary and this is what I will do about it – I will contact the police.”* (Louise)

*I just say at the beginning when working with families: “If someone were to threaten violence or to raise their voice whether that be towards me or other people in the room, I would need to contact the police, because we need to keep everybody safe.”* (Emily)

Participants stressed that these parents were the most taxing on their time and energy, not only due to the nature of their direct contact with the parents, but also the amount of time and energy involved in contacting and liaising with child protection services and other relevant agencies. For participants, making notifications involved a lot of time ringing and meeting with relevant agencies, often on multiple occasions as FaCS typically did not respond quickly enough. This shifted participants’ focus to advocating for the child’s safety needs rather than building the parent–counsellor relationship.

Other participants who did not work from such a clear child protection and occupational health and safety framework described how they tried to engage and
work with abusive parents in an effort to assist them to gain insight and change their behaviour. However, when discussing examples of such cases, participants identified that this usually led to them being verbally abused and threatened by the parent rather than achieving this goal. For example, in speaking about a father of a child she was seeing for counselling, although Elizabeth acknowledged the father was abusive to the child as well as Elizabeth, in an attempt to engage him, she continued to make herself available to speak to him when he contacted her by phone and in person (unannounced). Elizabeth stated she did this for approximately two years before coming to the conclusion that the father was not willing to change himself, and that she was beginning to have concerns for her own personal safety:

*I think a lot of people are scared of the man. He’s subtly threatening . . . I’m actually concerned about what he might be capable of . . . he’s come up VERY close to me before . . . he actually screamed at me that I had failed, I had failed him and I had failed his daughter basically because I wasn’t telling the mum [his ex-wife] what she should be doing . . . I suppose they’re the ones that are really troubling because it’s very hard to know what to do in that sort of situation . . . he’s come in, he’s walked in here, completely unannounced . . . I think he’s been coming here on and off for two years . . . sometimes we’ll leave here a little bit late and he’s the one person that sometimes flashes into my mind.* (Elizabeth)

Whether participants were making child protection notifications or trying to engage abusive parents, invariably participants described that their relational practices were impacted by a depletion in their energy. That is, the parents’ attitudes depleted participants’ energy, which then impacted on their relational practices with them. In turn, if participants did not address these energy issues, they stated they found they had less to energy to give to parents, both current parents they were working with and future parents. Indeed, as outlined in this and the previous three sections, participants identified that their relational practices with parents were most influenced by aspects of parents’ behaviour that taxed their energy. Additionally, participants identified that a compromise to their energy reserves impacted most on their emotional health, which they considered was one of the main counsellor-focused (as opposed to parent-focused) influences on working effectively both with children and parents. I discuss counsellors’ emotional health in the following section.
5.3.5 Understandings of counsellor’s emotional health

All participants identified how having negative experiences with parents impacted most on their emotional energy, and consequently on their emotional health. Participants conceptualised their emotional health as a function of their self-care practices. Participants defined self-care practices as self-initiated practices that assisted counsellors to maintain good emotional health. Although participants acknowledged that their emotional health could be compromised by any number of different experiences and events not specifically related to parents, they stressed that negative parent experiences had a more significant impact, and that negative experiences tended to outweigh more positive experiences with parents. Most participants discussed that, when they did have positive experiences with parents, these experiences energised them but this was typically a temporary impact, and did not linger in the way negative experiences did. Participants identified three main facets of their emotional health that influenced their relational practices with parents: (1) working with children and their parents required more time and energy than working with adult counselling clients, (2) negative energy lingers, and (3) ethics and conceptualisations of “extra work”.

Time and energy required when working with children versus working with adult clients

Five out of the seven participants worked with adult clients in their counselling practices, and commented how much more energy and time was required to work with children compared to adults. These participants stressed that the additional work was not from direct work with the child, but rather the contact with the child’s parents as well as liaising and advocating with other systems, such as the child’s school, doctor, and support agencies. Most participants recounted feeling an ever-present potential of burnout from working with children compared to adult clients. Participants explained that they felt they were more susceptible to burnout when working with children with mental health issues associated with complex trauma, given the extra time and energy required to advocate for them, and often being abused by their parents in the process. Most participants discussed the aporic nature of wanting to work with children but also needing to prioritise their emotional health. Participants attempted to address the issue in various ways. For example, four of the seven participants described how they addressed the issue by being mindful of the number of child clients they took on at any given time and balancing their counselling case load with adult clients who did not tax
them emotionally in the same way, and/or working part-time rather than full-time. Tammy and Emily’s discussions illustrate this approach:

*I think for me it’s the multiple systems that they’re in . . . it’s the level of advocacy I think that I often have to do that takes up a lot of my time, and in some ways I feel like I’m more responsible for some reason when working with children, and that’s quite draining . . . So I know that I can only have a certain amount and I can only do that for a set number of times in my day so I’m not so drained. I feel like I just need a balance. Even today I got three child referrals and I’m considering what I’m going to do with them right now because I think I have enough kids, but if they were adults I probably could have taken them on next week. I would see them next week straight away. But if it’s a child referral I’m just thinking: “Mmm, what am I going to tell them?” because I know I don’t have any afternoon slots, and I know that’s what they want, but even just that it’s more “ohhh”. It’s all the extra stuff that I know is coming. As soon as I see the age of the referral I know. And there’s almost an instantaneous reaction I get at the moment [of the referral] it’s that “pffff” [sigh], so, here we go, what am I in for now? Which is kind of sad for the child because I do want to offer them support, but I also know what it’s going to take for me to be able to do that . . . yeah, it’s just that there’s so much more work. So much more work. (Tammy)*

*It hasn’t affected me to the extent that I don’t want to see children altogether. But I definitely want to be more discriminating about the ones that I accept, and keep certain loads of clients and balance them out, and take less clients and work less days, like less hours. Like all that really does come down to is how you process the energy from the parents. It does. So a lot of the decisions that I’ve been making about my career, all focus around how am I going to protect myself from them [laughs] . . . Like how many clients you see in a week and how many days you work, it’s like I’d rather earn less money than deal with this. I’ll take a $20,000 pay cut not to have to deal with that as much . . . like if I worked 5 days a week I’d earn more but I’d need 2 days to like recover from dealing with parents [laughs]. (Emily)*

Participants considered that deliberately minimising the number of child referrals they took on at any given time was a self-care strategy, and had the impact of assisting them to manage their emotional health, which then gave them the energy required to effectively work with current and future child clients and their parents. Participants understood that, if they did not adopt this self-care strategy, they were more likely to burn out, and not make themselves available to work with children and their parents altogether.
Negative energy lingers

All participants identified that they did not see negative parent experiences as contained experiences, but rather as experiences which carry over to other experiences via the emotional charge they generate. For example, Luisa talked about her emotional response to a mother who did not allow her child to come to the final session with Luisa because Luisa refused to provide the mother with a court report. Luisa recounted how she and the child had planned their final session together and the finalising activities they would do and that the child was really looking forward to it. Luisa talked about how the mother’s action left her feeling and how the negative feelings lingered after the event:

Well, I was really angry. I was furious . . . It’s certainly an experience you don’t forget. Like I probably will never forget it. Because her little boy and I had a good therapeutic relationship, he had a lot of fun, and she openly acknowledged that when he came away he was lighter, and you know, he had benefitted. Despite that, she would be prepared to do that [drop out]. So you know, it left a bad taste in my mouth . . . it was quite mean I thought of the mum. You know. So of course you don’t forget that. (Luisa)

Luisa continued to discuss the impact of this negative experience in that she had a car accident as she was leaving work on the day the parent failed to show for the final session, and how in retrospect she believed that her unprocessed negative emotions from the parent experience contributed to her having the accident:

I should have sat down, and I mean I knew I was, you know, upset. I was angry with her. I should have given, placed more importance on that. And kind of sat down and just sat through that and thought about it a little bit and work through it a little bit before I left, because it was late by that stage. I just wanted to get home. I should have, I think, had a cup of tea or something and, you know, walked around the block or something to settle myself, or just to process it a little bit. Even though I would have gotten home later, I think that’s what I should have done. (Luisa)

Luisa ended up leaving her part-time private practice to work full-time as a counsellor in a school where she did not have to engage or have nearly as much contact with parents, as children in schools can self-refer to counselling and can get themselves to and from their counselling appointments without the involvement of their parents.
Most participants discussed that they had to spend a significant amount of time debriefing with colleagues and scheduling extra supervision sessions in an attempt to recharge their energy and minimise the impact of their depleted energy when working with some of the parents of their child clients. Anne considered leaving her job altogether following a negative experience with a father who was a domestic violence perpetrator and who would ring Anne and verbally abuse her:

_He rang me and abused me on the mobile phone, and I think that was when I said to X [colleague] that I didn’t really want to go back. I didn’t want to go back and work . . . I didn’t want to work back there again. (Anne)_

Most participants described how the cumulative effect of negative energy from challenging experiences with parents impacted on their relational practices with future parents, in that if a parent reminded them of a previous parent and/or engaged in behaviour indicative of being challenging, this influenced how the participants approached new referrals. Josephine described this response:

_And because in some ways some of those bad experiences are such a NIGHTMARE, there’s that energy that’s HELD around those parents. So I’m actually storing that energy, so when I meet one of them, or come up against one of those (I’m already calling them “those” parents), I can feel my energy deflating. Even on the phone when I’m taking down an intake, and I’ll be talking to a parent, and I’ll get that feeling and thinking: “This person’s going to be hard work, there’s a lot of complex issues, the person hasn’t got a lot of self-awareness or insight”, even then I’m getting up my prejudices, they’re coming forward on the phone, I can feel it. Like, I’m sitting there and it’ll be like: “Ohhhhh, it’s one of these”. (Josephine)_

Elizabeth described a negative experience she had with a father of a child she was seeing for counselling, the impact it had on her wellbeing and overall functioning, and how she had to address it immediately in order to continue working effectively:

_That time when he yelled and screamed and told me I was a failure, that stayed with me for days. I honestly felt like he had really dumped all this like horrible, horrible energy onto me. And I actually had a couple of energetic healing sessions, because I could feel it on me . . . I was like boiling, like it was really, it was an incredible experience. I needed to go twice to really properly cleanse that guy off me [laughs] and so I’m really conscious of that. (Elizabeth)_
Although all participants highlighted the important role of clinical supervision in assisting to process emotions generated by their challenging experiences with parents, for most participants this was not sufficient as they highlighted how often they needed processing immediately rather than waiting for their scheduled supervision appointment. Additionally, some participants felt they needed the service of a practitioner who specialised in clearing the body of emotions rather than only the mind. Four of the seven participants spoke about going to alternative body healing practitioners as a way of dispensing the negative energetic charge from negative parent encounters. Emily and Louise described their approach to energy clearing:

*I've always gone to something or another, whether that's been chiropractor, acupuncture, like yoga, meditation. And a lot of what I try and do when I go to those things is like to move energy on of stuff that I've absorbed and, on the whole, that is from parents not clients themselves. (Emily)*

*It can definitely slime you. But I like to see it more as a slime that you can get rid of quite easily, but you actually have to do certain things to prevent it from sticking to you and staying with you . . . I always know if I’m not doing it [energy release] regularly enough, I start carrying it around, but then once I go back into my habit of it, especially my boundaries, then it’s not an issue. (Louise)*

Participants identified that the quality of their emotional health, and in turn their relational practices with parents, was compromised if they did not tend to the lingering effect of negative energy generated by challenging experiences with some parents. For most participants, maintaining good energy hygiene was a very conscious self-care objective, as it influenced their overall functioning as well as their willingness and capacity to continue to work with parents.

**Ethics and conceptualisations of “extra work”**

Most participants recounted aporic situations where they felt they had to decide between putting their emotional health needs first, or putting in copious amounts of time and energy to advocate for children’s needs, particularly children being abused. Most participants saw one compromising the other and vice versa. That is, parents who were on the extreme end of the continuum (abusing their children) potentially undermined participants’ emotional health, and if participants prioritised their emotional health, they would not be working as much or at all with children whom they considered needed counselling the most. Most participants expressed their angst in the
face of this aporic dilemma. That is, if they felt they had not advocated enough for a child, they were left with feelings of guilt, and if they overextended themselves, they felt drained and hesitant to continue taking more high-need child referrals. Some participants discussed how they avoided making a definitive choice between the two, but rather oscillated at various times between putting either their emotional health or the child’s advocacy needs first. Others felt they had to make a definitive choice. For example, Josephine identified that one of the influences undermining her emotional health was overextending herself when advocating for children’s needs, something she had done for many years but that had gradually eroded her emotional wellbeing. This resulted in physical illness and periodic absences from work. The interview transcript below illustrates the nature of the aporic dilemma between being annoyed and drained by the time and energy that advocacy requires, and feeling compelled to advocate for the needs of the child. It also illustrates the ominous fear of burnout, and how in some cases it can be fatal:

Josephine: I was getting really annoyed because I’m sitting at home on my day off ringing a JIRT [Joint Investigation Response Team] worker and thinking: “I shouldn’t be doing this!” And then I was going: “Nah, nah, put in the boundaries, put in the boundaries”, and then it’s like: “What about the CHILD?” And it kept coming back to seeking justice for this child . . . It’s that time that, you know, it does sound cold and hard but you’re not getting paid for these things. Every time I was on the phone to the Children’s Commission, no-one was paying me for that . . . but then I think, Rosa, there’s some social workers that do it [advocacy] really, really well. Like you know, my friend who died a few years ago, she was BRILLIANT at the social advocacy, like she would make appointments with the Minister . . . she was very, very good at doing that, but Rosa, she was a genius and she lived her work and she died, Rosa. She was one of my best friends and she died, and she died through illness, and I suspected, and she did too, it was, you know, it was part of her unhealthy work stuff she was taking on.

Rosa: Burnout, you mean?


Although all participants identified aporic dilemmas they faced due to working with children, some participants attempted to address the issue by consciously cultivating an ethical position which they deliberately used as a way of energising themselves in the face of draining situations. For example, although Louise acknowledged the real dangers of burnout brought about by advocating for children with complex needs, she
was mindful of approaching her work with children with a clear ethical position that functioned as an energy sustainer rather than drainer. Louise’s ethical position was characterised by not seeing advocacy as a choice or indeed “extra work”, but rather as an integral part of counselling children. Thus, Louise conceptualised advocacy work associated with working with children as a fundamental, non-negotiable part of the work, rather than an additional part that is unpaid:

“All that advocacy and, you know, reports, and meetings, phone calls, you just don’t get paid for it, but you can’t go into this job like a solicitor thinking I will bill in five-minute increments. Because it’s not the job . . . I think going into this job I really see myself as an advocate for children and young people, and sometimes that means doing really hard work for not much outcome over a long period of time . . . and I think you can only do that through ethics . . . Because I always think, you know, if I went into this for money, if I went into this saying, “I need to make this dollar by this time”, I wouldn’t have survived. (Louise)

Tammy also discussed using ethics as a focus for her work and stated that this served two purposes: the focus allowed her to be less distracted by challenges, and it also sustained her energy because she had one very clear goal. For example, Tammy worked with a significant number of traumatised children, and she conceptualised her ability to develop a powerful and healing therapeutic relationship with children as her ethical duty. She explained that this served as a compass and overall work goal for her, that in turn assisted her to navigate emotional health challenges:

“For me I think building a really great therapeutic alliance with the child is magical, it really is, and actually being able to really accept that child and EVERYTHING they throw at me. I think that’s a really privileged way of working, and I think for me that’s often an unmet need for most of the kids, and something that I’m available to provide and I want to provide, even though it comes with so much else . . . So even if the work with their parents causes me grief or confusion or burnout at times even, if I’m able to do that, then I think that’s really respecting that child. So that’s I think part of my value system, and that’s why I think I work in that way. (Tammy)

Louise and Tammy’s use of ethics to reconceptualise what other participants considered extra work, and to use it to consciously assist to energise themselves rather than drain them, provides another example of how influences such as counsellors’ emotional health are not influences in and of themselves, but rather are a function of counsellors’ understandings of them.
In this section, I have highlighted three main facets of participants’ understandings of their emotional health: (1) working with children and their parents required more time and energy than working with adult counselling clients, (2) negative energy lingers, and (3) ethics and conceptualisations of extra work. Participants identified their emotional health as a significant influence on their relational practices with parents, mostly because its management determined the energy and time resources they had available to effectively engage with parents, particularly parents whom they felt depleted their resources the most. Conversely, if participants considered their emotional health was compromised, this influenced how and to what extent they made themselves available to work with parents.

5.3.6 Understandings of counsellor’s psychic health

Five of the seven participants identified the state of their psychic health as an important influence on their relational practices with parents. Psychic in this context relates to participants’ psyche, particularly their personal unconscious. Participants conceptualised their psychic health as a function of their ability to manage their countertransference reactions in response to parents’ transference. Parents’ transference was defined as the parent projecting unresolved emotional issues onto the counsellor, particularly regarding their own experiences of being parented. This typically involved projecting the counsellor in the role of their own parents or significant others, and consequently transferring their unresolved emotional issues from these past or current relationships onto the counsellor. Participants conceptualised countertransference as a form of emotional projection involving one of three scenarios: (1) the way in which counsellors respond to parent transference, (2) the counsellor’s unresolved emotional issues pertaining to their own experiences of having been parented, and unconsciously projecting these issues onto parents, and (3) the counsellor falling into the role of the child and experiencing what the child (client) feels to be parented by the parent, and then reacting accordingly. Emily and Louise’s quotations illustrate participants’ general understandings of the nature of countertransference:

Well, I think that might be because it’s when things aren’t going well with a parent you’re working with, it can be quite emotional. There can be quite a lot of transference and maybe countertransference stuff going on, and so that could be feeling the child’s anxiety and the things the child might be experiencing, but it could also be of the parent, and it could also be some of my
own stuff that could be triggered with my own experiences of having parents myself too. So there’s many different layers in there . . . and the other thing is when you’re working with adult clients, their parents aren’t physically making contact with you, so you’re dealing with it theoretically in the sense of what they’re talking to you about their experiences . . . but when you’re working with children, you’re actually getting those triggers right directly there because you’re actually seeing their parents, so you have to learn to deal with the triggers. (Emily)

I think countertransference is probably the biggest soft point for therapists [laughs]. Because we’ve all been parented. That’s a common experience, so in working with a parent you’ve got to be aware of that it’s going to bring up stuff for you . . . all of us have a parent, so yeah, God, if you’re not aware of it [countertransference], you’d be doing it [unconsciously projecting] all the time. (Louise)

Although participants highlighted the importance of supervision in managing their countertransference reactions, most stressed that they needed to consciously work through their reactions while they were taking place amid a session with a parent, and that these were the most challenging situations because, if they did not do this well, the parent–counsellor relationship could deteriorate very quickly. Josephine described a countertransference situation she encountered with a parent, and discussed how difficult it was to manage her countertransference reactions:

You’ve got to iron out your own problems with being parented and parenting before you can engage the parents . . . there was one woman that particularly triggered me [laughs], she even wore the same PERFUME as my mother, she had the same HAIR style, it was just incredible. And the same, you know, anger [Laughs]. And it was like full on, even the same lipstick, Rosa, it was just bizarre. So I picked that one up because I couldn’t not pick that one up. And it was a really difficult session to get through. And I didn’t like this woman. It was a really interesting process, because she was very angry, very blaming . . . I actually got her to come in three or four times before I said I’d work with the child . . . so it took a lot of strength to stay with her, but it was an interesting relationship. In the end she warmed very well and we continued the therapy. (Josephine)

Some participants who had children or grandchildren of their own identified how their work with children made them particularly susceptible to negative countertransference reactions with parents. For example, Anne explained that, as a parent of a young child the age of many children she saw for counselling, she was
mindful when working with parents dealing with the same emotional issues she was dealing with her own child, and how this could adversely affect her relationship with the parent if she did not consciously reflect on her countertransference response and reactions. Other participants who specialised in complex trauma, where most of the children’s trauma was a direct result of their parents’ abuse, highlighted how they consciously tried to only accept referrals of children who were not the same age as their own children or grandchildren as a strategy to minimise countertransference reactions. Some participants acknowledged the importance of having their own personal counselling to assist them to manage countertransference reactions with parents. For example, Josephine discussed how, approximately a year prior to the interviews, she decided to take six months off work to engage in her own personal counselling to work on her experiences of being parented and issues that had arisen from that. Josephine recounted how working through these issues assisted her to minimise her countertransference reactions to parents, and consequently helped improve her professional relationships with them:

And maybe that’s where I was stuck before with most parents, and that’s probably the biggest shift . . . I mean, yeah, it would raise judgments . . . the minute I’ve got judgments going, it’s in the air, yeah, it’s in the counselling room. As soon as I bring that into it, it’s in the room whether you want it to be or not. Whether it’s unspoken or not it will be felt. So what I think I sort of probably had going on there was a little bit of that, it probably took a lot longer to engage safely with parents actually . . . Now it’s got a cleaner energy, it’s got a cleaner feel, it’s easier to see the transference, the countertransference. It’s like easier to see those dynamics, because I think being the healthy adult gives you flexibility, whereas being in that child archetype, and I call it the “needy child”, like not getting what I need, it keeps you very fixed and rigid . . . So with my own work as I’ve shifted and cleared, I’ve noticed my relationships with parents have grown stronger. (Josephine)

Josephine’s comment regarding countertransference keeping her fixed and rigid illustrates the general understanding from other participants regarding how they understood unmanaged countertransference reactions influenced the quality of their relational practices with parents. Most participants talked about feeling anxious in anticipation of an interaction with parents who triggered a countertransference reaction in them, and consequently being defensive in future interactions with the parent. Ultimately, this vigilant and wary demeanour with parents prevented participants adopting practices that were more welcoming and open, that is, practices
that are typically associated with developing good relationships. The vigilant and wary
demeanour contributed to a negative tinge that characterised participants’ overall tone
and mood regarding their initial understandings of the influences on their relational
practices with parents. Although participants acknowledged they had positive parent
experiences, they had fewer examples to draw on compared with more challenging
experiences. This indicated that participants’ positive relational practices were
contingent on positive experiences with parents, rather than being independent of
them. Notably, not one participant spoke negatively of any of their child clients,
regardless of how challenging the child’s behaviour was, as participants both expected
and accepted this as part of the counselling process. In contrast to participants’
approach to parents, their relational practices with their child clients were independent
of the child’s practices. That is, they were able to maintain unconditional regard for
their child clients irrespective of the child’s behaviour, but did not do this for parents.
This suggests that the child–counsellor relationship is based on different
conceptualisations, attitudes, and practices than the parent–counsellor relationship.

Most participants described their emotional health and psychic health as
foundational influences on their relational practices with parents, in that these two
influences governed the extent to which participants were negatively impacted by the
parent-directed influences discussed in Sections 5.3.1 to 5.3.4. This suggests that the
parent-directed influences are not only a function of counsellors’ understandings of the
way in which they conceptualise their role as a CMHPT counsellor, but they are also a
function of counsellors’ self-care (emotional health) and countertransference (psychic
health) practices. Although I have presented the six influences somewhat separately,
my discussions of them highlight how they are interrelated. Thus, the personal
influences (parent-directed and counsellor-directed) are interconnected and
relationally dependent upon one another. Figure 5.1 depicts this relationship.
Figure 5.1. Participants’ understandings of personal influences on their relational practices with parents.\textsuperscript{20}

5.4 Conclusion

In this chapter, I have identified several personal influences that participants understood influenced their relational practices with parents: (1) parents’ conceptualisations of mental health, counselling, and the counsellor’s role, (2) parents’ responses to the counsellor’s boundary setting, (3) parents’ willingness to change themselves, (4) parents’ conceptualisations of child and parent, (5) the counsellor’s emotional health, and (6) the counsellor’s psychic health. As discussed in Chapter 1, the literature discusses some of the challenges that CMHPT counsellors face when working with parents, which mostly relate to the first influence, that is, parents’ conceptualisations of mental health, counselling, and the counsellor’s role. However, the literature identifies these as challenges in a reified sense rather than as influences that are a function of CMHPT counsellors’ understandings.

\textsuperscript{20} I chose a shape that depicted the interconnectivity and overlapping nature of the six influences. It was only after I had created the image that I noticed the six-pointed shape in the centre, which was synchronistically congruent with the six-pointed shape I used to depict the Bourdieusian and Jungian theoretical thinking tools (see figures 3.1 and 3.2).
My findings contribute new knowledge in several ways. First, they highlight and provide detailed information regarding how my participant CMHPT counsellors understood challenges to influence their relational practices with parents. Second, they revealed five additional influences participants understood as impacting on their relational practices with parents, which to date have been largely absent from the literature, namely, CMHPT counsellors’ understandings of parents’ responses to the counsellor’s boundary setting, parents’ willingness to change themselves, parents’ conceptualisations of child and parent, the counsellor’s emotional health, and the counsellor’s psychic health. Third, my research reveals how counsellors understand such challenges as key influences on their relational practices with parents. Specifically, it reveals that what my participant CMHPT counsellors understood to be challenging, are personal influences that tax their time and emotional resources. Fourth, my research findings suggest that the quality of CMHPT counsellors’ emotional and psychic health forms the foundation for them being able to effectively respond to and be minimally affected by the four parent-driven influences. That is, the parent-driven influences are more likely to impact negatively on CMHPT counsellors whose emotional and psychic health are compromised. Fifth, the few participant anomalies identified in my research (e.g., Louise and Tammy’s conscious and deliberate use of an ethics framework to reconceptualise notions of extra work) revealed that these influences are not fixed entities in the substantialist sense, but rather are based on CMHPT counsellors’ understandings and conceptualisations of various facets of their work. Lastly, my findings reveal that participants’ understandings of personal influences on their relational practices with parents primarily involved conscious influences rather than unconscious influences. With the exception of transference and countertransference, participants did not employ personal unconscious reflexive tools to identify personal influences on their relational practices with parents.

In the following chapter, I explore how the six personal influences identified in this chapter relate to participants’ deeper understandings of the research phenomenon, specifically, participants’ understandings of sociocultural influences on their relational practices with parents.
Deeper understandings

Then, like turning over a tapestry when you have only known the back of it, there is spread the pattern.
– Jane Gardam, Crusoe’s daughter

In this chapter, I focus on answering the sub-question: How do CMHPT counsellors understand sociocultural influences on their relational practices with parents? I begin the chapter by discussing participants’ conceptualisations of the term sociocultural and then explore the various sociocultural influences they identified as influencing their relational practices with parents. As with the previous chapter, this chapter explores what sociocultural influences counsellors understood to influence their relational practices as well as key features of how this understanding was formed.

Participants’ understandings of sociocultural influences on their relational practices with parents were not for the most part a feature of their initial understandings. Rather, they were garnered predominantly from the second interview via probing from me. I did this primarily by considering the main elements of sociocultural influences (discussed in Chapter 1) and asking participants whether they understood them as influencing their relational practices with parents. Thus, participants’ understandings of sociocultural influences on their relational practices with parents were derived from a co-constructed process with me, the interviewer. This represents the interconnectedness of the double helix mentioned in the previous chapter, and explores a deeper layer of participants’ understandings of the research phenomenon. This layer was inextricably related to participants’ initial understandings of the phenomenon, that is, their understandings of personal influences on their relational practices with parents (discussed in Chapter 5). This layer of understanding revealed a distinct pattern which was akin to firstly only knowing a tapestry from the back, and the delight when one turns it over and the pattern is fully revealed. The merging pattern of this interconnectedness between initial and deeper understanding is discussed throughout the chapter and depicted in a diagram at the end of the chapter.
6.1 Conceptual understandings of sociocultural

When asked about sociocultural influences on their relational practices with parents, most participants asked for clarification. The most common question was: “Do you mean ethnicity?” When I suggested it could be broader than ethnicity, most participants’ understandings were limited to demographic characteristics (e.g., class, occupation, gender). Although participants did not recognise the term sociocultural in the sociological sense, in that it could encompass structural, ideological, temporal, spatial, and material features, participants did identify these broader aspects of sociocultural influences through the co-constructed process of in-depth interview dialogues.

Additionally, once participants identified various aspects of sociocultural influences, they initially approached these influences as objective variables impacting on parents’ practices rather than contextualised influences that also shaped their practices. This tendency to focus on the influence on parents’ practices, rather than their own, was something I was particularly mindful of throughout the second and third interviews. Consequently, I found I needed to frequently steer the dialogues to focus on how participants understood that the various sociocultural influences we explored influenced their relational practices with parents, rather than simply parents’ practices. For example, when discussing class, participants mostly began discussing how particular social classes caused or were associated with parents acting in certain ways. I then probed and asked participants how working with parents from these social class backgrounds impacted on their practices with these parents.

6.2 Demographic influences

Although several demographic influences were explored in the in-depth interviews with participants (including gender, ethnicity, race, age, geographic location, class, occupation, income, professional identity), the demographic influences that participants understood to more directly shape their relational practices with parents were class and professional identity.

6.2.1 Class

All participants identified what they understood to be parents’ class as an influence on their relational practices with parents. Most participants referred to three main social
classes: lower, middle, and upper class. Only one participant, Emily, included working class in her conceptualisation of class, and she also distinguished between financially comfortable middle class and financially struggling middle class. Participants primarily determined parents’ class based on parents’ occupation, education, and/or financial status. Participants identified three main facets of class that influenced their relational practices with parents: (1) class, defensiveness, and emotional nurturance; (2) class and time; and (3) class and child abuse.

**Class, defensiveness, and emotional nurturance**

Six of the seven participants identified that parents whom they considered were from middle- and upper-class backgrounds were the most challenging parents to work with.\(^{21}\) Participants understood this to be the case for a few reasons. Participants felt that parents from middle- to upper-class backgrounds were less open to receiving feedback about their parenting and more focused on providing material and status-oriented experiences for their children, rather than emotional nurturance. Louise’s quotation captures the general sentiment that participants understood middle- to upper-class parents to be less open to seeing their child’s mental health issues as related to themselves in some way, and were therefore less willing to change themselves:

> I find with the parents of lower classes you can be more direct, and they want you to be direct, they want you to be honest, they want you to be straight up with them, and if you’re transparent with them, you can engage them quite quickly . . . The upper class, they don’t want you to be honest with them . . . They just want you to go along with what their hypothesis is – that it’s all the child’s fault, that their family is fabulous, and their parenting is wonderful, and they’ve got no idea why this is happening in their home. (Louise)

Louise’s quotation also illustrates most participants’ understanding that parents from middle- to upper-class backgrounds are more defensive regarding receiving feedback from counsellors (particularly feedback that relates to the primary issue driving their child’s symptoms), and more defensive and resistant to making any changes to themselves (e.g., their parenting practices). Tammy revealed a similar understanding:

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\(^{21}\) Throughout this chapter, where I discuss parents’ social class, I am referring to participants’ understandings of parents’ social class, rather than parents’ class independently of this understanding.
I find with lower socioeconomic parents, they’re often used to being told where they’re going wrong kind of thing, it’s not a shock. They say: “Yeah, I stuffed that up”, or “Yeah, I shouldn’t have been doing that”, or kind of, “Yeah, I get that kind of thing, I can see that”. It’s almost like there isn’t that denial. But middle-class parents, they’re doing all the right things: “I’m giving them everything, I’m taking them to this, I let them do this, they’ve got all of these things. Really, what else can I do?” And with some of what they can do is quite simple, it involves emotionally connecting to their child, but it’s too much for them because it impacts too much on their time and how they see their role as a parent . . . I think there’s a pride element, their pride is affected. (Tammy)

Tammy’s quotation illustrates the general understanding among participants that many parents they work with from middle-class backgrounds see the emotional nurturance of their child as less of a priority than providing their child with material goods and status-oriented experiences. Emily also revealed this understanding; however, Emily honed the middle-class influence specifically to parents who are financially struggling:

They have money because they have good jobs, but they also have a lot of stress, and they also have a lot of bills to pay, and they have to work really hard, both parents. And so they’re working all the time, and it’s like they don’t see their job as a parent as being there to nurture the emotional side of their child, or if they do, it’s like kind of a bit ad hoc, or like occasional, or here and there, or whenever they have time. Not really something they need to be doing every day, every week, every month, every year . . . it’s meeting the physical needs but it’s also about their IDEA of physical needs. It’s not just about putting a roof over their head and giving them clothes, it’s also about ideas about what they should be having, like they should go to a private school, they should go to Europe at least two or three times during their childhood, that kind of thing. (Emily)

Tammy offered yet another dimension to understanding middle-class parents, whom she understood prioritised material acquisition above emotional provision. Tammy considered that these parents were only newly arrived on the middle-class scene, as it were, and were striving to provide their children opportunities that they themselves did not have. Tammy discussed this in the context of what she described as “Generation X parents” who were trying to be socially mobile, doing this via materialistic pursuits, and in the process neglecting their children emotionally:

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22 Tammy clarified this statement stating that lower socioeconomic parents are usually “being told where they’re going wrong” by the Department of Family and Community Services, that is, in relation to child protection concerns and their parenting.
I always feel they’re children of baby boomers, so I feel like they may have struggled in some way . . . I feel they’re giving their children everything that money can offer and they’re doing a good job of it, but what they’re not giving their children is emotional connectedness and freedom . . . they want to make sure their children have everything, maybe what they didn’t have. They’re giving them this amazing private education, all these extracurricular activities, all this tuition . . . So they’re trying to give them ALL of those things, trying to set them up to succeed, but what they’re not giving them is real quality parenting . . . that’s why these children are not progressing. So I try to put that back on them, but they don’t want to hear it, that’s not how they’re seeing their role. They see their role more as [material] provider rather than emotional provider. (Tammy)

Luisa echoed the understanding that some parents focus on upward social mobility as a function of where they themselves have come from, and added another element to the mix in the way of ethnicity. Luisa was the only participant who identified ethnicity as a significant influence on her relational practices with parents; however, she discussed ethnicity inextricably with class. Luisa worked as a school counsellor for a selective school and described that approximately two thirds of the students’ parents were born overseas, with the majority being from an Asian background. Luisa described that the overwhelming number of these parents push their children to achieve academically so that they can attain money and status in adulthood:

I saw a girl here today, she’s getting five hours sleep a night . . . And I said: “What?!” and she said: “Oh, my parents encourage me to sleep less and study more” . . . for many of the parents of this school it’s a huge status symbol, and it’s like the marks, they can’t see beyond getting those marks and those high-status careers . . . It’s like a passport to a brilliant career and lots of money and status. (Luisa)

In discussing the parent groups she ran for parents whose 10-year-old children had been accepted into a primary school’s “opportunity class” (previously known as the gifted class), Luisa observed that she typically met with parent resistance when she recommended they not put pressure on their children regarding academic performance:

I say: “Let them have fun, these could be two of the best years of their lives”, and they’re like this [imitating parents crossing their arms] . . . I say: “Kids are more than their marks”, I say this every year, and this is what I see before my eyes [imitating parents crossing their arms] . . . These are Year 5 kids, parents of kids
Luisa argued that these parents’ extreme focus on their children’s academic performance blinded them to their children’s mental health issues such as anxiety and depression. Luisa described the aporic dilemma of, on the one hand, wanting to advocate for the children’s need to not have so much pressure put on them by their parents, but, on the other hand, feeling that if she advocated too strongly she would undermine the parent–counsellor relationship. Additionally, Luisa stated that if these parents became angered by her or indeed any staff member of the school, they typically harassed staff (via incessant phone calls and coming to the school), and were more likely to complain to the Department of Education than parents at non-selective schools she had also worked at.

In sum, participants understood that it was not so much parents’ class as a static entity, but rather parents’ striving for class mobility relative to their early childhood background that impacted the most on their parenting priorities. Participants’ identification of this aspect of class as an influence on their relational practices emerged as a sociocultural influence that shaped the four parent-driven personal influences discussed in the previous chapter, that is, participants’ understandings of: (1) parents’ conceptualisations of mental health, counselling, and the counsellor’s role, (2) parents’ responses to the counsellor’s boundary setting, (3) parents’ willingness to change themselves, and (4) parents’ conceptualisations of child and parent.

Class and time

An additional feature of class identified by participants as impacting on their relational practices was how parents approached time. Most participants identified that issues regarding time were more common with middle-class parents, whom they described as the most “time poor”. Participants identified several aspects of class and time that influenced their relational practices with parents. First, when participants made recommendations for parents to become more involved in their child’s emotional health, participants identified that this potentially undermined their relationship with the parent, as the parent frequently interpreted this as the counsellor taking their time away from doing other things the parent considered more important. Second, participants also considered parents’ approach to scheduling counselling appointment.
times as indicative of their priority, where middle-class parents would often not prioritise counselling appointments, but instead tried to fit them around other appointments. Third, participants understood that middle-class parents were more likely to insist on a “quick fix” for their child’s mental health issues, as they were focused on addressing the child’s symptoms rather than primary issues discussed in the previous chapter. Fourth, middle-class parents were more likely to be impatient in terms of not being able to wait until the review session to get feedback on the child’s progress and the counsellor’s prognosis. In other words, they did not give the counsellor sufficient time to assess and diagnose the cause of the child’s issues compared to other parents who were not as time poor. Lastly, participants noted that many of these parents did not like being told that they needed to remain in the waiting room for the duration of the child’s session. Participants reflected that parents were frustrated by this policy because they were time poor, and sitting in the waiting room was seen as dead time when they could be doing something else. Tammy explained her understanding of these aspects of time:

I don’t think it’s the money. I think it’s their time. I find it’s the bringing the child, it’s the sitting in the waiting room, it’s the rearranging after-school stuff. . . . They want to have it fixed and it’s a problem, and they want a solution, and they want it finished and completed, and it’s the time factor that’s making them more frustrated . . . And the ones that are causing me difficulty, I think they may have more of that “children should be seen not heard”, so really thinking: “I should be able to go on with my life, do what I need to do, and not have the EXTRA task of managing their anxiety, or their challenging behaviour, or their depression. They should fit in MY schedule, not the other way around”. . . . so counselling becomes a burden because it has to fix something that shouldn’t even be there. It’s getting in the way kind of thing. And the symptoms of these children are often the ones that make the parents more time poor: they have less sleep, they’re getting called into meetings at school, they’re having to stay back later, so it’s really impacting on them. (Tammy)

Tammy contrasted this with parents she did not find challenging to work with because she considered they prioritised their child’s counselling above all else:

The parents that will come and bring their child at 9 o’clock or even at 2 o’clock and are willing to actually prioritise even over school, which is important but their mental health is more important. . . . If they’re willing to do that, I’m getting a good feel for them. (Tammy)
The temporal aspect of participants' understanding of class highlighted that participants considered time is related to their understanding of what a quality relationship is, both parents’ relationship with their children (how much emotionally focused time parents spend with their children), and the parent–counsellor relationship (respecting the counsellor’s approach to time). Additionally, participants understood that parents who constantly and consistently challenge their time in the various ways discussed above are ultimately challenging the counsellor’s role and not respecting their boundaries. Most participants described this as a “power struggle”. This additional aspect of class also highlighted how it shaped some of the personal influences explored in the previous chapter, particularly participants’ understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role, as well as parents’ responses to the counsellor’s boundary setting.

**Class and child abuse**

Another feature participants identified in terms of class was its association with how child abuse issues are responded to. Specifically, participants identified that, if parents were from a middle- or upper-class background and they were abusing and/or neglecting their children, their material and social status (or semblance of it) made child protection advocacy much more challenging than advocacy involving parents from lower socioeconomic backgrounds. Participants identified three main reasons for this. First, parents from middle- and upper-class backgrounds could present well in terms of meeting their children’s needs, and hide behind a veneer of a “good parent”, particularly when presenting in front of child protection authorities or the police. Second, parents from middle- and upper-class backgrounds could directly and/or indirectly use what participants simply referred to as “power” to legally challenge any questions regarding their parenting. Third, child protection authorities were less likely to challenge parents from middle- and upper-class backgrounds due to an institutional culture of focusing predominantly on parents without the legal means to challenge them. The quotations below from Louise, Elizabeth, and Emily capture aspects of this understanding:

*Once you start stripping away the layers, the issues are similar to the lower classes, it’s just better hidden. They’ve got money to hide it . . . The middle- and upper-class families, they also know that they’ve got power, and that they can go legal and no-one’s removing their kids, no-one’s even looking at their parenting. (Louise)*
We definitely get middle-class and upper-class families and there’s some very ugly things going on, but they manage to get away with stuff, talk their way around it, you know what I mean? These are professional people who have skills and yeah, very manipulative . . . Narcissistic. You know, charming, very clever . . . it is I think more difficult in a way ’cause a lot of people go: “Oh no, they’re fine”, and it’s like: “Ah, no, they’re not!” (Elizabeth)

I have come across this in working in this geographic area quite a lot, where if it’s a wealthy family or someone who’s in a position of power or something like that, the police or someone will go by there, but they’ll just wrap it up and dismiss the whole thing really quickly, whereas I feel if it was exactly the same facts in a different suburb, in a different family, they would treat it differently. (Emily)

The main way in which participants identified that parents from middle- and upper-class backgrounds abusing their children influenced their relational practices was that these parents took more of the counsellor’s time and energy in trying to advocate for the child because of the reluctance of Family and Community Services (FaCS), police, and sometimes the child’s school to respond. Additionally, some participants’ energy was also taxed because they experienced more attacks from parents once they had made a notification to FaCS. These attacks would take the form of an indirect vitriolic attempt to discredit the counsellor via submitting a complaint to the counsellor’s professional board or association, and/or direct verbal or physical attacks on the counsellor. For example, Anne recounted her experience with a father who was a doctor at the local hospital and the perpetrator of domestic violence, and who began verbally harassing her on the phone:

_He rang me and abused me on the mobile phone . . . I didn’t want to go back to work . . . That experience was horrible. Plus, being a doctor at the hospital . . . his emails were getting really abusive: “How dare you get involved in our private life rah, rah, rah!” . . . I kept thinking he was going to be out in the car park. That’s how stressed I was about it. I thought: “Oh my God, he’s the type of man, if he’s doing that to his family, he’s going to be waiting for me in the car park.” (Anne)

Anne further reflected that she was early in her career at the time this happened and did not FaCS of this father’s domestic violence or contact police regarding his verbal abuse and threats towards her. Anne reflected that she did not make a child protection notification or contact the police due to the power the parent held as a result of his position in society, and how this could impact on her reputation:
I thought my fear around was him I guess, because he was a doctor and we’re in the same sort of field, in the health field, he would start saying to people that I told his wife to leave him and I hadn’t done that, and it was like he was making me feel like I had. Yeah, so . . . And it’s because of the power of his position that I didn’t say anything. (Anne)

Elizabeth also described experiences in which she felt intimidated by the power of a parent’s position in society. Elizabeth provided an example where she was aware that a father’s occupation made her hesitant to challenge him regarding his verbal abuse of her (the counsellor) as well as his psychological abuse of his daughter. Elizabeth spoke in the third person to suggest she was not alone in her summation of why she found this parent intimidating, as the child’s school teachers and principal had similar thoughts:

This guy is a professional person [a dentist] . . . I think people actually then go: “Oooh, well” . . . if he was just some, I don’t know, whatever, unemployed person from somewhere [laughs], I think people might sort of go . . . might question him more, but because he is, yeah, he’s someone of some standing, I think, he uses that, he really uses that. He’s very intelligent . . . I think a lot of people are scared of the man. (Elizabeth)

Anne and Elizabeth understood that these parents’ social class impacted on their relational practices in that their practices were characterised by complicity and compliance based on fear. Additionally, Anne and Elizabeth expressed how emotionally taxing they found these parent experiences and how the experiences threatened to undermine their emotional health. Through the process of in-depth interviewing, both Anne and Elizabeth identified that their fear and trepidation associated with these parents was a form of countertransference in that they were experiencing feelings and reacting in ways similar to that of their child clients, and typical of victims of abuse. Thus, Anne and Elizabeth understood that issues related to parents’ social class potentially influenced their psychic health – one of the personal influences participants understood to influence their relational practices with parents and discussed in the previous chapter.

Only one participant (Josephine) did not identify middle- or upper-class parents as having a negative influence on her relational practices. Rather, Josephine identified that she found middle-class parents less challenging to work with than parents from
lower- or working-class backgrounds, as she found middle-class parents were more likely to accept her policies and procedures and were generally more committed to working on their own issues. Given Josephine was the only participant from a rural area, and the other participants were based in metropolitan areas, this discrepancy in understanding the influence of class could be associated with class as a function of geographic location, particularly metropolitan versus rural manifestations and understandings of class.

A notable feature of participants’ understanding of class as an influence on their relational practices with parents is that participants focused entirely on what they understood to be parents’ social class rather than their own. That is, they did not consider the influence of class as relational, namely, their understanding of their own class background relative to that of parents’. For example, Elizabeth did not discuss the intimidation she experienced from the father who was a dentist as a function of her understanding of her profession and class relative to the father's, but rather she considered it as a variable in the substantialist sense, in that his social class would have impacted on any counsellor in much the same way.

In this section, I have discussed three main facets of class that participants understood had a significant influence on their relational practices with parents: (1) class, defensiveness, and emotional nurturance; (2) class and time; and (3) class and child abuse. These facets of class revealed that class was not understood to be an influence in addition to the personal influences discussed in the previous chapter, but rather a sociocultural influence that shaped all six of the personal influences; namely, participants’ understandings of: (1) parents’ conceptualisations of mental health, counselling, and the counsellor's role, (2) parents’ responses to the counsellor’s boundary setting, (3) parents’ willingness to change themselves, (4) parents’ conceptualisations of child and parent, (5) the counsellor's emotional health, and (6) the counsellor's psychic health. An additional finding that emerged was that participants did not consider class as a sociocultural influence in relation to their understanding of their own class background; rather, the focus of their understanding was on what they considered was the parents' social class as a reified entity.
6.2.2 Professional identity

In this section, I discuss that more than half of the participants understood their professional identity as a sociocultural influence on their relational practices with parents. Participants understood professional identity to be a function of both parents’ and referrers’ conceptualisations of mental health, counselling, and the counsellor’s role.

All participants who were not psychologists identified their professional identity as an influence on their relational practices with parents. These were Josephine and Louise (two social workers), Elizabeth (a mental health nurse), and Anne (a mental health counsellor). These participants identified their non-psychologist status as a frequent source of confusion for parents and referring parties, many of whom understood psychologists as the primary profession providing counselling, and consequently had limited knowledge of other professions providing counselling services. This confusion impacted on these participants’ relational practices in various ways. Some participants described how some parents and referrers would not continue with their service once they realised the counsellor was not a psychologist. Some participants discussed that they often needed to spend a significant amount of additional time and energy explaining how their skills, expertise, and overall service was comparable to psychologists’ services, and that the success of this explanation determined whether the parent decided to engage their child in counselling or not. Participants recounted how the misunderstanding and constant need to distinguish themselves from psychologists often left them feeling frustrated. Josephine expressed this sentiment:

A lot of them still think I’m a psychologist. I have been UNABLE to get rid of that. That’s still a problem where people will come and say: “You’re a psychologist” and I’ll say: “No, no!” or they’ll say: “I’ve been told I’ve got to see a psychologist by my doctor” and I’ll say: “Well, I’m not a psychologist, I can refer you to two psychologists in town” . . . I really do think when people ring, they’ve got no idea what counselling is. (Josephine)

Upon further discussion, it was apparent that Josephine herself was often conflicted and confused about how to identify and describe her services and what professional title to use. For example, Josephine reflected on how the social work profession has historically been associated with casework and social advocacy rather than counselling,
and to emphasise she was not a caseworker but a counsellor she needed to think carefully about the language she used to describe herself and the service she provided. Considering the different roles associated with social work, Josephine demonstrated her own uncertainty and difficulty in choosing language to describe herself and her service:

Yeah, look I’ve always had a problem with the language of what to call myself . . . whether to call myself a psychotherapist, or have the word psychotherapy, because you know some people think that’s a really bad thing. I don’t really like the term counsellor but it’s what I use . . . then I liked the word therapist but someone told me its breakdown is “the-rapist” . . . Yeah. And that’s so true, Rosa, it is so true. An unsafe therapist is a psychic rapist . . . And with my information packages, what I recalled happened was deciding what do I name myself and what do I name the process? I named it counselLING, and I tried not to use the term counsellOR, but then I wasn’t really happy with the counselLING, but I thought if I used the term psychotherapy, I wasn’t really happy with that term either. (Josephine)

Louise, the other social worker, described how parents frequently compared her services to the psychology clinic located near her practice, and how she had to spend time and energy discussing the similarities in terms of being a provider of counselling as well as differences in terms of her specialisations, one of which was CMHPT counselling. Like Josephine, Louise conceded that her professional title of social worker confused many parents, and required her to spend additional time and energy educating parents about her counselling service.

The other non-psychologist participants also identified that their choice of job titles influenced their relational practices with parents. The two participants (Anne and Elizabeth) who worked for an organisation where their job title was “play therapist” rather than their professional background (mental health counsellor and mental health nurse respectively) discussed issues regarding their professional identity, particularly when parents were going through the courts and were questioned by forensic psychologists about their child’s treatment. Anne provided an example:

So one mother who’s going through court at the moment called me and said to me: “I’ve just been speaking to the child psychologist that’s been referred to us through the courts, and he’s very uppity about what you do and wants to know what your qualifications are and why you’re working with X [the child]” . . .
Anne and the other non-psychologist participants expressed considerable frustration when discussing the misconceptions about their work, profession, and job titles. In terms of influencing their relational practices with parents, these participants described situations where parents would not proceed with the service once they discovered the counsellor was not a psychologist, and how much this frustrated participants. This at times led participants to react defensively when parents asked about or compared their services to those of psychologists, which sometimes soured the first contact with parents. In contrast, none of the three participants who were psychologists identified issues regarding professional identity as a negative influence on their relational practices with parents. They identified as “psychologist” as their primary title and used their CMHPT counselling qualifications as a way of indicating their counselling specialisation.

Like class, professional identity was considered by participants largely as how parents understood their profession and their counselling role rather than how participants themselves understood their professional identity and how their understanding of their profession influenced their relational practices with parents. Also like class, participants approached professional identity primarily as a reified entity impacting their practices, rather than an influence that was shaped by their own understanding of their professional identity. As with class, it emerged that participants’ understandings of the influence of professional identity on their relational practices with parents shaped the personal influences discussed in the previous chapter, specifically, participants’ understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role.

Two main findings emerged from my exploration of the two demographic influences (class and professional identity) participants identified as shaping their relational practices with parents. First, participants’ understandings of these demographic influences shaped the various personal influences discussed in the previous chapter. Consequently, a pattern began to emerge revealing that sociocultural (macro) influences are intimately linked to personal (micro) influences. Second, participants’ understandings of these demographic influences did not include a relational
understanding whereby they considered the influence of their own demographic background on their understandings.

6.3 Structural influences

Several structural influences were explored in the in-depth interviews with participants, including participants’ core mental health education and CMHPT counselling education, CMHPT counselling literature, participants’ theoretical orientation, Medicare, clinical supervision, and referrers. However, the structural influences that participants understood to more directly shape their relational practices with parents were Medicare and referrers, both of which I discuss in this section.

6.3.1 Medicare

Participants identified Medicare as a significant structural influence on their relational practices with parents. Medicare’s influence was identified by both participants who offered Medicare-rebated services and those who did not. When discussing Medicare, participants generally referred to the Better Access scheme, which involved the government subsidising 6–10 mental health counselling sessions per calendar year for people assessed as having a mental disorder by their GP, psychiatrist, or paediatrician.

Participants identified two main aspects of Medicare that influenced their relational practices with parents: (1) it encourages a focus on addressing the symptoms rather than the primary issues driving the symptoms, and (2) it does not fund parent-only sessions.

Encourages a focus on addressing the symptoms rather than the primary issues driving the symptoms

Participants identified that Medicare’s policy to only fund a maximum of 10 sessions per calendar year (initially six sessions and an extra four sessions if approved by the referring doctor) strongly perpetuated the notion that the acceptable way in which to address mental health issues is to manage the symptoms rather than to address the primary issues driving the symptoms. Emily reflected that the traditional conceptualisation of counselling as a medium- to long-term process of self-exploration and healing had been severely eroded by Medicare’s very short-term approach, which had given parents permission to not reflect on and change aspects of themselves that may be contributing to their child’s mental health issues:
I’ve spoken to people that have been practising for a number of years, like 15 or 20 years or more, they have said that this whole idea of the “fix my child drop them off thing” has always kind of been there, but it’s gotten much worse around the time of Medicare because it’s this idea of like anybody can be “fixed” in 10 sessions . . . whereas prior to that there was more of a like, say 15–20 years ago, more psychotherapy, where it was all about personal growth, and exploration was kind of more accepted as what people understood what therapy was. It was all about understanding yourself and like, you know, growth and that kind of stuff. Whereas now it’s all about the skills you’re going to learn to COPE with symptoms. And so then they see that their child has anxiety but rather than looking at where that’s coming from or why that child might be feeling anxious . . . how much the family system impacts, like, where those thoughts are coming from . . . what’s going on in the family, what’s going on with the parent, what is the child picking up on. (Emily)

Emily’s quotation reflects the general sentiment shared amongst participants which was that Medicare has institutionalised the expectation that treatment is synonymous with symptom reduction, rather than addressing the primary issues driving the symptoms, and that the focus should be on the child rather than the child’s systems, particularly their family. Participants interpreted this as Medicare’s policy contradicting their (participants’) conceptualisation of counselling, where they consider that addressing the primary issues driving the symptoms is paramount. This mostly impacted on relational practices with parents who were looking for a quick fix and/or were reluctant to work on themselves. This frequently resulted in dropouts as parents went in search of a counsellor who was happy to focus on symptom reduction and did not require the parent to do any work themselves.

**Does not fund parent-only sessions**

Participants identified that Medicare’s policy stipulating that children accessing the service must be present in all sessions had an adverse impact on building the parent–counsellor relationship, as parent-only sessions are not funded. Participants working under the Medicare model discussed the aporic dilemma they frequently faced regarding Medicare’s exclusion of parent-only sessions. They recognised they needed parent-only sessions as a way of building the parent–counsellor relationship, but they also felt that if they insisted on these non-subsidised parent-only sessions many parents would drop out. On the other hand, the participants recognised that attempting to work within Medicare’s child-only session policy was not best or good practice as they were not seeing the child for the time the child needed and additionally they did not have
time to build the parent–counsellor relationship. Thus, the dilemma participants felt they faced was whether to work within Medicare’s system and not effectively address children’s mental health issues, or work outside it and risk parents being unwilling to fund the sessions themselves.

An additional pressure participants identified in relation to Medicare not funding parent-only sessions is that the policy does not facilitate counsellors conducting a systemic assessment of the child’s needs, which would include in-depth discussions with relevant third parties such as the child’s parents and school. Participants identified two main impacts of this on their practices. First, it meant that participants were working with children without having conducted an adequate assessment and therefore not having a sufficient understanding of the systemic factors impacting on the child’s mental health issues. Second, it meant that often it was only once they commenced seeing the child that either the counsellor or the parent came to the conclusion that the counsellor and/or their service was not the right fit for the child (or the parent). This was considered as “wasted” sessions for the child as it meant that, if the child was to see another counsellor, the number of subsidised sessions they had would be reduced for the year, leaving even less time to effectively address the child’s mental health issues. Luisa explained:

Because you and the parent both know they’ve got six sessions and this is one of them, and if it turns out at the end of the session to be that you’re not the right person, then they’ve lost a session. I mean losing a session is better than wasting six sessions, but still. (Luisa)

Luisa and other participants who were working or had previously worked within Medicare’s subsidised funding scheme discussed the pressure they felt this placed on them to in effect address a child’s mental health issues in an insufficient amount of time, and at the same time attempt to build a relationship with the parent. This mostly impacted on participants’ time and energy as they felt parents tried to extend the little time they did have with the counsellor (e.g., when bringing the child to and from counselling sessions), and then the participant needed to enforce boundaries with parents regarding this.

As a consequence of experiencing constant pressure and frustration regarding Medicare’s restricted practice, Josephine described how she implemented a new policy
at her practice that stipulated a minimum of 16 sessions were involved in child counselling, and only six of them would be funded by Medicare. Thus, if parents wanted her to see their child, they had to contract with her and agree to fund the remaining sessions. Josephine’s new policy also stipulated that she met with parents at least three times prior to seeing the child (i.e., parent-only sessions), and that once she commenced seeing the child for counselling, she required the parent to meet with her at least every three weeks for parent-only sessions to discuss not only the child’s progress, but also to discuss the parent’s progress on various issues Josephine required they work on:

*With the Medicare thing, the way I’ve got parents to view that, is it’s a bonus. It’s not an entitlement . . . I’m so much more clearer and structured about actually what counselling is . . . I say: “We’re not going to work through this in anything less than 16 sessions because I need to be able to offer the child so many sessions, and I need to do some work with you, and with you and the child as well, so you’re going to have some out of pocket expenses” . . . that’s part of my policy. Also, I’ll say: “If your child is in therapy, you must meet with me every three weeks, minimum.”* (Josephine)

Josephine reflected that, since she implemented her new policy (which she outlined in her information packs she sent to parents when they first made contact with her), she had more parents decide not to engage her services after discovering the financial and time commitment involved. However, Josephine found that the parents who did agree to her terms were much more committed to her service. As a result, Josephine reflected that her emotional health had improved considerably as she was working with parents who respected her policy, and therefore she did not find herself having to enforce boundaries as she previously did. Josephine’s example highlights how Medicare is not a fixed, reified entity that impacts counsellors equally, but rather it is participants’ understanding of it, and in turn the level of personal agency they afford themselves, that influences their relational practices with parents.

### 6.3.2 Referrers

All participants were acutely aware of the role referrers had on their relational practices with parents. Referrers included those associated with government bodies (e.g., Victims Services and FaCS) and government-funded programs (e.g., Medicare), as well as referrers who were part of the participants’ smaller networks such as parents...
referring other parents. Participants identified two main aspects of referrers’ influence: (1) the quality of the counsellor’s relationship with the referrer, and (2) the referrer’s conceptualisation of mental health, counselling, and the counsellor’s role.

**Quality of the counsellor’s relationship with the referrer**

Participants identified that the role or influence of referrers differed depending on the nature of the counsellor’s relationship with the referrer. This counsellor–referrer relationship was discussed on a continuum, where at one end there were referrers whom the counsellor knew well and considered part of their community of practice, and at the other end referrers who did not know the counsellor and had acquired their details through a registry of counsellors. Generally, participants noted that, the more they knew the referrer and had established a professional relationship with them over time, the more likely parents were to respect their policy and procedures, and in turn the participant was less likely to have to enforce limits with them. Tammy described how a good counsellor–referrer relationship contributed to parents approaching her counselling service in a relaxed, trusting way with less defensiveness:

> So I sometimes have some parents who’ll say: “My GP told me that I’m safe with you and this will be good”. So I guess that alleviates some of their anticipation or anxiety, so I guess yeah, that definitely comes into it . . . because I think often when parents bring their kids to come and see me, there’s already so much that’s difficult for them to get to that point, and sometimes having that positive feedback or reassurance from others, whether it’s their GP or their friend, can just take that little bit of pressure off. And for me that’s important because I think as a parent, being able to have faith and trust in someone to work with your child is a big deal . . . So yeah, those relationships with those referring bodies can definitely feed those parents in a good way . . . if there’s been a strong recommendation from the GP, I feel that makes the process a little bit more seamless. (Tammy)

Tammy and other participants stressed that a good counsellor–referrer relationship not only put parents at ease but made the counsellor feel more relaxed about their work with parents. Participants described not feeling as much pressure to justify their way of working, particularly if the referrer had seen positive outcomes with other clients and could vouch for the counsellor prior to the parent making contact with them. Although referrers were not part of participants’ workplace, they contributed to participants feeling they were part of a supportive network. In this way, referrers formed part of a
community of practice for the participants and consequently influenced participants’ emotional health.

All four participants who worked as solo private practitioners (Emily, Louise, Josephine, and Tammy) discussed how they consciously put time and energy into developing a community of practice that included regular referrers. These participants recognised the importance of building solid, ongoing relationships with regular referrers, as they acknowledged the positive influence this had on building good relationships with parents. Thus, building the counsellor–referrer relationship was identified as a form of relational practice with parents, even if indirect in nature. Conversely, what emerged through the process of in-depth interviewing was that many of the parents whom participants described as challenging to work with were not referred by a referrer the counsellor knew, or the parent was recommended by someone they had an acrimonious relationship with, for example their ex-partner.

For some participants, the parents themselves were key referrers who recommended the service to other parents. However, this role could also work against participants if their relationship with the referring parent deteriorated for some reason. For instance, Tammy identified that current and former parents held a lot of power in terms of making or breaking her reputation:

*Sometimes I feel the parents have power in terms of building, or partly building, my reputation… I was seeing someone who their friend referred but things have gone sour with that one, so I started to reflect on it: “Mmm, has she then spoken to that friend and then am I getting resistance from the parent because of that?” So that’s a kind of power in some ways. They’re not articulating it in that way of course but you know there’s that underlying message: “I have the ability to name and shame you” [laughs] or “I have the ability to, you know, bring you heaps of people to come in”, kind of thing. (Tammy)*

In sum, participants identified that referrers form a triadic relationship with the parent and counsellor and provide a scaffolding for the counsellor’s relational practices with parents. If the relationship between the referrer and counsellor and/or the referrer and parent is solid, then participants identified they did not need to expend as much time and energy in building the parent–counsellor relationship. Participants also noted that the quality of their relationship with the referrer impacted on how much time and
energy they need to explain and defend their policy and procedures to parents and parents' willingness to change themselves.

**Referrers’ conceptualisations of mental health, counselling, and the counsellor’s role**

Participants identified the influence of referrers’ conceptualisation of mental health, counselling, and the counsellor’s role and whether it was congruent with the counsellor’s. For instance, some participants discussed receiving referrals from people they did not know or did not have a solid working relationship with, and who were therefore unaware of their way of working. This often caused many issues in terms of the referrer giving parents misleading or inaccurate information regarding what to expect from the counsellor’s service. For example, Emily identified how many of the referrals she received from schools were based on the premise she believed was perpetuated by the general psychology field that mental health issues can be addressed by managing symptoms, which was incongruent with her approach that focused on addressing the primary issues:

> It’s the way psychology is going that it’s all about “we learn skills to help us cope with the symptoms”, and I get this A LOT with schools too, like if schools are referring . . . And no matter how many times you try and explain it to certain people, they just can’t grasp it. They think that you can teach the client a few tricks or something and that they’re just going to be resilient. (Emily)

Emily and other participants who experienced this incongruence between referrers’ understanding of mental health treatment and their own approach described how they then typically needed to spend additional time and energy counteracting this assumption when speaking with parents. In some cases, participants felt that the discrepancy between what the referrer had said to the parent about what to expect from the counsellor’s service and what the counsellor actually did contributed significantly to the parent dropping out. For example, Josephine described a situation where the Joint Investigation Response Team (JIRT) was coordinating court hearings regarding a school teacher who had sexually assaulted one of Josephine’s clients:

> JIRT was telling the mum: “Oh, the counsellor will come to court with you, the counsellor will support you, get the counsellor to take you on a tour of the court”, and I was like: “This is NOT my role!” . . . And then JIRT rang me and said: “Have you been preparing her for court?” and I was like: “No, no, no, no, no. Not my...
Josephine further explained that the mother became increasingly confused by the mixed messages she was receiving from JIRT and Josephine regarding the level of support she could expect from counselling. The mother was already under considerable stress as some members of the small town had vocally banded together to support the teacher rather than the child. In the end, the mother dropped out of counselling altogether. Josephine described the situation as a form of “systems abuse”, as she felt that the mother saw her (Josephine) among all the other social players (e.g., JIRT, the police, the community) who had failed to support her. Josephine speculated that JIRT had confused her role with that of the sexual assault counsellors working for the Department of Health who did provide court support as part of their role. Josephine, like the other participants discussing the influence of referrers on their relational practices with parents, focused primarily on the parents’ responses to the referrers as an influence, rather than her own responses to referrers as an influence on her relational practices.

The above examples highlight how participants generally understood referrers to form part of their community of practice and that, when referrers’ conceptualisations of mental health, counselling, and the counsellor’s role aligned with their own, they felt supported in their work and required less time and energy to explain and defend their services. However, when there was a misalignment and incongruence amongst referrers and the counsellor’s conceptualisations of mental health, counselling, and the counsellor’s role, this undermined participants’ attempts to clarify their role and type of service provision. Participants’ understanding of referrers as an influence was found to shape two of the personal influences discussed in the previous chapter; namely, participants’ understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role, and the counsellor’s emotional health.

In this section, I have explored two structural influences participants identified as influences on their relational practices with parents: Medicare and referrers. Both these structural influences were identified as shaping the four parent-driven influences discussed in the previous chapter. That is, participants’ understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role; parents’
responses to the counsellor’s boundary setting; parents’ willingness to change themselves; and the counsellor’s emotional health. An additional finding was that participants identified structural influences largely by how parents approached these influences rather than how they themselves responded to these influences.

6.4 Time

Participants understood time to influence their relational practices with parents on a number of levels, some of which I have explored in previous sections. For the most part, participants understood time as a quantifiable, objective entity that could be given, withdrawn, wasted, and tinkered with. For example, I have discussed how participants understood time in association with other sociocultural influences, such as class and time (see Section 6.2.1), where time was considered quantifiable and something that parents either gave or withheld from their children. In this section, I discuss participants’ understandings of the influence of the sequence of time as it applied to structuring their practices and how they understood it to influence their relational practices with parents. Although participants’ discussions encompassed the interconnectedness of temporality, materiality, and spatiality, participants mostly approached these as objective and separate (although interconnected) aspects of reality. For this reason, I discuss participants’ understandings of time separately to their discussions of materiality and spatiality, although there are some overlaps.

All participants described time as a delicate consideration in that if they did not get “the timing right” regarding various relational practices with parents, the parent–counsellor relationship suffered, and subsequently dropouts frequently occurred. Participants identified five main aspects of time that influenced their relational practices: (1) time and the initial contact; (2) relationship building occurring over the duration of the child’s treatment; (3) frequency, duration, and timing of parent contact; (4) point in treatment when parent is initially engaged; and (5) time of dropouts.

6.4.1 Time and the initial contact

Most participants considered that the relationship with the parent began at the very first point of contact, which was typically on the phone. Most participants described this contact as “making or breaking” the relationship in terms of whether the parent
decided to make an appointment. Some participants discussed that, if a parent rang to enquire about their service and did not get to speak to them immediately, the parent would often not leave a message and would instead go in search of a service where they could speak to a counsellor instantly. The participants also identified that the amount of time they made themselves available in the initial contact with the parent was an important influence. For example, Elizabeth recounted her experience with a mother whom she had built a very positive parent–counsellor relationship with, and how Elizabeth felt that the relationship got off to a good start because of the amount of time she spent on the phone when the mother first made contact:

I actually spoke to her initially on the phone and at great length. And it was a day that we weren’t very busy, so I actually had time. And she had so many questions, and she didn’t give me a grilling but, you know, she had a lot of questions . . . But I did spend a long time with her . . . and she said afterwards when she did actually call back and booked in, she said: “I really appreciate that time you spent with me, I know you had other things to do” . . . and even her feedback, that big letter [of thanks] she wrote [at the end of treatment], that was one of the big things she said that at the beginning I actually spent that time with her . . . and in the real world, you can’t always sit there and spend, you know, half an hour to 45 minutes on the phone to someone who may never even come into the place. (Elizabeth)

Elizabeth highlighted how, paradoxically, although this amount of time is ideal and possibly crucial in building the parent–counsellor relationship, it is not a realistic amount of time for most counsellors to spend on each enquiry they receive. Other participants also described that when many parents first made contact they wanted to spend more time on the phone than the counsellor had to give. Some participants explained that they were conscious of attempting to strike a balance between being warm and affable on the phone and at the same time placing boundaries around the amount of time they were available to speak with parents. Participants felt that, if their practices leaned too much toward boundary setting, many parents would not show up for their first appointment, and if they gave too much time they (the counsellor) would feel resentful and drained by the amount of time they had spent on the phone, as it was often a precedent that was set for future phone contact with the parent.
6.4.2 Relationship building over the duration of the child’s treatment

In addition to the length of time spent or given to the parent at the initial enquiry, most participants stressed that the parent–counsellor relationship was not simply built in the initial stages and taken as a static given, but rather needed to be consistently and constantly worked on over the full duration of the child’s treatment. For example, Louise discussed how she needed to consciously engage in relational practices with parents over the long-term rather than the short-term:

> Engagement with the parents is probably something I have to be consciously aware of throughout the WHOLE process. So right from the initial phone call, right through . . . if I want that child to really hang in there until the termination session, I have to work doubly hard with the parent the whole way through. I might not be seeing them as much as the child, but I’m working hard with them all the time . . . For example, doing follow-up phone calls after sessions and scheduling meetings on a monthly basis to really update them and go through themes that I’m seeing in the play. (Louise)

Tammy explained that, even if she felt she had built and maintained the parent–counsellor relationship, it was fragile and could quickly change and therefore needed to be maintained over time and not be taken for granted:

> I used to think that the relationship was something that with parents you do at the beginning. I think that was quite naïve, because the challenges that come through then working with the child either strengthen that relationship or they really hinder the relationship . . . it’s a process . . . that relationship over time will change, and that it’s not necessarily you know, kind of an upward progression, it’s a bit like this sometimes [moves hand up and down to form a wave-like pattern]. (Tammy)

Tammy’s quotation reflects the general understanding among participants that the parent–counsellor relationship is not a goal that is achieved once and then remains a given. Rather, like other professional and indeed personal relationships, it is susceptible to change, and counsellors need to monitor its quality throughout the entire process. Participants discussed how this aspect of seeing children required double the amount of time and energy compared to seeing adult clients, as they were required to maintain and develop both the relationship with the client (the child) and the child’s parent. Participants identified how this challenged the structure of their weekly schedules as they needed to allocate more time to accommodate discussions with
parents and other significant stakeholders in the child’s life (e.g., the child’s doctor and school) than they would if they saw only adult clients. Consequently, participants reflected that they were limited in the number of child clients they could take on at any given time, and that this mostly impacted on private practitioners as this typically meant less income for them. As with the previous point, participants discussed that they were constantly striving to strike a balance between setting aside enough time over an extended period to nurture the parent–counsellor relationship, and setting boundaries around the amount of time they were available so they could effectively manage their emotional health.

6.4.3 Frequency and duration of parent contact

All participants identified that seeing the parent before commencing counselling with the child was imperative to building a positive working relationship with the parent and clarifying goals for counselling. However, there was significant variability in how long participants saw parents for the parent meeting, and whether they saw the parent for more than one meeting. For example, some participants reported seeing parents for a half-hour or one-hour meeting before commencing counselling with the child, and others such as Louise and Josephine saw the parent for multiple sessions before seeing the child. Josephine described how, after reflecting on past issues with parents, she adjusted the amount of time she saw the parent before seeing the child, concluding that parents needed more time to develop a trusting relationship with her:

You actually need to have at LEAST three sessions with parents before you start with the child so that they feel safe, because a lot of the stuff is about them changing what THEY’RE doing, and I think if they see your alliance is strongly with the child, then they’re fearful that you’re going to be really critical. Because I know that so many parents are TERRIFIED of being called a bad parent. They don’t want to be bad parents. And they’re really stuck. So I think having those extra sessions allows them to build trust with you, that you’re not judging them, you’re not, you know, going to read them the riot act . . . It gives them that opportunity so they can FEEL out that therapy space. (Josephine)

In addition to the length of the initial parent meeting, a further consideration participants identified in terms of time was the nature and amount of time to spend with parents between the initial meeting and the parent review meeting. All participants said that most parents wanted more frequent contact and for longer periods of time than participants were available to give them, and that parents were
generally impatient about waiting for the parent review session to hear about their child’s progress. Participants discussed how the discrepancy between the time parents wanted and what participants could give frequently caused friction and the participants needed to reinstate boundaries with parents. Participants identified that, if the parent interpreted this as a form of rejection, they were more likely to drop out.

Most participants described various ways in which they attempted to tweak, adjust, and modify their contact with parents in an attempt to “strike the right balance” between being available for parents and placing boundaries around their time. For example, Anne attempted to address the issue by using the parent’s time in the waiting room to engage with them indirectly by asking them to complete a weekly feedback form. The form asked the parent to describe their thoughts regarding how the child was progressing at home and school, any concerns the parent may have, and whether the parent would like Anne to call them after the session. Anne discussed that this relational practice assisted her not only to contain the parent’s anxieties by having the parent divulge them in the weekly feedback form, but also to maintain communication between her and the parents, albeit in writing. Anne described it as “a nice way of parents feeling heard”. Since she started to use the form, Anne reflected, she has had fewer issues with parents attempting to contact her outside of scheduled times. Anne also had an epiphany while discussing this issue, reflecting that the parents that she had the most difficulties with had declined to complete the form. Instead, they preferred to verbally engage her at every opportunity, which she was not always in a position to facilitate. Anne interpreted this as the parents being “resistant” to her attempts to contain the communication, and therefore she understood the issue to be related to parents’ responses to boundary setting, rather than Anne’s use of time or other possibilities such as the parent not being comfortable or able to express themselves in writing.

6.4.4 Point in treatment when the parent is initially engaged

A few participants noted that the parent–counsellor relationship was frequently undermined if one of the child’s parents was not present at the initial parent meeting and then wanted to engage afterwards. Most of the situations participants discussed involved parents who were separated or divorced and who had an acrimonious relationship with the other parent. Participants identified that the nature of the parents’ relationship with one another typically impacted negatively on the parent–counsellor
relationship, and ultimately resulted in more dropouts. Consequently, several participants developed a policy of either not seeing children who were in the process of going through the Family Law Court, or insisting that both parents’ consent be obtained before proceeding to provide counselling to the child. Participants observed that some parents interpreted this as a restrictive practice and as such did not proceed with the service.

Another problematic scenario two participants identified was if the counsellor commenced seeing a child for counselling but another counsellor had conducted the initial intake assessment. These two participants were Anne and Elizabeth, who worked within a team of other counsellors. For example, Elizabeth identified that some of her most challenging parent experiences involved parents whom she had “inherited” from other counsellors, and therefore she did not conduct the initial parent consultation. Elizabeth described one such situation:

*It was an unfortunate situation where, see normally we do our own initial parent consultation, so you’ve got that connection, rapport, you’ve done all that, but this one somebody else had done the initial consultation . . . and you know, I learnt a good lesson from that. Don’t do that again or else bring them in again. Have another, you know, session with them before you see the child. (Elizabeth).*

Elizabeth’s understanding suggests that an important feature of the parent–counsellor relationship is that it is fundamentally built and maintained between individuals, that is, the individual parent and the individual counsellor, rather than the counselling service/team as a whole.

### 6.4.5 Time of dropouts

All participants identified that dropouts they experienced typically occurred just before or directly after the review meeting with the parent. Participants speculated that when dropouts occurred before the review session it was because the parent did not perceive the counselling to be working fast enough and/or they felt threatened by the child–counsellor relationship that was developing. Participants identified two probable reasons for dropouts occurring directly following the review session: parents either did not agree with the counsellor’s assessment of their child’s needs discussed in the review session (particularly if the assessment drew attention to the parent’s issues as a driving factor), or the parent came to the realisation that there was no quick fix to their child’s
condition, and they were therefore required to do work on themselves, which they were not ready for or interested in doing.

Most participants described the initial stages of parent contact, that is, between the first parent meeting and the review session, as a period of quiet hypervigilance as they recognised it was the time most susceptible to dropouts occurring, but they often could not predict when and if this would happen, and therefore could not adjust their relational practices accordingly. Participants explained that their anxiety about dropouts was mostly related to the feeling of wasted time and energy, in that they often built a very good relationship with the child and were excited about the child’s progress in counselling only to have the parent take them out prematurely. Thus, not only were participants not given the opportunity to complete their intervention, but they also experienced the abrupt severing of the relationship with the child. Participants expressed how emotionally draining this could be for them and that, if unchecked, it could negatively impact on their emotional health, morale, and motivation to work.

One of the ways in which repeated dropouts impacted on some participants’ practices, particularly those in private practice who had a considerable amount of autonomy in terms of changing their policies and procedures, was that participants were more likely to implement practices that attempted to cull parents whom they thought would drop out prematurely. That is, participants’ practices became more focused on assessing the parents’ readiness for their service. Participants described doing this in both formal and informal ways. Formal screening processes involved some participants asking parents to complete readiness to change questionnaires such as the Readiness, Efficacy, Attributions, Defensiveness, & Importance Scale (READI). The READI measures parent readiness for treatment, parent belief that they can make changes through treatment, parent belief regarding the source of their child’s behaviour problems, parent defensiveness towards treatment, and parent belief in the importance of treatment (Brestan, Ondersma, Simpson, & Gurwitch, 1999). Informal screening practices involved some participants noting the parent’s ability to come to the scheduled parent sessions on time and whether they completed tasks the counsellor set them between sessions. If participants considered the parent’s responses to these measures indicated that the parent was not committed to the counselling process, participants used this as an opportunity to discuss the issue with the parent before agreeing or not agreeing to see the child. Participants implementing these practices
identified that some parents found this focus on them too confronting and exposing and withdrew at this point. Participants who used this approach stated they were happy for non-committed parents to leave before they commenced seeing the child, which after all was the main goal of the screening process.

Notably, participants did not consider their own relationship to time as an influence on their understanding of its influence on relational practices with parents, but rather focused primarily on parents’ use of and approach to time. For instance, if the participant encountered issues concerning parents’ tardiness, this was typically understood as an issue associated with parents not respecting the counsellor’s boundaries rather than the counsellor’s inability or reluctance to enforce boundaries in a timely fashion (as opposed to allowing resentment to build up over time before raising the issue with the parent).

In this section, I have discussed five aspects of time that participants identified as influencing their relational practices with parents: (1) time and the initial contact; (2) relationship building occurring over the duration of the child’s treatment; (3) frequency, duration, and timing of parent contact; (4) point in treatment when the parent is initially engaged; and (5) time of dropouts. All aspects revealed how participants approached the use of time as something that requires constant reflecting, tinkering, and fine-tuning. As with other sociocultural influences explored in this chapter, time was a sociocultural influence participants identified as shaping individual influences discussed in the previous chapter, specifically, participants’ understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role; parents’ responses to the counsellor’s boundary setting; parents’ willingness to change themselves; and the counsellor’s emotional health. An additional finding revealed in this section was that, like the other sociocultural influences discussed in this chapter, participants’ understandings of the influence of time centred around how they understood parents approached time rather than their own relationship to time.

6.5 Material environment

All participants identified the significant influence the material environment and artefacts had on their relational practices with parents. Through the process of in-depth interviewing, it emerged that participants understood that the influence of the material environment was inextricably connected to time. Specifically, the material
environment assisted or hindered the development and maintenance of the parent–counsellor relationship over the course of time; namely, before, during, and after face-to-face meetings with the counsellor. In this section, I present participants’ understandings of the influence of the material environment as interwoven with different points of contacts they had with parents over the course of time, or what I have previously referred to as practice episodes (see Section 5.2.3). These points of contact included: (1) material impressions before the first meeting, (2) place of the first meeting, (3) the waiting room, and (4) technology and communication in between meetings.

### 6.5.1 Material impressions before the first meeting

Most participants identified the role of the material environment in assisting parents to feel welcomed, relaxed, and comfortable accessing their service. In particular, participants who owned and operated their own private practice described the considerable amount of thought and time they put into choosing the right space for their practices, and how the building’s exterior was a significant part of this choice. For instance, these participants identified the role of the building’s exterior as a symbolic representation of their values and overall approach to mental health counselling, which assisted in setting the tone for the parent–counsellor relationship.

**Building’s exterior**

A few participants discussed the significance of the exterior qualities of their building and how they considered it to embody their values and the way in which they approached treatment of mental health issues. For example, these participants described deliberately locating their practice in a cottage or “homely” space to emphasise that their approach to mental health treatment was based on warm, personalised care, rather than a cold, impersonal approach. Tammy expressed this sentiment:

> I’m wanting to convey openness. I think that’s something that I’m really trying to convey. And respect for the variety of needs, and trying to communicate a lot of warmth as well . . . I chose a building that I think looks like a home so it helps convey that. It’s not a, there’s no negative stigma in terms of mental health stuff, it’s not a stark, medical-looking space. (Tammy)
One participant, who hired her space from a church, discussed that the cottage had the church’s name on the plaque on the front of the building and that she had to be mindful of explaining to parents before they came to the building that she was not associated with the church, only leasing its building. The participant explained she came to this realisation because a few parents had asked her what her connection was to the church/religion, and one parent made it clear she did not want “Christian counselling” for her child. Consequently, the participant felt that it was important to bring this up with parents before they saw the plaque themselves, by explaining she had no religious affiliation with the owners of the building. The participant did this over the phone when giving parents directions to the building. The two examples discussed above of features of the material environment parents encountered prior to meeting the counsellor illustrate how the material environment assisted in shaping one of the personal influences explored in the previous chapter, namely, participants' understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role.

6.5.2 Place of the first meeting

Most participants identified that the location of their first meeting with parents was an important material influence on their relational practices with parents. The location of the meeting varied amongst participants. Some participants had a separate room they used for adult clients and/or parent meetings. Some participants had only one room with the dual purpose of meeting with parents and seeing children. Two participants who worked as employees for a play therapy organisation had a booking system which meant they did not have a fixed space that was theirs only, and were therefore frequently in different rooms when meeting with parents, depending on room availability. The consensus amongst participants was that having two separate rooms was ideal, that is, one adult-focused room for meeting parents and a playroom for counselling children. In other words, they needed different spaces to build different relationships.

Tammy, who had two separate rooms (an adult and child room) as well as a waiting room, provided an example of the way in which she consciously and deliberately used these separate spaces to convey her conceptualisation of mental health, counselling, and her role:
I show them all my spaces including the playroom in the first appointment . . . they can see there’s a lot of effort that goes into the space, and they can see that I work in a very specific way . . . so they’re not just coming into a dingy little room that heaps of other people use. They’re respected in terms of confidentiality, there’s different rooms for different purposes, entrance and exits. There’s respect of their time – they’re not waiting five, ten minutes to start a session, that’s something that’s communicated quite strongly . . . I’m trying to really empower the parent as well . . . I introduce the space, so for me, that’s a part of that partnership, it’s helping them feel comfortable in the physical space . . . And when I show them the playroom, they kind of get this message: “Oh you’re not just putting out some toys, you’ve got a special, WHOLE ROOM, for our child, like wow, they’re so important they get their own room.” And I also say that to parents: “I haven’t just gone to Kmart and bought every toy I can think of. There’s a method to this.” (Tammy)

Thus, Tammy uses the parent tour of her spaces to highlight that she uses different spaces for different aspects of her service; that she values the parent’s time; that she values the child’s and parent’s confidentiality, so the respective spaces they use have been positioned with this in mind; and that CMHPT counselling is a specialised intervention requiring a specialised space for children, which is set up in a systematic, deliberate way. Tammy stressed that, although she outlines these values in her initial contact with parents over the phone, she felt that physically showing parents her material environment with a running commentary on why she has set it up the way she has was a more powerful way of conveying her conceptualisation of mental health, counselling, and her role as a counsellor, and in turn building the parent–counsellor relationship.

Anne, who worked in an organisation that did not have a designated adult room, expressed that she felt uneasy about not having an adult-specific space in which to see parents:

And this is the only room you can take a parent that doesn’t look childish because of the chairs . . . I feel a bit uncomfortable when you’ve got to go into the other rooms to do the assessment or more formal sort of stuff. (Anne)

Further exploration of this topic with Anne revealed that her organisation’s focus on Child-Centred Play Therapy (CCPT) was reflected through the material environment, that is, it was a space focused primarily on children rather than adults (parents). Although this assisted in cementing the philosophy of the organisation, Anne felt it had
the propensity to not look professional enough and to put parents off, particularly parents who were not eligible for the organisation’s subsidy, and therefore had to pay for the service. Anne equated the professional look of the space with the professionalism of her service, and in turn its value. An observation I made when interviewing Anne was that her qualifications were not on display. Anne advised me that the staff’s qualifications were on display in the staffroom because counsellors in the service did not have their own counselling rooms and had to share with others. We discussed the implications of parents not being able to physically see the qualifications, particularly in light of Anne’s previous comments regarding many parents not understanding her professional identity (see Section 6.2.2). Upon further discussion, Anne reflected that parents being unable to see her qualifications may have also contributed to the lack of formality that Anne felt was important when meeting with parents. Other participants also identified the influence of qualifications being displayed as a way of conceptualising play therapy as part of professional practice and practice associated with an established mental health counselling profession. For example, Josephine’s reflections on displaying her qualifications, as opposed to not doing so in the past, exemplify the general sentiment among participants regarding the importance of emphasising play therapy as part of professional practice:

_This is the first office I’ve had my shingles up . . . Yeah. [Pointing to qualifications] . . . That was with the intention to LOOK professional. To have a clinical practice. Whereas before, I never framed them or anything. I’d have them in my little album but it was sort of this intention to hide that, to not look like an expert . . . and I’ve come full circle with that. It’s like “no, put the shingles on the wall, you’ve worked really hard for them, they actually show your clinical expertise” . . . And I do see parents looking across to have a look at them . . . Yeah, and then the other thing I was sort of thinking of doing next year is, you know, putting up a brass plaque up the front . . . and that’s with that intentionality of making it look like a PROFESSIONAL practice._ (Josephine)

Josephine further explained that she had previously not emphasised her qualifications because she felt that would hinder the parent–counsellor relationship as she equated this with a power imbalance, and attempted to meet parents at a “non-expert” level. However, over time she came to the conclusion that this was detrimental to the relationship-building process as parents were less likely to respect her conceptualisation of mental health, counselling, and her role as a counsellor, as well as less likely to respect her boundaries. Josephine’s example, as well as the other examples
of the place of first meeting the parent presented above, illustrate how participants’ understandings of material influences shape one of the personal influences discussed in the previous chapter, that is, participants’ understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role.

6.5.3 The waiting room

The waiting room was a feature of the material environment that participants understood prominently influenced their relational practices with parents. There were four main waiting room set-ups participants worked in or had worked in which informed their understanding of its influence on their relational practices with parents: (1) no waiting room, (2) waiting room without receptionist, (3) waiting room with receptionist who greeted clients but did not do any of the counsellor’s administration (e.g., did not make appointments and did not process payments), and (4) waiting room with a receptionist who greeted clients and did the counsellor’s administration.

Absence of waiting room

A few participants had worked in practices without a waiting room and identified the influence of the absence of a waiting room on their relational practices with parents. For example, Emily reflected on her former private practice which did not have a waiting room, and how she felt it instilled misconceptions about her counselling service and her role as a counsellor:

There was this attitude [from parents]: “I’m paying you these fees to see my child, to fix my child”, kind of thing, like: “You’re supposed to know exactly what is wrong with my child” and “change them” kind of thing . . . I don’t know if it was because I didn’t have a waiting area and so the whole thing was about drop off at the front door, pick up at the front door, kind of like they were more likely to run an errand and come back kind of thing, rather than waiting around, so maybe that brings about this sense of if you drop something off, like you drop your car off to get serviced and you come back and you pick it up kind of thing.

(Emily)

Anne, who also used to work in a private practice where there was no waiting room, stated parents frequently did not stay on the premises or in their car, but rather would leave to run errands and frequently be late returning. Parents’ tardiness was an ongoing issue for Anne, who not only became frustrated about having to wait with the child, but
frustrated that she had to wait with them outside where she had to shift her role from a counsellor to a parent-like role:

> *That happened ALL the time . . . There was no waiting room there and I’d be outside, because if they [the child] were back in the playroom then it would just be back into, you know, the counselling space, so yeah, I’d be outside saying: “Ooohhh don’t hurt yourself”. So you’re going from a non-directive approach inside and then outside into a role where you’re having to be a parent.* (Anne)

Anne identified that her experience of working in a practice without a waiting area increased her frustration and annoyance with parents, as she found it synonymous with parents arriving late to pick up their children, and in turn taxing her time and energy. Anne described how she became increasingly stressed about having to continuously set boundaries with parents about arriving late, and felt this impacted on her ability to develop a genuine parent–counsellor relationship where she was not trying to mask her frustrations toward them. Ultimately, Anne left the practice as she felt her emotional health was being compromised by the isolation she felt at the practice and the lack of material and collegial support associated with a practice without a waiting room.

**Waiting room without receptionist**

One participant, Tammy, had a waiting room without an on-site receptionist. Instead, she had a virtual receptionist to answer her phone calls. Despite not having an on-site receptionist, Tammy personified her waiting room and considered it a type of a co-worker in the sense that she imbued it with a clear sense of purpose in terms of greeting and engaging parents. Tammy discussed how she consciously intended to make her waiting room reflect her overall therapeutic approach which was depth therapy, that is, focusing on addressing the primary issues driving children’s symptoms. Tammy did this by deliberately creating a “textured” feeling in the waiting room. She described its furnishings and colours as warm, inviting, but also multilayered in the sense that there was lots of detail in the room (e.g., custom upholstered sofa chairs, furnishings, books, and resources). Tammy intended the richness of the space to reflect a layering or unwrapping that mirrored her therapeutic approach. In other words, she used the waiting room set-up to symbolise her conceptualisation of and approach to mental health and counselling:
It’s something that’s quite sensory, it’s something to me that has a lot of detail to it. So the physical environment, it has a lot in it which for me reflects this. There’s a lot of different layers and elements to it, but it’s more than just what it looks like . . . I’m working at that deeper level, so the physical is important, but there’s emotional and all the other elements that go deeper than that as well. And that’s what I’m trying to understand in terms of their child as well, that it’s deeper than just the reason for the referral, all those presenting issues, that it is deeper than that. (Tammy)

Similarly, Tammy used the waiting room and the timing of appointments to stress her values regarding both child and parent confidentiality. For instance, Tammy consciously positioned the waiting room so that it was far enough from the playroom, meaning parents could not hear what was taking place in the child’s sessions. Tammy also considered the parents’ need for confidentiality in terms of potentially bumping into other parents in the waiting room. To make parents feel at ease and to maintain their confidentiality regarding seeking her services, Tammy intentionally set up her appointment times so that parents would not be in the waiting room with other parents:

They’re not talking to other people, it’s not like: “Oh, you come here too”, there’s none of that conversation that happens, and they won’t bump into anyone else as well because I’ve structured the timing that way, so there is I guess, for me it’s that safety, it’s that temenos. (Tammy)

Although Tammy stressed there were many advantages to her waiting room set-up, she identified that one of the main disadvantages was that it did not have a receptionist on site. Tammy felt that the absence of a receptionist made it more difficult to maintain boundaries with parents when she had to shift from her counselling role into an administration role, particularly processing payments:

Being a private practitioner and not having a receptionist, it’s ALL going through me. I think it blurs the boundaries. I also think that taking payment directly from parents blurs another boundary as well which sometimes, I don’t know, sometimes there’s a bit of that martyr kind of, you know, if they’re struggling financially and you see them saying: “Oh, that card hasn’t worked . . . Let me try this credit card”, you know, that kind of stuff, and I don’t want to have to deal with all that. Whereas if I had a receptionist they would deal with that, not me

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23 Temenos is a term used in Jungian psychology to indicate the sacred, contained space of the counselling room and how it is set apart or distinguished from everyday spaces.
. . . So I think it blurs up the boundaries not having a receptionist . . . especially if they’re struggling and you see it. You swipe their credit card and have to say: “Oh, that’s declined” [laughs]. Having to have that kind of conversation, and the credit card getting declined [makes a noise when card is declined] . . . “beep, beep, beep, beep” [laughs] . . . I really don’t like having to deal with that. (Tammy)

Participants who did not have a receptionist to process their payments, and therefore processed their own payments, also identified that the timing of processing payments could undermine the relationship-building process with parents. For example, Tammy found that processing payments at the beginning of the child’s counselling session rather than the end assisted in maintaining boundaries regarding her role as counsellor, as she felt that paying at the end of the session shifted the relationship too abruptly to a financial one that did not gel with the flow of the session:

Because sometimes you have some emotionally charged sessions which are very insightful and powerful but also really hard work, and then you have to say: “Ok, come and pay me”. I hate that. I just, you know, that does not work for me ’cause it’s switching me to a financial position. And yes, it’s a business and they know that, and it’s a service but me having to do it is a whole other ball game. So that’s why I’ve started it [processing payment] at the beginning. (Tammy)

Waiting room with a receptionist who greets clients

Two participants worked in a building where they had a shared waiting area with other allied health services. These set-ups included a receptionist who greeted clients but did not process the counsellor’s payments. Louise, who had this set-up, explained that, because most of her referrals were from third parties who paid her via an invoicing system, many of the parents she saw did not pay her directly, so she mostly only needed a receptionist who greeted her clients. Louise placed a lot of importance on this role in terms of making parents feel at ease and acknowledged. Louise stressed that she felt the receptionists assisted with reinforcing her own approach with parents, that is, a balance of warmth and professional boundaries. Louise also felt it was an advantage to share a waiting room used by other allied health practitioners, as her clients were not singled out as the “mental health” clients:

They’re probably the best receptionists I’ve had because reception staff have always been the bane of my life, and yeah, they’re possibly the best I’ve had . . . Probably because I’ve been really clear with them from the very start about my
expectations, but I think they’re the type of people who just know what their role is as receptionists. They don’t want to be practitioners... They’re not like some medical admin who actually want to be the doctor... They’re not power and control type people. Not at all. They’re really non-judgmental, you know, just never ask questions... other practitioners in the building have clients who use that waiting room too, so my clients aren’t singled out as the mental health ones. You could be there to see anyone and that makes such a difference.

(Louise)

Thus, Louise’s understanding of the role of the receptionist in tandem with the waiting room included that they assisted in reinforcing her values of balance between congeniality and professional boundaries. Louise also discussed how the receptionists would feed back to Louise any significant observations they made regarding her clients in the waiting room; for example, the nature of parents’ interaction with and supervision of their children while waiting in the waiting room. Louise explained that she found this information valuable as she often was not in a position to be able to observe parents in this way. Thus, the receptionists via their positioning in the waiting room enacted a co-worker role in assisting Louise with her assessment of parents’ parenting practices.

**Waiting room with a receptionist who greets clients and processes administration**

Emily, who had experienced different practice set-ups, reflected on the important influence receptionists had on her relational practices with parents, particularly receptionists who answered phone enquires and organised her appointments. One of the main areas Emily identified that had changed in her practice since having a receptionist was that boundaries were now mostly maintained by the receptionist rather than herself, and parents were less likely to engage in transference reactions with her because she was not setting the boundaries:

*There’s this real thing about containment, and so even though the receptionist, she’s not a psychologist but she certainly has been trained in regard to this idea of containment and boundaries, like definitely is, it runs through the practice in terms of the culture, and the way she speaks to people on the phone, and when they come in. She’s very respectful and very kind but yet she’s like more, she’s really able to say: “Oh well no, we don’t do that”, and like there’s not a lot of fluffing around, and it is made quite clear particularly when a parent tries to contact you like on a day when you’re not working and asks to write a court report. Like this mother rang saying she wanted me to write a court report and*
saying she needed it by the end of the day [laughs], and the receptionist dealt with that. I didn’t even have to deal with that at all . . . and for the parent, because the boundary setting is not coming from me, they’re less likely to take it personally, there’s less transference. (Emily)

Emily also identified the advantage of having a supervised waiting area as it allowed her and other counsellors to see parents on their own while the receptionist minded their child. Emily reflected that this increased face-to-face contact with the parent improved the parent–counsellor relationship:

The good thing about the new set-up is there’s kind of a supervised waiting area, because there’s reception there for children to give them colouring in or something if you want to see the parents separately before or after the session. And so I’ve been structuring the Child-Centred Play Therapy ones, more or less I see the child for 30 minutes and then I see the parent for 15 minutes, so because I have this opportunity available to me to see them, I’m engaging them a lot more . . . like I was engaging them before but there was a lot more phone and email kind of correspondence going on than now. (Emily)

Emily also identified that having a receptionist that took all phone calls assisted in managing boundary issues with parents, and in turn her emotional health, as she was no longer anxious and drained by out-of-session phone contact. Emily contrasted this to her previous solo private practice set-up where she used to take all the phone calls:

I think that when they speak to a receptionist, they kind of understand that that person’s not really going to be able to help them because their job is there to make appointments and cancel appointments and what not. But when they know they’re speaking to the psychologist, especially because I was the principal psychologist of the practice, they’re like: “Oh, I’ve got her on the phone now and I’m going to get the most out of this conversation that I can”, . . . so yes, I was resentful about the phone calls. I’d feel anxious if my phone went off. That’s why I let it go to voicemail all the time . . . I’d feel anxious because I would think: “Oh, is this going to be a referral and now I’m going to be on the phone for 20 minutes or a half hour with somebody, and by the time we actually get to the point where they book in or maybe they won’t even book in”. You know, you get those sometimes, where they just probably just want to talk to someone on the phone but they’re not actually intending to make an appointment, or you get to the point where you tell them your availability and they’re like: “Oh we can only do, you know, 4 o’clock on Tuesday and since that’s not available then I’m not going to come in to see you” . . . so you’ve just spent 20 minutes on the phone
Participants’ understandings of the influence of the waiting room on their relational practices with parents revealed that it shaped three of the personal influences discussed in Chapter 5; namely, participants’ understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role; parents’ responses to the counsellor’s boundaries; and the counsellor’s emotional health.

6.5.4 Technology and communication in between meetings

All participants identified the influence of phone, text, and email contact with parents between meetings as a potential source of stress for them, particularly if the contact was not administrative in nature (e.g., changing an appointment time), but rather involved the parent not being able to wait until the scheduled meeting before discussing various issues with the counsellor at length. Most participants who were in private practice reflected that, when they first started their practice, they wanted to be as available as possible for parents to build the parent–counsellor relationship, and in turn facilitate the likelihood the parent would choose their service. However, over time, participants realised that being so accessible made it a challenge to maintain boundaries with parents, particularly in terms of taking up too much of their time and consequently this impacted on their emotional health. Participants identified email and texting after hours and weekends as the most annoying and emotionally draining consequences of their availability facilitated by these technologies or material artefacts. Tammy reflected on this issue, and how she began to associate checking her emails as a negative emotional trigger because in the past she had either been attacked by parents via email, or parents had used email contact to discuss issues Tammy felt needed to be discussed in a face-to-face scheduled parent meeting:

So say if it’s been via email [boundary violations], it starts to then impact on how I see emails, if I want to even check them, if I even want to look at the screen, if I even want to respond, so it kind of impacts in that way. There will definitely be the fatigue and everything else associated with that energetically. (Tammy)

Other participants echoed Tammy’s sentiment, particularly those whose abusive and threatening experiences with parents had taken place over the phone and/or email. Participants identified an increased sense of emotional safety when they did not
give their mobile numbers or email addresses to parents, but rather had a receptionist (virtual or on-site) take the calls and emails for them. For example, Emily reflected on how much better she felt in her new workplace where staff were not encouraged to give their mobile number and email addresses to parents, but rather to direct all communication through the receptionist:

*Parents don’t have my mobile number or email address and they can’t contact me, so I really like that feeling of leaving work and knowing that I’m not going to have anyone contacting me when I’m not at work. (Emily)*

In terms of the impact this had on participants’ relational practices with parents, most participants interpreted parents’ contact between sessions as a boundary violation, and thus found it more difficult to develop a genuine relationship with the parent as they were so annoyed by them. Conversely, participants such as Emily who were not contactable in between sessions reflected that they were more relaxed (not annoyed) when they did see the parent, which assisted in developing a more genuine parent–counsellor relationship as they were not attempting to suppress emotions such as frustration and anger.

A notable aspect of participants’ understandings of the influence of the material environment on their relational practices with parents was that they focused primarily on parents’ use of or approach to the material environment rather than their own. For example, in the case of technology and communication between meetings with parents, participants did not consider whether the issue was related to their own ability or inability to maintain boundaries, rather than simply a feature of the material environment that parents used to not respect the counsellor’s boundaries.

In this section, I have identified four main aspects of the material environment that participants identified as influencing their relational practices with parents: (1) material impressions before the first meeting, (2) place of the first meeting, (3) the waiting room, and (4) technological communication in between meetings. These aspects were intricately related to the sequence of practice events occurring in time. That is, the various practice episodes that involved engagement with parents were not simply structured by time, but also structured by the material environment. As with the other sociocultural influences discussed in this chapter, the material environment was identified as a sociocultural influence that shaped the personal influences presented in
the previous chapter; specifically, participants’ understandings of parents’ conceptualisations of mental health, counselling, and the counsellor’s role; parents’ responses to the counsellor’s boundary setting; and the counsellor’s emotional health. An additional finding revealed in this section was that, like the other sociocultural influences discussed in this chapter, participants’ understandings of the influence of the material environment centred around how they understood that parents approached and responded to the material environment, rather than their own relationship to materiality and space.

The tone and mood of participants’ deeper understandings of the influences on their relational practices with parents continued to be mostly negative, as participants largely focused on their more challenging parent experiences and encounters rather than their positive ones. However, the somewhat negative timbre of participants’ deeper understandings also carried through when they talked about other stakeholders such as referrers, Medicare, FaCS, and the police. This suggests that it may not be simply parent-driven influences that CMHPT counsellors understand as influencing their relational practices with parents, but rather any third party outside the child–counsellor dyad that does not support their way of working.

6.6 Conclusion

In this chapter, I have explored a range of sociocultural influences participants understood as influencing their relational practices with parents. These sociocultural influences include demographic (class and professional identity), structural (Medicare and referrers), temporal, and material influences. My research revealed that these sociocultural influences were not simply additional influences separate from the personal influences discussed in the previous chapter, but rather they were intricately related to them. Specifically, participants’ understandings of the sociocultural influences on their relational practices with parents were interconnected with their understandings of personal influences, revealing an ecosystemic pattern of influences. Figure 6.1 depicts this relationship between participants’ understandings of personal influences and sociocultural influences. Although the diagram depicts a template of sorts, the actual pattern of influences would look, feel, and be different for each individual counsellor, as they each understand the influences in varying degrees, shades, and intensity.
Another finding that emerged was that participants' understandings of sociocultural influences on their relational practices with parents were derived primarily from focusing on how the influences first shaped parents' practices and then how participants responded to parents' practices, rather than approaching the influences in a relational sense where they shaped both parents' and participants' practices symbiotically. My findings also revealed that participants' understandings of sociocultural influences on their relational practices with parents primarily involved conscious influences rather than unconscious influences. That is, participants did not employ social unconscious reflexive tools to identify sociocultural influences on their relational practices with parents.
Critical and imaginal distanciation

He who would search for pearls, must dive below.
– John Dryden, All for love

In this chapter, I answer the research sub-question: What is the nature of CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their relational practices with parents? This sub-question penetrates an understanding of the research phenomenon further than the previous sub-questions in that I focus specifically on participants’ understandings of unconscious structural influences on their practices with parents. I begin the chapter by discussing participants’ use of critical reflexive tools to achieve this understanding. I then discuss my deepening understanding developed through my application of the Bourdieusian and Jungian theoretical thinking tools outlined in Chapter 3. The application of the theoretical thinking tools corresponded to the distanciation moment of my Critical Imaginal Hermeneutic Spiral, in that I moved away from focusing on participants’ intended meanings and understandings of the research phenomenon, to using the tools to expose unconscious personal, social, and collective structural features emanating through the texts. The distanciation moment included exploring participants’ imaginal product-making and imaginal sense-making processes, and how these imaginal processes assisted in exposing unconscious personal, social, and collective unconscious influences on participants’ relational practices with parents. It also included an exploration of how my own shadow prevented me from identifying unconscious influences on participants’ relational practices with parents. I conclude the chapter with reflections on how the thought partnership between Bourdieu and Jung yielded a deeper critical understanding of my research phenomenon.

7.1 Introduction

There was variability among participants in terms of their critical reflexivity regarding unconscious structural influences on their relational practices with parents. This
variability was found to be a function of participants’ critical reflexivity tools. Although most participants used transference and countertransference as critical reflexive tools, these were the only critical reflexive tools participants used to identify personal unconscious influences on their relational practices with parents. None of the participants used critical reflexive tools to identify unconscious social structural influences on their relational practices with parents. When directly asked about social theory, most participants took this to mean seeing children’s mental health issues in the context of their family system and wider social systems such as their school and geographic location. Participants’ understandings did not extend to broader and deeper understandings of social theory that encompassed notions of unconscious social structures shaping practices. Three participants (Emily, Louise, and Josephine) who were trained in Jungian psychology used archetypes as a critical reflexive tool to identify collective unconscious structural influences on their relational practices with parents. These participants actively used their imaginal product-making and imaginal sense-making processes in conjunction with archetypes to uncover collective unconscious influences on their practices. I discuss these participants’ critical reflexivity and their imaginal products in the sections of this chapter where I apply archetypes as one of my distanciation tools.

In the following sections, I present my application of the Bourdieusian and Jungian theoretical thinking tools discussed in Chapter 3. I used Bourdieu’s and Jung’s theoretical thinking tools as my structural analysis tools to uncover personal, social, and collective unconscious structural influences on participants’ relational practices with parents. This corresponded with the distanciation moment of my Critical Imaginal Hermeneutic Spiral. I also used the tools to reveal a relational understanding of how personal, social, and collective unconscious influences knit together to form a relational web that underpins participants’ relational practices. I start weaving this web by introducing the Jungian concept of the cultural complex, and then weave in other theoretical thinking tools to demonstrate a deeper, enhanced understanding of the research phenomenon they facilitate.

7.2 The parent complex

As discussed in Chapter 4, the first interview question I asked participants was designed to reveal whether there was the presence of a parent complex among them: *Without feeling the need to be politically correct, in the context of your work counselling children,*
what immediately comes to mind and how do you feel when I say the word “parents”? Six of the seven participants responded with negative or what they understood to be undesirable thoughts and emotions, suggesting a strong parent complex among them. The following six participant responses to my question illustrate thoughts and emotions centring around fatigue, shock, frustration, and anxiety:

Well, first thing I notice is my body went “pffhhh” like a sigh, like “oh, no”. So first thing that comes to mind is probably, um, slumped. Actually, I feel de-energised. Yep, yep, that’s an automatic position to come to. Yep. Even when you said that word “parents” my body collapsed. So it was like a “ahhh”, heavy, weight, burden. (Josephine)

A few different things. It’s some images, like of different people that I might associate that with, and I have to say that the emotions that kind of goes with it is probably anxiety and frustration and shock . . . I have been more shocked in my life than anything else . . . I can’t believe some of the things people say and do when it comes to their kids. (Emily)

Painful! [Laughs] As soon as you said “parents” it was that straight away. And it is usually my first response, even though I’m REALLY excited to do play therapy with kids, but if we’re talking about parents in particular, it’s just ohhh, it’s so much work to get them on board, understanding, and continuing that engagement with them long term over so many sessions. (Louise)

Kill me now! [laughs] That’s terrible but true. Kill me now. Yep. That would be yeah, my instant, that’s what comes to mind . . . Sounds really bad. Yeah. I think for me what brings me to it is they become for me such an obstacle with working with their child and I really enjoy working with kids but they themselves become the obstacle. (Tammy)

More work. To me it’s more work. It’s not one client, it’s a family. There’s more to what we’re going to be working with. More work . . . and I get anxious . . . I have more stress around the parent than working with the child. Basically. Yeah. (Anne)

Um, I guess it’s probably anxiety . . . I remember the ones that are the most difficult, but actually when I think about it there are quite a lot that went really well . . . I guess they were parents that weren’t quite so anxious about their child and the way that they were going. (Luisa)

Elizabeth was the only participant not to express a negative reaction to the word parents in terms of thought or affect:
Participants who expressed a negative response to the word parent seemed unaware that their emotional reactions may be the function of the social unconscious in the form of a cultural complex. My contention is that participants overlooked the possibility that their experiences were part of a cultural complex for three reasons. First, participants did not have the critical reflexive practice tools to unearth and identify social unconscious influences such as cultural complexes. Second, the CMHPT counselling habitus normalises the experience of parents being challenging and evoking strong emotions such as frustration, anxiety, and fatigue. That is, if participants encountered other CMHPT counsellors having similar thoughts and emotions associated with parents, the CMHPT counselling habitus and field normalised this as the natural order of things. Third, as stipulated by post-Jungian scholars, behind every cultural complex lies an archetype (Singer & Kaplinsky, 2010), which suggests most participants’ parent complex is driven by an archetype that generates emotions such as frustration, anxiety, and fatigue. In the following section, I explore how these unconscious structural influences contribute to the development and maintenance of the parent complex.

7.3 Archetypal fields, habitus, and tensions

In this section I discuss how, in applying Jung’s theoretical thinking tool of archetypes with Bourdieu’s habitus and field thinking tools, I uncovered key archetypes structuring the CMHPT counselling field and influencing participants’ relational practices with parents. I refer to archetypal predispositions as archetypal habitus, as each archetype has a clear predisposition that drives its characteristic sayings, doings, and relatings. In identifying archetypes, I refer to their corresponding archetypal fields (e.g., the healer archetype functions in the healing field). I deliberately use field to

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24 Although there could be any number of reasons for Elizabeth’s positive, optimistic, strength-based response, in Jung’s word association activity participants’ reaction time is interpreted, particularly if there was a “marked prolongation of the reaction time” (Jung, 1910, p. 224). Jung generally considered a delayed response to indicate that the participant was censoring the first thing that they thought or felt in relation to the word (Jung, 1961/1995). From this perspective, Elizabeth’s long pause and possible censorship of her response may have been associated with Elizabeth being the only participant I had not met before, and therefore she may have been attempting to maintain a professional persona despite me saying she should not be concerned with political correctness.
describe both social field (as per Bourdieu) and archetypal field, as I contend they represent different dimensions of the same thing. Given that archetypes function as prototypes or templates, they have definitive boundaries to their practices. Thus, when discussing archetypes I adopt language that reflects this tight structure. Throughout this section, I use participants’ imaginal products and imaginal sense-making processes as a springboard for my application of archetypes to my texts, and in turn my own process of distanciation. Where participants have themselves used archetypes as a tool, I make this distinction and discuss how it may differ from my own distanciation of the texts.

7.3.1 Healing field and the healer archetype

As indicated by participants’ comments pertaining to their parent complex as well as their sentiments discussed in Chapter 5, participants mostly wanted to focus on working with children and often saw parents as an obstacle to what they considered was their core business. From an archetypal perspective, participants considered their core business as a healer of wounds (mental health issues) presented by the wounded (the child), and the parent’s main role was to bring the child to and from healing sessions (healer’s assistant) as well as to provide an appropriate nurturing environment at home to enable the child’s recovery (nurturer). Considering the healer archetype is focused on serving the wounded by repairing and transforming their illness (Myss, 2001), they are less focused on those they do not consider their patient/client. Consequently, I argue that the healer habitus is mostly primed to facilitate relational practices associated with the wounded child rather than with other parties such as parents. This is reinforced by the main stakeholders in the CMHPT counselling field who expect that the CMHPT counsellor is primarily focused on healing the child. For instance, Medicare only funds sessions when the child is present in the room.

In the context of the CMHPT counselling field, the healer habitus is developed largely in counsellors’ core tertiary training where the focus is overwhelmingly on providing counselling (healing), rather than working with other stakeholders such as parents. The healer habitus functions like second nature when the healer is directly engaged with the wounded child and focused on carrying out healing practices. However, parents who require engagement with the counsellor beyond the healer’s assistant (e.g., if the parent requires their own healing, or attempts to dictate to the healer how they should be healing the child) cause an interruption in the healer
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habitus. Tammy’s imaginal product (see Figure 7.1) and imaginal sense-making process exemplifies the presence of the healer archetype and how it is unable to function to capacity when interrupted by parent demands.

Figure 7.1. Tammy’s imaginal product.

Below is a section of the interview transcript that explores Tammy’s imaginal sense-making process. Figure 7.2 at the end of the interview sequence provides a close-up image of the carousel that appears in the top right-hand corner of Figure 7.1.

Tammy: My intent in terms of working with families and what I hope, what I want to be able to do, is actually help . . . so I’ve chosen a wand [bottom centre of Figure 7.1]. So it’s not about a magic wand necessarily, it’s more about the notion of actually helping. And I guess that notion of helping has changed over time, I guess part of it was my ignorance I guess. I always did really want to help the child . . . I wanted to have them get better, and I still do. I still definitely do. But I think what I’ve noticed as well that sometimes that help might actually pan out in different ways. It might just have to be advocacy. It might just have to be pinpointing a primary issue at heart, accepting the dropout . . . and my intent as well I guess is that notion of culling, there’s a rubbish bin [to the left of the wand] [laughs] . . . whilst I want to work this way [pointing to the wand], it doesn’t always work this way . . . so I take the knowledge that I need before chucking it in the bin.

Rosa: I might have misunderstood. Is that dropouts or culling parents? Is that what the rubbish bin is for?
Tammy: Yeah, it’s both. But before they go in the bin, I have to think about whether there is any aspect I have to keep or hold onto, and then I’ll discard the rest.

Rosa: Do you mean learning from that experience?

Tammy: Yeah. Before assessing what needs to go in the rubbish . . . [referring to the magnifying glass symbol positioned above the wand] so for me the intent, the magnifying glass, is really being able to have a lens to be able to examine and understand the child . . . where I really start to get into the nitty gritty of it when I meet with the parent, where I start to better understand things . . . being able to look through deeper, understand what’s happening . . . it’s that deeper understanding, and that’s why it’s looking through, it’s not just at a surface level. It’s really trying to look at what’s governing the child, so going as deep as possible. And I do that all the way through the [counselling] process. Not just once. And there’s the hand [bottom centre below wand], I’m seeing this as two hands, it’s an agreement, it’s really about the notion of a shared understanding of my role, the parents’ understanding of my practice and my work . . . it’s an agreement normally that I’ll get at the beginning but this is tested sort of as it goes on.

Rosa: How is it tested?

Tammy: I think for me it’s kind of like this carousel [top right-hand corner] . . . there’s that up and down, but everyone’s still on board.

Rosa: . . . What would you say the function of a carousel is? If you were to describe it to someone who didn’t know what a carousel was?

Tammy: For me it’s like a bit of a dance in some ways . . . It works together with the rhythm, it works together with the music. It works together, it’s about working together. It can stop at times as well. It might need to be wound back up . . . even when we might stop, or even when one’s up and one’s down, they still kind of balance each other out . . . for it to be working really effectively there needs to be harmony. For me that’s sort of my intent with working with parents, regardless of whom I’m seeing, that it’s sort of how we communicate.

Rosa: . . . how many figures are in there? [looking at the carousel]

Tammy: Um, one, two, three horses, yeah, three.

Rosa: So who or what do they represent?
Tammy: Mmm. Two parents and me. Mmm [long pause] or parent, child, and me. Mmm. Definitely parent, child, and me. Yep. Mmm. I hadn’t noticed that there were three. I also hadn’t looked at the steps either [turned carousel around to show steps]. There are steps that they [parents] have to take before getting on the ride with me. Mmm.

Figure 7.2. Close-up of part of Tammy’s imaginal product.

The above interview sequence was from Tammy’s second interview. Tammy and I continued to explore what the three horses (fixed into the symbol, that is, not moveable parts) and steps symbolised for Tammy. Tammy stated that unpacking the specific features of the carousel had really resonated with her, as it provided her with deeper and more pertinent symbolic detail, helping her to clarify how she wanted to work with
parents and children, and what frequently stopped her from doing so. In Tammy’s third interview, she told me that in the month since we last met she had reflected on the carousel further:

Tammy: I’ve been working with the carousel . . . since I last saw you. Since then, I’ve rejected a possible client because I could tell from the first interview that there was no way me and the mother were on the same carousel, let alone the same theme park [laughs]. So it was making that decision not to see that child, because I wasn’t the right service I felt for that mother, and there was no way I think we could be on the same page ‘cause her agenda was really strong, and in the end I don’t think I fit that. So it was, yeah, it was kind of imagining this carousel, thinking: “Can you be on it with me, you and your child?” And yeah, I thought the child may well be on the carousel working with me but not the mother, so that was a strong visual for me . . . I couldn’t see her on it, on the carousel.

Rosa: So you were consciously aware of that?

Tammy: Yeah, definitely, definitely. And yeah, having to make the call to her after reflecting on what I was thinking post that interview with her, you know, it was quite a difficult interview. She really argued almost every point that I tried to make [laughs] . . . She had her own agenda and didn’t respect my way of working . . . I felt quite good about it that I wouldn’t get involved in something that wasn’t a primary issue [simply addressing the child’s symptoms] that would in the end have caused me stress and grief and frustration, because I know that that’s what it would do, I’ve seen it happen before. So it’s good that I don’t have to get into that, so yeah, that felt quite good that carousel. That carousel was quite strong.

Tammy further reflected that, in the case of the mother she described, she culled her (or symbolically binned her) relatively quickly as she had a clear image (the carousel) of what she wanted to offer in terms of her counselling service, and what was needed for a harmonious working relationship between her and the parent. Tammy reflected that, had she not actively used the symbol in this way and accepted the referral, the mother would have likely dropped out any way:

Tammy: It would have either fallen apart, she’d pull the child out or she would complain to someone about me or my practices or the lack of perhaps progress or whatever it was . . . yeah, it would have gone down that path. I don’t think it would have gone anywhere else. It would have been likely I would have taken it on in the hope that maybe I could change it, maybe idealistic kind of thinking,
but I think all the evidence was pretty strong for me, so yeah. I’m glad I said no. And it felt quite good saying no actually. I don’t do it a lot, I’m getting better at it I think. It felt quite good to stand for what I think my work and this practice is about. Especially working with kids.

Tammy did not use archetypes as a critical reflexive tool but my distanciation of her imaginal sense-making revealed that the wand represented the healer archetype and her desire to heal children, but she was often unable to use it as she would like as parents frequently posed obstacles to her approach to healing. Although Tammy expected some ups and downs and even some halts along the way (the carousel), if parents were not on board with her approach, they either dropped out or she culled them (the rubbish bin). From an archetypal perspective, I contend that aspects of Tammy’s assessment process (the magnifying glass), her expectation of how parents should behave and approach her and her service (the carousel), and her culling of parents if their practices were not congruent with hers (the rubbish bin) were not indicative of the healer archetype, but rather the private school principal archetype (to be discussed further in the following section).

Additionally, I contend that the presence of the non-healer archetype (i.e., the private school principal archetype) typically caused an interruption to the healer habitus performing its healing. This interruption was caused either because the parent dropped out due to not being happy with Tammy’s method of healing, or how fast the healing took place, or because Tammy rejected the parent because they did not demonstrate they were able to accept her conditions of service. Although Tammy’s example of the mother she rejected went relatively smoothly because she was consciously using the imaginal to reflexively clarify her practices and whom she wanted to work with, she still ended up not healing the child. As Tammy mentioned, in other scenarios where she typically said yes to the referral in the hope that she could convince the parent to come on board with her way of healing, there was usually a great deal of angst and conflict because the parent invariably would not accept Tammy’s way of working. In archetypal terms, I argue this conflict is due to the healer archetype trying to access the child for healing and the private school principal archetype trying to expel the parent. That is, each archetype has different motivations. I refer to this internal counsellor conflict as archetypal tensions. Similar archetypal tensions were evidenced in all participants’ imaginal products and imaginal sense-making processes. In exploring all participants’ imaginal processes, I identified two main overlapping
archetypal fields and their associated archetypes that penetrated the healing field: the parenting education field (school teacher archetype) and the trauma field (warrior archetype), which I discuss in the following sections.

7.3.2 Parenting education field and the teacher archetype

As a function of working with children, participants in my study discussed how they were required not solely to focus on addressing the child’s mental health issues (healer archetype) but also to regularly set boundaries with parents regarding their policies and procedures (teacher archetype), as well as to provide psycho-education to parents with the aim of informing and guiding their parenting practices (teacher archetype). Consequently, by engaging in these practices and activating the teacher archetype, participants unconsciously activated the education field, or more specifically the parenting education field. This in turn activated the student archetype in parents. In my study, the teacher archetype corresponded primarily to didactic teaching and assessment practices rather than practices focused on creative motivational learning.

Participants’ language was an important indicator of the presence of the teacher archetype. For instance, many of the practice episodes I discussed in Chapter 5 are replete with education-type language such as “parent interview” (school application interview), “parent review session” (parent–teacher interview), and “progress report” (school report). Medicare as a social structure assisted in the activation of or at the very least reinforced the teacher archetype, as participants who worked under the Medicare scheme were required to provide the referring GP with a “progress report”. In these progress reports, participants typically included the parent’s response and follow-through regarding recommendations concerning their parenting, that is, whether they had done their “homework”. For counsellors such as Tammy who gave parents a copy of the progress report, parents often responded like school students receiving a poor report card:

Tammy: And I’ve sent that off [the progress report] and that is sometimes the reason for the dropout, which I’ve noticed, they’re not happy with the report.

Rosa: That goes to the GP you mean?

Tammy: To them and the GP. Even though what I have discussed in the report I’ve discussed with the parent in person.
Rosa: So it’s in writing. Is that what it is?

Tammy: It really is . . . I think it’s more the medium itself. It’s physical, it’s not just the parent that has it, the GP has it too. Even if it’s a GP who is quite a, I don’t know, a lax GP who might not even read it, I think at least it’s there, somewhere, someone has a copy of what the primary issue is . . . the need for the parent to really work on their own stuff.

It is important to note that, as discussed in the previous chapter, almost all participants noted that dropouts occurred around the review session, that is, when they meet with the parent to discuss the child’s progress in counselling and invariably provide feedback (verbally and/or in writing) regarding the parent’s parenting. It was also a time when parents where often required to discuss with the counsellor the work they themselves had been doing since they last saw the counsellor. Josephine described having a review session with a parent to determine whether they had been implementing the strategies she had advised when she had last met with them:

When it came to review and we were looking at barriers and changes and what they’d been doing, I asked her: “How have you been going with the emotion coaching, how have you been going with this, how have you been going with that, have you got your house rules up?” And that’s often the stage when parents have to front up and put themselves on the line and say: “Oh, look I did this or I didn’t do this”. And I think that’s the time they’re more likely to drop out. And I do have some parents who will try to avoid the review stage. (Josephine)

Josephine’s example suggests a strong association with teachers giving students homework and parents (students) avoiding the teacher if they have not completed it, for fear of getting judged or receiving a poor Medicare progress report (report card). Although I found all participants embodied the teacher archetype, there were nuances regarding what type of teacher and what type of school they practised in. I discuss this further below.

**Private school field and school principal archetype**

From an archetypal perspective, my study revealed that participants who ran their own private practices were not simply embodying the teacher archetype but, as the owner of the practice, embodied the school principal archetype in a private school situated in the private school field. The private school principal archetype was evident in participants who operated their own private practices (as opposed to those working for
someone else), particularly in their approach to accepting or refusing referrals, and how they approached interviewing parents. Corresponding to a private school, the participants embodying the principal archetype had relatively high standards concerning parents (students) they admitted, and there was typically a more stringent admissions and assessment process to determine who would be accepted.

Josephine’s practices provide an example of this, as her sayings, doings, and relatings suggested a private school principal habitus. Although Josephine actively used archetypes as a critical reflexive tool, she was unaware of the influence of the education field on her practices with parents, and instead focused on archetypes typically found in the healing archetypal field (e.g., orphan and martyr archetypes). At the beginning of Josephine’s second interview, she reflected on the month since I last saw her for the first interview and how the topic of working with parents led her to reflect on her practices. This reflexivity included using archetypes as a way of making sense of parents’ behaviour and her frustrations with them. Specifically, Josephine identified that parents who embodied the orphan archetype triggered her most emotionally (namely, she felt frustrated and anxious), as they were less likely to commit to putting in the work she required of them, and instead expected Josephine to “fix” all their problems, including their child. In identifying the orphan archetype as driving these challenging experiences with parents, Josephine decided to implement practices to “weed” them out, as she described:

*So in the new assessments I’m doing [since the first research interview], I’m sort of reflecting on that process, so that’s been a REAL eye opener one as well, and I think it’s when I start to really break it down and look at the different archetypes that are presenting, that’s a lot where my triggers lie – the ORPHAN and those sorts of things . . . I suppose it’s that sort of orphan and victim, you know they’re my triggers, to have an orphan in the room.* (Josephine)

Josephine used her imaginal product-making to symbolise and to further reflect on and express what she meant regarding the orphan archetype. Josephine used Joseph Campbell’s (1949/2008) hero’s journey as a structure or template to symbolise how she saw parents’ journey through their child’s counselling process. Josephine divided the stages of the journey into the departure, initiation, and the return stages. Using these symbolic stages, Josephine described how she felt that parents needed to leave their comfort zone (old sayings, doings, and relatings) and embark on a journey where
they would be challenged (initiated into new sayings, doings, and relatings), and then return to their daily lives with their new knowledge and skills (new parenting habitus) about how to parent their children in a positive fashion. If Josephine assessed that parents did not demonstrate they were ready and committed to the journey ahead, Josephine did not accept them into her service. In describing the initial stages when parents first approached her service, Josephine created an image of a castle with lions on either side, which she described as gatekeepers (see Figure 7.3).

Figure 7.3. Part of Josephine’s imaginal product (page 1 of 3 pages).
Below is a section of the interview transcript that illustrates Josephine’s imaginal sense-making process:

Josephine: So then, you know, my little lions on either side of the parent/carer phone call, that’s my first territory marker. They’re my first gate keepers. It’s [parents] getting through those lions at the start. So, that could be as simple as, you know, sometimes I answer phone calls, sometimes I don’t. So it might just be that they’ve left a message. Sometimes it’ll take me a day or two to get back to people . . . So that’s sort of done on my terms, I think that’s what the lions to me represent, and I chose those ones because they’re not aggressive, they’re not, they’re quite static but they’ve got that strength.

Rosa: So what’s their main purpose or role? Is it to convey strength or is it more than that? Like, what’s the message you want parents to get from their initial phone call when they first phone you?

Josephine: Well, it’s sort of is a bit like walking into a lion’s den. You don’t know what’s going to happen. And it’s almost like they need to understand that, that counselling is not going to be easy. It takes commitment . . . So the lions are sort of the gatekeepers, and if you really haven’t got the strength for that journey, well then this isn’t the service for you. And that’s what I’m trying, and what that process seems to do is to weed out the orphans. I don’t see a lot of orphans here anymore . . . I’m not offering my services without consideration . . . When I worked in Health [state government department] it was more, I was much more in the martyr role. I think my core group of clients were orphans and victims and that I think was because of the free health service . . . you don’t have the right to refuse service. And that’s what I think is really different from private practice.

Rosa: So you like the idea of being able to refuse service if you want to?

Josephine: Yep. Well, see, refusing service or not offering service is actually taking care of their [parents’] safety. Because if they haven’t got the courage and right action and right time, if it is not the right time for them to pass through those lions and go into the castle, it’s not going to work.

Josephine’s imaginal product-making and imaginal sense-making illustrated that she was focused on “testing” parents’ commitment. “Testing” is another education field term. Josephine did this in an attempt to counteract the martyr archetype she had embodied for so long as a carry-on from her days working in a government department, and the orphan archetype that it attracted. Josephine and I further unpacked her castle image using the distanciation technique where I invited her to focus on what the image
represented outside her intended context. Through unpacking the symbol of the castle outside her intended context, Josephine identified that the purpose of a castle is to protect its inhabitants from invaders and pilferers:

*Rosa:* If you were to think about a castle, not in the context of the one you created in the image, and you were describing to an alien who had no knowledge of castles, how would you describe a castle? In particular, what is its main function?

*Josephine:* . . . [it’s] a barrier to the masses . . . to stop the hoi polloi peasants from getting in.

*Rosa:* Sticking with the metaphor of peasants and masses approaching the castle and wanting to get in, why would peasants and masses want to get into a castle? For example, how would you explain that to an alien? What’s attractive to peasants or the masses about the castle that they want to get in?

*Josephine:* The peasants want to get into the castle because of their real, abject poverty – physical, emotional, and spiritual. The peasants have faced famine and flood for many years. They can see the castle and everyone and everything inside is thriving . . . The castle offers refuge, sustenance, and growth and outside it is deprivation and stagnation . . . The peasants want what is inside but don’t want to or are unable to do the hard work to get there or to stay there, unlike the servants inside the castle who are willing to work, to give, dedicate, follow the queen’s rules, and contribute to the castle. If the peasants get in without effort and understanding and without giving something of themselves, they will abuse and destroy what is within, either subtly or overtly.

*Rosa:* If you relate what you’ve said to parents, what would you say is the danger to you? . . . Or put another way, if you didn’t have the protection of the castle and what it stands for, what would be different for you? How would it impact on you?

*Josephine:* The danger to me as a therapist is that the peasant/parents who are really at a pre-contemplative or contemplative stage of change is they will overtly smash and destroy the castle and the queen, or covertly erode the castle and queen’s power from within . . . the queen is in danger of losing her head or life – my own wellbeing – and society and community lose the queen and what she has to offer.

Reflecting on Josephine’s imaginal sense-making process, I argue that, by penetrating the image further, the castle was exposed as not simply a symbol representing a place to initiate parents’ learning journey, but also a symbol of
protection for Josephine from parents she considered non-committed and who would be likely to deplete her resources. Thus, I refer to non-committed parents not simply as orphans in the healing field context, but rather as orphan students, as Josephine is interacting with them from a teacher rather than healer archetype. The orphan student is a sub-archetype of the student archetype and is someone who expects the teacher to do everything for them. The martyr teacher is one that obliges and is unable to decline the orphan student’s constant requests for help. The martyr archetype’s habitus is characterised by giving more to the process than they are receiving, and as such is often the archetype that fuels burnout (Bologna, 2010). My interpretation of Josephine’s imaginal product based on her imaginal sense-making is that she had been a martyr teacher in the past and her emotional health has suffered as a result, and, in an attempt to protect her emotional health, she began to instigate strong, clear boundaries around the conditions of offering her services. Consequently, this activated the private school principal archetype. This was consistent with archetypal findings from other participants’ imaginal sense-making in that the orphan student archetype was strongly associated with taxing participants’ emotional energy and putting participants’ emotional wellbeing at risk. Additionally, participants in private practice either experienced burnout and left, or acted similarly to Josephine by establishing clearer boundaries around the conditions of their services. Josephine, like other participants who embodied the school principal archetype, generally responded by having a clear culling process regarding whom they would accept into their counselling service. This invariably led to more parents dropping out but, importantly, these participants did not interpret dropouts as a negative outcome. Rather, they considered it a necessary process to determine which parents were suitable for their services, and ultimately keeping themselves emotionally protected and safe.

Further reflecting on Josephine’s comments regarding her imaginal product, I also argue that parents seeking a quick fix are not necessarily parents who do not respect the counsellor’s approach to working with their children, but rather, like starving peasants, they present as dangerous and unruly simply because they are desperate, and desperate people are unlikely to adhere to rules – they are merely focused on getting sustenance and getting it quickly. This may mean they symbolically loot from others who have what they do not. This is a powerful image to shed light on participants’ understanding of parents wanting a quick fix and participants’ negative reaction to this expectation, and, perhaps more importantly, trying to protect themselves from what
they understand as deliberate looting when in fact it is simply starving people acting through desperation. Although participants identified in their initial and deeper understandings that the parents they found most challenging to work with were not providing sufficient emotional nurturance to their children, what they had not for the most part considered or identified was these parents were emotionally starved themselves. This offers a different perspective when considering parents participants identified as challenging. It suggests that parents required more than simply a healer’s assistant role as they themselves required healing. In other words, parents needed to be considered as clients rather than stakeholders.

**Charity school field and martyr teacher archetype**

In this section I discuss two participants who worked for a charity organisation and who I argue embodied the teacher archetype. In the context of the charity school field, the teacher is what I describe as the martyr teacher archetype. The martyr teacher archetype, unlike the private school principal archetype, operates in a charity school logic where no-one is rejected or denied access to the service. Like the private school field, the martyr teacher archetype is evidenced in the practices of the service and its counsellors, particularly the language used. In this section, I use a sequence from Anne’s interviews, including part of her imaginal product-making and imaginal sense-making process, as an example of the martyr teacher and charity school field.

Anne worked for a non-profit organisation that charged fees according to parents’ income. Anne explained that parents who came under the organisation’s salary threshold were eligible to apply for what the service refers to as a “scholarship”. The scholarship covered the cost of 12 CMHPT counselling sessions for the child. If the child needed more sessions, the parent could apply for an extended scholarship of six sessions. The scholarship funding came from businesses in the local community which the organisation had established partnerships with. If parents applying for the scholarship are successful, at the end of their child’s treatment they are required by the organisation to write a letter to the business that funded their child’s session to outline how they benefited from the service. The organisation also asks children to create a love heart out of craft material which is included in the letter of thanks to the business:

*Anne: They also have to write a letter, an anonymous letter to the company that funded the treatment, so it’s just a quick letter saying why they came, and*
“thank you for your support”, and then we get the child to do a heart. We have like a cut-out heart stamps out of foam, and they paint them and they do a lovely little heart, and then the receptionist frames them all, sends that with the scholarship letter that the families write.

Rosa: So how do the children make sense of doing the love hearts and the painting for the funders . . . do they know?

Anne: No, we just, no they don’t, we just, they don’t have to do it, we just leave it out and say: “Would you like to do a bit of an ending?” We have a drawing for the wall as well as you walk up the stairs.

Rosa: Yeah, I saw those.

Anne: So we have those. We get the kids to choose like a picture at the end, whichever one they want, colour it in, if they want to write something on it they can, if they don’t, they don’t. They don’t have to do it. With the heart, if they don’t do it we do ourselves.

Given the organisation focused exclusively on Child-Centred Play Therapy (CCPT) where the philosophy is that the play is child-led and not directed by the counsellor, I was curious how asking children to make love hearts for the funders as well as for the agency’s wall fitted in with the agency’s CCPT philosophy. Anne did not identify it as an issue as she felt the children had a choice, and reasoned it was something they all seemed to like doing anyway. Anne did not contemplate the power differential inherent in the situation, that is, although it may seem a choice, the child was unlikely to say no. It is important to note that as an employee of the organisation, Anne did not develop these policies and procedures; rather, they were developed by management staff.

From an archetypal perspective, Anne’s language and practices (which were part of her workplace community of practice) revealed the presence of archetypes associated with education. For instance, the term “scholarship” is not associated with the healing field but rather the education field. However, archetypally, the organisation functioned as a particular kind of school, namely, a charity school. The charity aspect is evidenced primarily by the source of funding for treatment and the way funders were engaged by the service. For instance, the businesses that funded the scholarships intimate the presence of the benefactor archetype, as they provided funding to parents who could not afford CMHPT counselling for their children. However, it was not simply a philanthropist, as a philanthropist often gives money anonymously. The benefactor
The archetype was indicated because the beneficiary (parent) was made aware of who had funded their child’s treatment, and was required to demonstrate thanks and provide feedback regarding what benefit they had brought to the beneficiary. In this context, the beneficiary is a derivative of the orphan archetype as they are someone who cannot resource and fund their needs and are dependent on outside support. However, there is a condition on the receiving. Parents are required by the agency to show gratitude via a letter to the benefactor at the end of their child’s treatment. Showing gratitude is one of the conditions the martyr archetype requires if it is to give to the orphan archetype (Pearson, 1986/1989). The service therefore is not totally free, as the parents are required to give concrete symbols of their gratitude to the benefactor in the form of the letter of thanks and the love heart made by the child. I contend that the letter and the love heart are symbolic capital that the funder (benefactor) can display to demonstrate their assistance to the poor and how grateful the poor are. This capital is exchanged in order to be in a good position to receive another scholarship from the service if needed. This suggests a form of archetypal capital.

The charity education field and its associated archetypes were also evident in the agency’s material environment. For example, as Anne mentioned, the agency used a prominent position on its wall (when first entering the building) to display love hearts children were asked to create at the end of treatment. I contend that these hearts are used by the agency as a form of symbolic capital to represent children’s satisfaction with the CMHPT counselling service. In Jungian terms, it nurtures the agency’s persona that conveys the message that children love the service. Children’s art work is typically not displayed in the counselling field, as “the general rule” is that any products or artefacts created are considered the property of the child (Davis, 2017, p. 86). This custom is based on an ethical framework where the child’s art work is given the same consideration in terms of protecting the child’s privacy and confidentiality (Hammond & Gantt, 1998, Sweeney, 2001). However, children’s art work is frequently on display at preschools, schools, and other education-focused environments. Additionally, the agency also had a small library where parents could borrow books, which also indicated the education field at play. Anne discussed how she would recommend which book parents should borrow based on the issues she determined they needed to work on, and felt an effective way of ending the session was to lead the parent out to the library and give them something to take home. Anne reflected that she felt giving parents transient objects to take home such as books was also an effective way to build the parent–
counsellor relationship. Thus, the material environment such as children’s love hearts and the library books assisted in conveying the message of the charity school’s warmth and generosity.

Notably, Anne reflected that the parents she encountered as most challenging were not those receiving a scholarship but parents who did not qualify for it, and therefore had to pay a counselling fee. Anne recounted how every year at Christmas the organisation erected a Christmas tree in the waiting area with presents under it for children, but only children receiving a scholarship were entitled to receive them. Anne stated that, frustratingly, fee-paying parents would frequently try to take presents from the tree despite knowing they were not entitled to them. Anne understood this action as fee-paying parents “never being satisfied and always wanting more and more”, rather than these parents expressing dissatisfaction with what they may have understood to be discriminatory and unfair relational practices where not all parents (and their children) are treated the same.

7.3.3 Trauma field and the warrior archetype

An additional archetypal field I identified operating as an overlapping field is what I describe as the trauma field. As discussed in Chapter 5, some participants’ client case load consisted of up to 90 per cent trauma cases, most of which involved trauma perpetrated by the children’s parents. This typically required participants to engage in practices involving advocating for children, reporting child abuse and neglect to Family and Community Services (FaCS) and the police, having their files subpoenaed to court, and appearing in court to give testimony and be cross-examined. From an archetypal perspective, these practices are characteristic of the warrior archetype. In the context of my study, the trauma field features abused children (wounded child archetype) who are being traumatised by their parents (villain archetype) and need advocacy and protection from the counsellor (warrior archetype). Even in cases where the parent was not directly abusing their child, if the counsellor deemed the parent did not act to protect the child and/or make amends for not doing so (i.e., if the parent was not a fellow warrior), they were approached as an enabler of the abuse (villain). Louise’s quotation below illustrates this powerfully. Although Louise did not in this instance identify the archetype she felt she was embodying, her language is laden with combative and military overtones which correspond to the warrior archetype:
See, I see boundaries as a shield, you know, it can still be penetrated, it doesn’t stop it from happening but it can provide a barrier. . . . I have the shield to push them back sort of thing, if I use that symbolism. . . . I think it’s that role model, because I’m behind the shield and behind me is the child. Like it’s not, I don’t picture it as the child being on the same side as the parent or the teacher or the case worker. The child is behind me, so I do have to role model you know, “this is what safety and protection looks like, this is what I’m talking about when I’m keeping your child safe”. (Louise).

Participants embodying a pronounced warrior archetype were also aware that they need “reinforcements”, to borrow a military term, to protect the wounded children. That is, they needed other colleagues fighting on the same side to assist in getting the child out of the war zone and to safety. These participants were more active in enlisting FaCS case workers, family support workers, and other workers in the child protection field to assist them to achieve their goals. Metaphorically, they understood the dangers of working as lone wolves and thus enlisted a pack that could assist them. Participants who embodied a clear warrior archetype, such as Louise, were also very conscious of not commencing CMHPT counselling until the child was safe, that is, until the child was out of the war zone. This usually meant the child had been removed from the care of their offending parents or an offending parent had been removed from the home. Metaphorically, it was considered unsafe to attempt to heal an injured person while they were still in a battle zone. For this reason, these participants often chose to spend their time and resources advocating for a child’s safety prior to accepting the child as a CMHPT counselling client.

Additionally, participants who embodied the warrior archetype were those who were very consciously driven by an ethical code where they considered the level of child advocacy and protection discussed above as their ethical duty. This typically led to a breakdown in the parent–counsellor relationship as the counsellor’s practices were based on the parent being a source of danger for the child and therefore someone to protect the child from, rather than someone to engage. Identifying the presence of the warrior archetype also shed light on the anomaly I discussed in Chapter 5 where Louise was one of the only participants to understand boundary setting with parents as a fundamental aspect of CMHPT counselling practice, and that boundary violations were not the parent’s issue, but rather the counsellor’s issue in terms of not having the capability to set and maintain boundaries. This attitude corresponds to a strongly
embodied warrior archetype, as boundary setting is a core feature of the warrior (Bologna, 2010).

An additional feature of the warrior habitus demonstrated by some of the participants in my study was a predisposition to detect archetypes hiding behind other archetypes (in warrior terms, detecting a camouflaged enemy). For example, Emily used her knowledge of archetypes in conjunction with her embodied warrior archetype (not as strong as Louise’s but nonetheless present) to detect and look beyond archetypal façades to uncover a villain parent hiding behind the mask of the martyr archetype:

She [the parent] had this really weird, like victim, like overly concerned about the son, like saying: “Whatever it takes, I’m so worried about him”, and so she came across as this really helpless mother who just wanted to help her son, and it was this real role she was playing actually, because she’s a real perpetrator that one, like one of the freakiest perpetrators I’ve ever met to be honest with you… but she’s a bit trickier, like I can see how she’d slip under some therapists’ radar because she’s got that whole martyr archetype thing going on, and it’s only when you start to see what’s under the surface, it’s wow, she’s actually probably the worst perpetrator. (Emily)

Emily’s use of archetypal concepts and knowledge and her own embodied warrior archetype enabled her to quickly detect the parent’s camouflage and expose the systematic physical and verbal abuse of her son, which was discovered to have taken place over many years. Participants who did not have a strongly developed warrior archetype were more likely to fall victim to parents’ deceptive behaviour. This I argue is largely due to the archetypal tension or clash between the healer archetype and the warrior archetype. For instance, the warrior’s habitus predisposes them to expect many parents to be the hidden enemy, as it were, and consequently they have strategies to detect them. In contrast, the healer archetype typically expects and trusts that whoever is approaching them is there to be healed or is there to bring someone for healing (healer’s assistant), and therefore suspicion about the person’s motives is not a feature of their habitus. Luisa’s imaginal product-making and imaginal sense-making process provides an example of this. Part of Luisa’s imaginal product-making involved her using the play therapy technique of sandplay to create a scene depicting her experience with the mother discussed in Chapter 5 who had taken her child out of counselling.
prematurely when Luisa refused to provide her with a court report for an upcoming custody hearing with her ex-husband (see Figure 7.4).

In the following interview sequence, Luisa discusses her imaginal product where she used a spider (top centre, just in front of the figure of the clock) to depict the mother:

Luisa: This is me, kind of the fairy, the good fairy and there’s a shell there as well which is kind of, I guess, kind of like being a bit fragile, and then the little boy is this little boy playing soccer [tennis]. There’s also a deer there which I guess is his fragility as well, and then mum is represented by the spider and up a bit and kind of, kind of attacking. And then there’s this little web here you can’t see very well, it’s white. And then the barb wire . . . and also there’s a clock and money which is kind her preoccupation of what it’s costing and the time it’s taking and all that kind of thing. Then I’ve got quite a strong link for their relationship, mum and him, and then the barbed wired for hers and mine. Although you know, it started out good. And then this is over near us is like the little boy and me [magic lamp], there’s magic happening there but it’s definitely just over there, just between us . . .

Rosa: And in the web, is he caught up in it or not?

Despite giving Luisa the instructions for the imaginal product-making activity verbally and in writing (via email), she misunderstood the instructions and instead created a scene involving a specific parent encounter. I interpreted the misunderstanding as Luisa’s personal unconscious taking the opportunity to express unresolved issues pertaining to the parent in question. Despite this, I included her example as it powerfully reveals archetypal influences on her relational practices, and is an example of accepting the organic direction of the hermeneutic process.
Luisa: No, no, it’s between us [Luisa and the mother]. I tried to keep that, keep him out of that. But nevertheless, it impacted on him of course because you know, her whole attitude as things went on and then pulling him out before he finished and all that.

Rosa: So would you say, well what sort of spider would you say it is?

Luisa: Oh certainly it’s an aggressive spider. It’s a spider you need to be careful of.

Rosa: Is it poisonous?

Luisa: Mmm. Yes.

Rosa: So with the symbol of the spider, if you were to describe to someone who doesn’t know what a spider is, like an alien or something, what would you say its key function is, or what does a spider mainly do? What defines it?

Luisa: Um, well it has to catch prey. I mean I guess when you think, well when I think about spiders, they’ve either got a web or . . . Spiders that don’t have webs either have other kinds of traps don’t they? Either a trap door or they’re kind of powerful enough to be able to walk about and attack out in sight. And that’s the kind that she is [a trapdoor spider] . . . In fact a trap door is probably just another kind of web. But less visible.

As we continued to unpack her imaginal product, Luisa reflected that, although she thought the parent was genuine in bringing her son for CMHPT counselling (healing), the parent had from the beginning tried to constantly lure Luisa into her trap of providing a court report for her to assist her to build a case against her ex-husband. Archetypally, I contend that Luisa was embodying the healer archetype (the “good fairy”), was focused on healing the child (the fairy is looking at the child, not the mother/spider), and did not have a sufficiently developed warrior archetype (she describes the fairy as fragile like the shell) to detect that she was being lured into a trap by the mother (poisonous spider). Luisa reasoned that she did not challenge or confront the mother about her ongoing disregard for Luisa’s policies and procedures for fear the mother would take the child out of counselling (healer archetype). However, through the imaginal sense-making process, Luisa reflected she would have been better off challenging and confronting the mother at the very beginning of the process, as her fear of the mother dropping out eventuated anyway, and at the same time caused a lot of
damage. Luisa went on to explain that in the bottom right-hand corner of her imaginal product she placed an upturned car, which represents the car accident she had directly after this mother had failed to bring her child for the scheduled final session (discussed in Chapter 5, Section 5.3.5). Luisa’s reflections on how the situation had impacted on her self-care, particularly managing countertransference and the negative energy ensuing from it, highlights another important feature of the warrior habitus, that is, it has a predisposition to defend itself from attacks. Conversely, participants such as Luisa who did not embody a developed warrior archetype found boundary setting more difficult, were less able to protect themselves emotionally and psychically, and in turn their emotional health and psychic health were undermined.

Emily provided an example of the self-protection aspect of the warrior archetype through her imaginal sense-making process. Emily was one of the few participants to use archetypes in a relational and complementary sense in that she saw the importance of embodying and integrating more than one at a time. Emily discussed her imaginal product, which included the servant, the warrior, and the king cards from Carolyn Myss’ (2003) Archetype cards deck (see Figure 7.5).

Figure 7.5. Emily’s imaginal product.
Emily discussed the importance of merging the king26 and warrior archetypes and of delegating the servant27 archetype to the receptionist rather than taking it on herself. Emily used both the images depicted on the cards as well as the writing on the cards as part of her imaginal sense-making process:

Emily: The one that’s standing out to me now, which I don’t know if it’s going off topic or not, but it’s this one that says “warrior” . . . I don’t know, that one really stood out to me in terms of working with the parents. I think it probably relates to what I was saying before is that I thought I was really good with boundaries and I wasn’t. So it’s like the king, if you look at all three, like the king needs their slaves or their servants to do the menial tasks of running the kingdom . . . the king needs their warriors too because the warriors help to keep the kingdom safe from invasions and treason and being overthrown and all of that kind of stuff, but that’s not external, like the servants were more like you delegate. The warrior is more I suppose part of yourself that you also need to have . . . It’s like putting the boundaries in place and being really clear and tight about things and also to a certain extent being confrontational about things that need to be addressed as well.

Rosa: Can I ask you about that warrior card, Emily. What’s the warrior holding in that image?

Emily: It is like a spear, there’s a little bit of reflection going on there, but it’s kind of in the shape of a lightning rod [bolt] . . . And it’s like the spear is kind of looking at the face too ’cause the eyes are, the eyes are like little slits, they almost look like they’re closed, but to me, if I were to look at that without the word “warrior”, I would think of “protection” actually, straight away.

Rosa: So the warrior, one of its key roles or functions is to protect?

Emily: Yeah. Protect. Absolutely. Like now that we’re talking this through, that has to do with it, yeah.

Rosa: And so bringing this back to your work with parents or, you know, from the beginning, through the middle to the end, where do you find you need the most protection, if I can even put it that way?

Emily: Yeah, well definitely you can. I think that when you get through the nicey nices of the first few sessions and then the stuff starts to come out . . . like more

26 In my distanciation interpretation of Emily’s king, the king represents the private school principal archetype, much like Josephine’s queen of the castle represents the private school principal archetype.

27 In my distanciation interpretation of Emily’s servant, the servant represents the healer’s assistant archetype.
likely around that review time, like the six-session mark, maybe a little bit later, something’s going to come to the surface . . . you need the most protection around that time. That’s probably where the transference and the countertransference stuff is going to probably start to come out or the risk of dropout because, you know, when things start to come out like that or like if they’re getting too close to their own issues, they might pull their child out of that. So that’s the tricky time when things might change . . . And part of the protection is like the spear can represent that like, training and skills that you have had, and it’s still an ongoing process but like, when we were talking about my intern, he was completely defenceless and just let it go completely into him like a sponge, like ABSORBED all the transference, felt it. Because a lot of psychologists, especially good ones who are able to engage well with clients, have that sensitive nature that they pick up on other people’s emotions, so here’s this lady that’s throwing all of her trauma at him and he is just sucking it in, and then basically just burns out and crashes from that happening over a few times . . . it’s important to have like good boundaries and stuff, that’s like your spear to say, “I can handle this”.

Emily’s example suggests that it is not sufficient for CMHPT counsellors to embody the healer archetype and that they also need to integrate the warrior archetype in their habitus to effectively work with children and their parents. It highlights an important finding from my research, which is that to effectively work with parents CMHPT counsellors need to consciously embrace and develop healthy manifestations of the healer, teacher, and warrior, and create a conscious working relationship with all three. Additionally, as Emily’s example illustrates, CMHPT counsellors need to develop a flexible and temporally sensitive habitus that can activate different archetypes at different times for different practices. This finding suggests that, by more consciously working with and harmonising these archetypal influences, CMHPT counsellors are less likely to experience the archetypal tensions they currently do, which will in turn positively impact on their relational practices with parents. Table 7.1 provides a summary of the main overlapping archetypal fields and their corresponding CMHPT counsellor, parent, and child archetypes discussed in this section.
Table 7.1
Summary of archetypal fields and archetypes

<table>
<thead>
<tr>
<th>Archetypal field</th>
<th>CMHPT counsellor archetype</th>
<th>Parent archetype</th>
<th>Child archetype</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healing field</td>
<td>Healer</td>
<td>Healer's assistant and nurturer</td>
<td>Wounded child</td>
</tr>
<tr>
<td>Parent education field</td>
<td>Teacher</td>
<td>Student</td>
<td>Wounded child</td>
</tr>
<tr>
<td>- Private school field</td>
<td>- Private school teacher/principal</td>
<td>- Dedicated student</td>
<td></td>
</tr>
<tr>
<td>- Charity school field</td>
<td>- Martyr teacher</td>
<td>- Orphan student</td>
<td></td>
</tr>
<tr>
<td>Trauma field</td>
<td>Warrior</td>
<td>Fellow warrior or villain</td>
<td>Wounded child</td>
</tr>
</tbody>
</table>

In this section, I have discussed how, via the process of distanciation, I identified three main archetypal fields and their corresponding archetypes that influenced participants' relational practices with parents: the healing field (healer archetype), the parent education field (teacher archetype), and the trauma field (warrior archetype). I discussed how each of these fields and their archetypes created archetypal tensions in the CMHPT counselling field as the archetypal fields' interests and the individual player's archetypal habitus were often incongruent. I argued the archetypal tensions were at the heart of many challenges participants experience with parents, and in turn contribute to the development of the parent complex. My findings also highlight how the application of Bourdieu's concepts of field and habitus with Jung's concept of archetypes can achieve a more critical and deeper understanding of unconscious influences on participants' relational practices with parents.

7.4 CMHPT counselling habitus and archetypes

To further explore the influence of unconscious structural influences on participants' relational practices with parents, I applied Bourdieu's habitus to my text sets and then applied Jung's archetypes to my habitus analysis. Considering habitus is a predisposition that generates practices that seem the natural order of things in a field of practice, I examined my texts for language, particularly affective tones (e.g., anger, frustration, contentment), that indicated practices that participants considered incongruent with their expectations of both parents' and counsellors' practices in the field, as well as practices that they considered flowed and were harmonious. Given the focus of my study was counsellors’ understandings of their relational practices with parents
parents, I discuss the CMHPT counselling habitus by dividing it into parent habitus and counsellor habitus.

7.4.1 Parent habitus and archetypes

In applying Bourdieu's habitus thinking tool to my text sets, clear patterns emerged regarding what participants considered appropriate and inappropriate parent practices or, in Bourdieu's language, what participants considered was good or poor taste. The pattern that was evident was that participants' expectations of parents' practices (forming part of the parent habitus) directly corresponded to the four parent-driven personal influences participants identified and discussed in Chapter 5: (1) parents' conceptualisations of mental health, counselling, and the counsellor's role; (2) parents' responses to the counsellor's boundary setting; (3) parents' willingness to change themselves; and (4) parents' conceptualisations of child and parent. Table 7.2 depicts the four parent-driven influences (first column) and the corresponding core features of the parent habitus (second column) I distilled from my text sets. Given habitus is about distinction in a field of practice, I distilled the features of the parent habitus by examining my text sets for overarching themes regarding what participants considered “do's and don'ts” concerning parents' practices, and then arrived at participants’ ideal parent habitus. Although the features of the parent habitus I have outlined in Table 7.2 imply specific practices and even rules, I emphasise that habitus operates at an unconscious level, so these implied practices and rules are in fact deep-seated unconscious predispositions to think and act in these ways as if they are second nature, and therefore do not require conscious thinking. Additionally, examining the language associated with the first and second columns, I surmised the archetypes implied by each (third column).

My findings revealed that participants' relational practices were more congenial in nature with parents whose practices indicated they had a parent habitus with features depicted in the second column in Table 7.2. Conversely, parents whose habitus did not align with these features were more likely to trigger less genial practices from counsellors. The archetypal analysis of the respective habitus depicted in the third column supports my archetypal analysis of participants' imaginal products discussed in the previous section. However, it highlights that the student archetype was the dominant archetype shaping parents' ideal habitus. Archetypally, this suggests that, for parents to be accepted in the CMHPT counselling field, they need to be “good” students.
Table 7.2
Distanced features of parent habitus and archetypal analysis

<table>
<thead>
<tr>
<th>Participants' understandings of parent-driven personal influences on relational practices with parents (from Chapter 5)</th>
<th>Distanced features of participants' ideal parent habitus</th>
<th>Archetypal analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Parents' conceptualisations of mental health, counselling, and the counsellor's role</strong></td>
<td><strong>Knowings</strong></td>
<td></td>
</tr>
<tr>
<td>• Cause of mental health issues</td>
<td>• Mental health issues stem from unresolved trauma or attachment issues</td>
<td>Student</td>
</tr>
<tr>
<td>• Parent as client vs child as client</td>
<td>• The child is the client (not the parent)</td>
<td>Student</td>
</tr>
<tr>
<td>• The “quick fix” vs developing the child–counsellor relationship</td>
<td>• Counselling takes time to address the child’s mental health issues and there is no quick fix</td>
<td>Student</td>
</tr>
<tr>
<td>• Counsellor as report writer for courts vs therapeutic agent</td>
<td>• Counselling is an investment, not simply an expense</td>
<td>Student</td>
</tr>
<tr>
<td>• Counsellor as instructor vs counsellor as unconditional therapeutic agent</td>
<td>• The counsellor is a therapeutic agent, not a court reporter</td>
<td>Student</td>
</tr>
<tr>
<td>• The counsellor’s focus is on building a positive relationship with the child, not to instruct the child how to behave</td>
<td>• The counsellor’s focus is on building a positive relationship with the child, not to instruct the child how to behave</td>
<td>Student</td>
</tr>
<tr>
<td>• The counsellor is child-focused and considers the child’s emotional wellbeing as their central concern</td>
<td>• The counsellor is a mandatory reporter regarding children being at risk of harm</td>
<td>Student</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parents' responses to counsellor’s boundary setting</th>
<th>Doings and sayings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Parents speaking about the child in front of the child</td>
<td>• Not speaking about the child in front of the child</td>
<td>Student</td>
</tr>
<tr>
<td>• Parents not remaining in the waiting room or on the premises</td>
<td>• Remaining in the waiting room or on the premises while the child is in their counselling session</td>
<td>Student</td>
</tr>
<tr>
<td>• Parents contacting counsellor outside scheduled times</td>
<td>• Not contacting the counsellor outside scheduled times unless for administrative purposes</td>
<td>Student</td>
</tr>
<tr>
<td>• Being punctual</td>
<td></td>
<td>Student</td>
</tr>
<tr>
<td>• Respecting counsellor’s policy and procedures and accepting boundary setting enforced by the counsellor</td>
<td></td>
<td>Student</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parents' willingness to change themselves</th>
<th>Doings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Being willing to address own mental health issues</td>
<td></td>
<td>Student</td>
</tr>
<tr>
<td>• Being willing to change aspects of parenting practices as recommended by the counsellor</td>
<td></td>
<td>Student</td>
</tr>
</tbody>
</table>
• Being open to constructive criticism and feedback from the counsellor  
  **Student**

<table>
<thead>
<tr>
<th>Parents’ conceptualisations of child and parent</th>
<th>Relating</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Being child-focused and seeing children as unique individuals with unique needs</td>
<td></td>
</tr>
</tbody>
</table>
  **Nurturer**
| • Nurturing the child and assisting them to grow and develop their unique qualities and talents  
  **Nurturer**
| • Protecting the child from harm and advocating for their needs  
  **Warrior**

Additionally, parents’ conceptualisations of the child and parent and their corresponding nurturer and warrior archetypes suggest that parents need to have these features already developed before approaching the counsellor, that is, they are not features counsellors expect parents to learn (student) but to have already acquired. This suggests that parents who are referred from the child protection system are at a disadvantage in the CMHPT counselling field, as these are areas of their parenting they struggle with most. In other words, the teacher archetype, particularly the private school teacher archetype, assists in creating a form of social exclusion.

### 7.4.2 CMHPT counsellor habitus and archetypes

As with the parent habitus, in applying Bourdieu’s habitus thinking tool to my text sets, clear patterns emerged regarding what participants considered appropriate and inappropriate counsellor practices necessary to successfully work with parents (and at the same time remain child-focused), as well as to manage the stresses and demands of working in the CMHPT counselling field. I refer to this as the CMHPT counsellor habitus. Analogous to the parent habitus, the core features of the CMHPT counsellor habitus I identified corresponded to the two counsellor-driven personal influences discussed in Chapter 5: (1) the counsellor’s emotional health, and (2) the counsellor’s psychic health. Table 7.3 illustrates the two counsellor-driven influences (first column) and the corresponding features of the CMHPT counsellor habitus (second column) I distilled from my text sets. As with the parent habitus discussed earlier, I distilled the features of the CMHPT counsellor habitus by examining my text sets for overarching themes regarding what participants considered “do’s and don’ts” concerning counsellors’ practices, and then arrived at participants’ ideal CMHPT counselling habitus. Additionally, examining the language associated with the first and second columns, I surmised the archetype implied by each (third column).
Table 7.3
Distanciated features of CMHPT counsellor habitus and archetypal analysis

<table>
<thead>
<tr>
<th>Participants’ understandings of counsellor-driven personal influences on relational practices with parents (from Chapter 5)</th>
<th>Distanciated features of participants’ ideal CMHPT counsellor habitus</th>
<th>Archetypal analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Counsellor’s emotional health</strong></td>
<td>Knowing and accepting that:</td>
<td></td>
</tr>
<tr>
<td>• Time and energy required for working with children vs working with adults</td>
<td>• Working with parents requires a lot of time and energy which is not extra work but an integral part of working with children and addressing their needs, e.g., advocacy work</td>
<td>Warrior</td>
</tr>
<tr>
<td>• Emotional health vs ethics: conceptualisations of “extra work”</td>
<td>• A range of self-care strategies need to be implemented consistently, frequently, and regularly to address lingering negative energy generated from working with parents</td>
<td>Wounded healer</td>
</tr>
<tr>
<td>• Negative energy lingers</td>
<td>• Many parents will initially not understand CMHPT counselling and the counsellor’s role and therefore the counsellor needs to provide the parent with psycho-education about this</td>
<td>Teacher</td>
</tr>
<tr>
<td></td>
<td>• Many parents will push the counsellor’s boundaries; therefore, the counsellor needs to be comfortable and effective in setting and maintaining boundaries in a firm and respectful way</td>
<td>Teacher and warrior</td>
</tr>
<tr>
<td></td>
<td>• Many parents will not be willing to change themselves and will undermine the child’s progress; therefore, the counsellor may not be able to offer them a service</td>
<td>Teacher and warrior</td>
</tr>
<tr>
<td></td>
<td>• Many parents will have different conceptualisations of child and parent than the counsellor; therefore, the counsellor needs to provide the parent with psycho-education about this</td>
<td>Teacher</td>
</tr>
<tr>
<td><strong>Counsellor’s psychic health</strong></td>
<td><strong>Doings</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Regularly addressing countertransference issues via reflexive practice</td>
<td>Wounded healer</td>
</tr>
<tr>
<td></td>
<td>• Having regular, quality supervision to address countertransference issues</td>
<td>Wounded healer</td>
</tr>
<tr>
<td></td>
<td>• Engaging in continuous professional learning to stay abreast of effective ways to address countertransference</td>
<td>Wounded healer</td>
</tr>
<tr>
<td></td>
<td>• Engaging in personal therapy when needed to address countertransference issues</td>
<td>Wounded healer</td>
</tr>
</tbody>
</table>
The findings from my study show that the participants were more likely to be prepared for and successfully manage challenges concerning working with parents, and in turn maintain a congenial relationship with them, if participants’ habitus included most of the features outlined in the second column in Table 7.3. Conversely, participants whose habitus did not include as many of these habitus features were more likely to discuss signs of burnout or to avoid working with parents altogether. Notably, the CMHPT counsellor habitus that emphasised that counsellors should accept (that is, not simply expect) that parents will be challenging to work with was weak among most participants and not a robust feature of their habitus. This was evident in participants’ initial responses to the word “parent” discussed earlier in the chapter. It implied that, if this aspect of the CMHPT counsellor habitus is underdeveloped, it contributes to the development of the parent complex. This mismatch between parents’ and counsellors’ individual habitus and the ideal habitus can be referred to as a form of hysteresis, as the person’s habitus is incongruent with the ideal habitus of the field. This suggests a direct relationship and synergy between the Jungian concept of cultural complex and Bourdieu’s hysteresis. Specifically, a field–habitus clash contributes to the development of a cultural complex.

The archetypal analysis of the respective habitus (depicted in the third column) implies that the teacher, warrior, and wounded healer archetypes were the dominant archetypes in counsellors’ ideal habitus. Notably, the wounded healer archetype did not feature in my analysis of participants’ imaginal products discussed in the previous section. I contend that this is the case because participants’ reflexivity primarily took place on action rather than in action. For example, the wounded healer archetype is associated with features of the CMHPT counsellor habitus that drive practices such as having supervision and engaging in self-care and professional development, all of which take place outside their direct practices with parents. Similarly, it suggests that participants are not activating the wounded healer, or any archetype responsible for reflexivity, in or during their practices with parents. This temporal difference in terms of when a reflexively focused archetype is activated can contribute to practice issues such as dropouts, as some issues with parents may require immediate, in-the-moment reflexivity to effectively maintain or repair the parent–counsellor relationship.

In this section, I have discussed how the application of Bourdieu’s theoretical thinking tools of habitus to my text sets revealed that the six personal influences on
relational practices discussed in Chapter 5 contain core features of the parent habitus and CMHPT counsellor habitus. Viewing the six personal influences on counsellors' relational practices with parents as core features of the parent and CMHPT counsellor habitus provided a deeper understanding of my research phenomenon. It generated four main findings. First, what counsellors identify as influences on their practices exposes the field's habitus, and in turn the field's interest. Second, what counsellors identify as challenges are driven by a deeper layer of social unconscious influence in the way of a hysteresis effect, where their individual habitus does not match the ideal habitus of the field. Third, hysteresis contributes to the development of the parent complex as the habitus–field clash generates challenging emotions which participants project onto parents. Fourth, there is a conceptual relationship between the Jungian concept of cultural complex and Bourdieu's concept of hysteresis. Additionally, my application of Jung's archetypes supported my imaginal archetypal analysis as well as providing additional, more detailed understanding of how archetypes influence participants' relational practices with parents.

7.5 Parent capital, archetypes, professional practice values, ego, persona, and shadow

The presence of two other fields, highlighted in the previous section, indicates that different types of capital are valued and exchanged, that is, not simply capital associated with the healing field. In this section, I discuss how I applied Bourdieu's thinking tool of capital to my text sets to explore the capital participants valued in the CMHPT field, particularly capital parents acquired and exchanged. I refer to it as parent capital and explore how participants valued it, the nature of its exchange in the field, and how the capital exchange influenced participants' relational practices with parents. Although I acknowledge parent capital is not the only capital acquired and exchanged in the CMHPT field, I focus on parent capital in this section as it most directly relates to my research phenomenon.

In applying Bourdieu's capital thinking tool to my text sets, I began by focusing on examples participants discussed involving parents they had really positive experiences with and those they had really negative experiences with – two opposite ends of the continuum as it were. I examined the language and sentiment of these quotations to arrive at archetypal themes. From an archetypal perspective, the themes that were evident when participants spoke about parents they held in higher esteem were
commitment to learning new practices (student), putting their child’s needs before their own (nurturer), being courageous (warrior), and demonstrating a clear ethical attitude (warrior). Conversely, the themes that were evident regarding parents whom participants did not hold in high esteem were being uncommitted (poor student), and deceitful, selfish, and focused on presenting a façade (villain). These archetypal themes also correspond to dimensions of professional practice I discussed in Chapter 2 (an ethical attitude, reflexivity, and professional/personal becoming), as well as Jung’s concepts of ego, persona, and shadow. To provide examples of these archetypal capital themes, I provide dialogue extracts from my participant text sets followed by my structural analysis using the Jungian and Bourdieusian theoretical thinking tools.

Louise discussed the mother of a client, a 14-year-old girl, and how Louise identified and valued the mother’s ethical attitude, commitment to introspection (reflexivity), and personal development (becoming):

*Louise:* The girl was sexually assaulted by her boss where she worked part-time, and as soon as the mum found out, she was SOOO protective, so motivated for counselling. She came to groups herself, had been on the ethics committee of the local health district as a parent representative . . . So had a really good understanding of what ethics looked like and what practice looked like and, you know, supported her daughter. Her daughter pulled out of court the day before she was due to give evidence, but the mum supported her in doing that and was able to really see, really reflect on how she [the mother] was making it about her [the mother] and getting this guy, but really then looking at what was right for this girl. Yep, she was one of the most amazing women I’ve met . . . She was a single mum, did not care what people thought of her, actually went to this place [where her daughter had worked] and made sure that people knew what had happened. This guy was still working there and employing young teenage girls . . . People thought she was crazy but she just didn’t care. She made sure she notified the school and said: “You need to make sure you’re really careful about girls employed there.” So I think she really saw her daughter as a human being and she actually had a right to be safe and this man took that away . . . and I believe she would have acted exactly the same way had it been, had she found out that it was her partner [who was the perpetrator].

*Rosa:* Yep. So putting her child’s needs before her own?

*Louise:* Yeah. Saw her role, that she was primarily in this world to protect her child.
Rosa: But it sounds like other children as well, by warning others?

Louise: Yep, yep, yep. Yep, so really saw her role to let people know. Because she wasn’t let known about the situation and this was well known apparently in the community, and then when this came out with her daughter, then people started saying: “Oh, I have heard that about that guy.” So a lot of guilt came from that as well, which she had to work through about not being able to protect her daughter. So yeah . . . And very trusting of my ability to engage her daughter in counselling. Didn’t need to know everything that her daughter said to me.

Louise’s example of this mother whom she held in high esteem demonstrates a connection between an ethical attitude, reflexivity, and personal becoming and Jung’s concepts of ego, shadow, and persona. For instance, the mother’s focus on exposing the child abuser (personal and community shadow) was greater than caring about what others thought of her (persona). This mother had the inner strength (ego) to recognise she had “work to do” on herself such as working through difficult emotions like guilt. From an archetypal perspective, this mother embodied three main archetypes: (1) the warrior archetype (advocating and seeking social justice which meant the counsellor did not need to do this), (2) nurturer archetype (putting her child’s emotional needs before her own), and (3) student archetype (committing to work on herself and learn new ways of doing things). All participants cited examples of parents they enjoyed working with and, from a capital perspective, these parents demonstrated some if not all the attributes discussed in the above example. Parents who acquired this symbolic capital typically exchanged the capital by getting priority over others on the waiting list, being given their preferred appointment times, and securing systems support from the counsellor if needed (e.g., advocacy with the courts). In other words, participants’ policies and procedures were more flexible for these parents than for parents who did not have this capital.

Findings from my study suggest that diminished capital or capital that is not valued in the field was also exchanged, but in the way of punishment or admonishment. For example, parents who had the least amount of capital or diminished value in participants’ estimation were those who viewed their children as capital. This included parents who abused their children and used children to meet their physical, sexual, and/or emotional needs. It also included parents who saw their children as symbolic capital rather than as individuals with separate needs and interests to themselves.
Emily’s discussion regarding a mother and father’s treatment of their son illustrates this sentiment:

These kids all had to go to the private school the dad picked and, because they were [originally] from Melbourne . . . since they were young they all had to play AFL [Australian Football League]. And a lot of the fights they were getting over was they [the parents] wanted him to do maths at school because that was his dad’s strongest subject, and they wanted him to play AFL, but he wanted to play Rugby Union . . . in the parents’ mind he was a horrible person because he didn’t just want to do all the same things they wanted to do . . . because she [the mother] just wants him to be the obedient child that fits in, doesn’t stand out from the crowd, because that makes her look bad, so it’s all about the shame and embarrassment ‘cause they’re involved in the AFL club and they don’t want him to tell their friends that he doesn’t want to play that code of Rugby. (Emily)

Emily’s example also demonstrates a connection between an ethical attitude, reflexivity, and personal becoming and Jung’s concepts of ego, shadow, and persona. For instance, these parents focused entirely on using their child to reinforce and support their position in the AFL community (persona), and when their son rebelled against this, they deemed him a “horrible person” but did not reflect this was a projection of their own horribleness (shadow), and they did not have the internal strength (ego) to allow their son to develop interests outside their own. From an archetypal perspective, Emily’s description of these parents suggests they were embodying the villain archetype as they were largely unconcerned about their son’s needs, they were focused on their own needs, they were deceitful, and they were abusive. The consequences of these parents having no parent capital, in Emily’s eyes, is that Emily reported them both to the police and FaCS for physically assaulting their son. Although it could be argued that as a mandatory reporter any counsellor would have reported these parents, Emily mentioned that the child’s school counsellor was aware of the ongoing domestic violence perpetrated by the boy’s parents (the child had repeatedly told the counsellor and school) but, rather than notify FaCS or the police, the school counsellor’s response was to offer family therapy. This suggests that the school counsellor was perhaps embodying the healer archetype rather than the warrior archetype or, similarly, had an underdeveloped warrior archetype, therefore healing rather than advocacy was her focus. This also suggests the school counsellor was operating on a different system of archetypal capital to Emily.
In this section, I have discussed two main findings pertaining to parent capital. First, that the professional practice dimensions discussed in Chapter 2 (ethical attitude, reflexivity, and professional or personal becoming) are not only core dimensions of professional practice, but also core features of what participants consider parent capital in the CMHPT counselling field. Additionally, this capital is structured by the warrior, nurturer, and student archetypes and the exchange of this capital influenced the nature of participants’ relational practices with parents. Second, the findings highlight the interrelationship between Bourdieu’s concept of capital and Jung’s concepts of the ego, shadow, persona, and archetypes. Specifically, how participants understood parents approached their persona, ego, and shadow determined the currency participants afforded parents, that is, parents’ capital in the CMHPT counselling field.

7.6 Archetypal doxa, misrecognition, and symbolic violence

In this section I discuss how applying Jung’s concept of archetypes to Bourdieu’s other conceptual triad of doxa, misrecognition, and symbolic violence continues to offer a growing understanding of unconscious influences on participants’ relational practices with parents. I explore an example where I have applied these concepts. The example features Louise’s imaginal product and the imaginal sense-making process that ensued. Louise constructed her imaginal product by using 11 image cards from Isha Lerner and Mark Lerner’s (1992) Inner child cards deck. Figure 7.6 depicts one of these cards and symbolises Louise’s intention when she commences seeing a child for CMHPT counselling, that is, after she has spoken to the parent on the phone and conducted the initial assessment with them.
The following interview sequence includes Louise’s initial discussion and then deeper imaginal sense-making of the card depicted in Figure 7.6.

*Louise:* This card represents commencing sessions with the child. So really my intention is that they [the parent] almost just let me do this with the child. Just let me go with the child. Sort of that Pied Piper thing where the child’s really engaged, the child won’t be the problem here. But the parent has to let me do it almost. They have to just let me start weaving the magic I guess of play therapy, and they have to stay right out of it in terms of that therapeutic space.

*Rosa:* So that’s what they resist the most, would you say?

*Louise:* Yep. Yep. ’Cause that’s when I reinforce “I’m not going to talk to you before or after the session, I’m just seeing the child. You won’t know what’s happening in that room, I won’t be telling you every single detail” . . . so they aren’t in control of their child or what their child is saying necessarily.
Rosa: . . . If you just look at the symbol of the Pied Piper outside the context of your work, what would you say he is? What does he do?

Louise: [Long pause] He steals the children away from the parents! [Laughs] . . . I’m not wanting to do that but almost I am I guess!

Rosa: I’m wondering if that’s how parents might feel or interpret that?

Louise: Possibly! Well I probably am in some sense because I’m wanting to take the child away from them for an hour each week and work on pretty deep, secretive, unknown stuff that they [the parents] have been able to keep private within that family for so long . . . And here I am going “yep, come on, let’s go” and the child just comes and parents don’t like that either . . . because what the child may say may have ongoing consequences for this family. You know. They might disclose things that might mean massive changes in the home, result in notification and confrontations. So yeah, the parents are fearful in some sense.

A feature of the CMHPT counselling field’s doxa illustrated in Louise’s example is that parents being excluded from significant stages of the child’s treatment is something that both counsellors and parents accept as the natural order of things. This doxa stems primarily from the healer archetype whose focus is to heal the child (rather than the parent), as well as the warrior archetype whose focus is to see the child on their own away from the parent in the event the child has something to disclose about the parent (villain). The failure to meaningfully engage parents in their own affective process is the ensuing symbolic violence. Thus, my application of doxa, misrecognition, and symbolic violence with archetypes suggests that doxa is not only a function of social fields and habitus (as per Bourdieu), but is also a function of collective unconscious influences, namely, archetypes. By penetrating past the social unconscious to the collective unconscious layer, I contend that symbolic violence is in fact archetypal symbolic violence which is a function of archetypal doxa, that is, the archetypal misrecognition regarding the influences of the healer and warrior archetypes which exclude parents from the counselling process. Additionally, at the heart of the archetypal symbolic violence in Louise’s example is a tension of opposites characterised by an “us and them” mentality fuelled by the archetypal dyad between the warrior and villain.

Ironically, the Pied Piper is often thought to be a paedophile who lures children away from their parents (e.g., Manchester, 2014), that is, a villain masked as a warrior saving
the town from its rat infestation. Thus, he represents the very archetype that the warrior archetype attempts to expose in the trauma field. Louise’s example powerfully illustrates an aspect of the CMHPT counselling field’s shadow. That is, counsellors use their magical flute (play therapy) to lure children away from their parents. Metaphorically, the nature of this irony signifies the presence of Hermes the mischievous god of communication at work. In a court jester-like fashion, he points out our fallacy in thinking we are inseparable from that which we denounce.

When I saw Louise one month later for the final interview, she commented on the reflexivity she had been doing since, and her continued imaginal sense-making regarding the Pied Piper image:

*The story of the Pied Piper gave me new insights . . . that it would be really difficult for parents if you haven’t done all the stages before, and built up that sort of rapport with them, to just walk up and say: “Yep, your child is in with me and you have to wait out there, that’s it.” That would be really hard, you know, because essentially I am a stranger, and you’re taught not to leave your kids with strangers, and here am I saying the total opposite. So I think it gave me perhaps a new perspective of how parents saw therapy, and maybe just being really mindful of the importance of that rapport and engagement and building strong foundations with parents first. (Louise)*

Louise went on to share that, inspired by the imaginal product-making activity she did with me in the research interview, she decided to invite newly referred parents to create their own imaginal product as part of her intake process. She discussed how she asked parents to choose image cards to represent different stages and/or services they had been through before bringing their child to her for counselling, as a way of engaging with them and making room in the process to acknowledge their affective processes prior to entering her service. Below is excerpt of an interview transcript where Louise described using the imaginal product-making process with parents who had recently had one of their children removed from their home by FaCS following the child sexually abusing his sibling (one of their other children):

*Louise: It brought up some fascinating stuff in, you know, them feeling as though not being listened to, not being acknowledged, sort of not being trusted in terms of being able to protect their children in an ongoing manner. Just being told what to do and “this is what you will do otherwise we’ll remove all of your*
children”. So it was quite fascinating . . . Because what they spoke about was lots of anxiety around meeting me.

Rosa: So are you saying then that with the tweaking you've done, you're focusing on acknowledging their feelings about not just coming into your service for the first time, but most likely with what they've experienced with previous services?

Louise: Exactly. Yeah, and even just the process of getting to me. Even just acknowledging that all this, all these stages happened even before I get in there. Because I think they felt in doing the activity that they were heard for the first time in this whole process, and actually someone being really interested in how they found the process, rather than focusing on the abuse itself . . . And as we began to unpack each card and really draw out the story but also draw out how it related to them, their feelings and who were they in the card, I think lots of light bulb moments came on, and it was just like, “Oh my god, that was so awful at that point in time, and no-one has really asked us about that”, or yeah, “one of our children has been removed from the home but no-one wanted to talk to us about that, and how we were feeling about that”.

Louise was impressed most by how quickly she felt she built a rapport with these parents following the imaginal product-making activity. Louise reflected that, although she frequently uses play therapy mediums in various activities she asks parents to do, these activities are centred around assessing the dynamics in the family as well as assessing the parents’ parenting. This new activity, however, was focused on giving parents a safe forum to express their affective experiences regarding their child’s situation (that is, expressing affect, not assessing their parenting), and for this reason she felt it was so effective as a relational practice to build the parent–counsellor relationship. Archetypally, the new practice Louise implemented shifted her from a warrior who is focused on assessing whether the parents are villains, to a healer who is focused on their wounds, not just their child’s wounds. This was achieved by first recognising the shadow she and the CMHPT counselling field were projecting in terms of being metaphoric Pied Piper child abductors (villains).

In this section, I have provided an example of archetypal doxa, misrecognition, and symbolic violence taking place in the CMHPT counselling field and its influence on one participant’s relational practices with two parents. My findings included how, through critically reflecting on her imaginal product-making and imaginal sense-making process, a participant recognised the inherent doxa in the counselling process, ensuing
symbolic violence, and an aspect of her and the CMHPT counselling field’s shadow. This recognition led the participant to organically seek solutions to address the symbolic violence. That is, the critical reflexivity facilitated by the imaginal sense-making process spurred agentic capabilities in the participant.

7.7 Critical reflexivity and shadow integration

My findings showed that, regardless of which archetype participants embodied (the healer, teacher, or warrior), they consistently approached the child as helpless and therefore relegated the wounded child archetype. Consequently, my findings highlighted the absence of archetypal influences that offered a different or alternative approach to seeing children as helpless and wounded and their parents as either potentially rebellious, unruly students, or villains. Jung’s Self archetype (what I refer to as the higher self archetype) offers this. As discussed in Chapter 3, the higher self archetype is predicated on individuation, and the heart of individuation is engaging in reflexivity where shadow integration is the focus. In this section I discuss the nature of participants’ shadow integration in relation to their critical reflexivity. I also discuss how creating my own imaginal product and my subsequent imaginal sense-making process assisted in identifying aspects of participants’ shadow that were unacknowledged and unexplored, and understanding how these impacted on their relational practices with parents.

7.7.1 Participants’ shadow integration

Some participants in my study reported that they engaged in a range of reflexive practices to counteract the influence of shadow projections on their relational practices with parents. For example, as discussed in Chapter 5, Josephine engaged in personal therapy for a time to work through the influences of her own experiences of having been parented, and most participants discussed using their clinical supervision to work through countertransference issues. This I argue is the wounded healer archetype, that is, participants acknowledged that their personal wounding needed to be addressed before they could heal others. However, the wounded healer falls short as it deals with wounds inflicted on them by others, but not their own unowned attributes, behaviour, and thoughts. That is, the wounded healer deals with shadow projections related to their experiences with their own parents and the child’s parents, rather than deeper suppressed aspects of themselves and/or their field of practice. I propose that there are
two main reasons why participants did not focus on shadow integration in their critical reflexivity. First, participants did not have critical reflexive tools to assist them to name, identify, and ultimately integrate their shadow. Second, participants’ critical reflexivity was characterised primarily by dualistic thinking, which in Jungian terms leads to a tension of opposites. That is, their reflexivity centred around identifying dyadic oppositions (e.g., the warrior and villain) rather than a transformative union of opposites as indicated by Jung’s transcendent function. Adopting a transformative, liminal approach to oppositions provides a key to integrating our shadow as we recognise that what we think is an opposite is in fact a reflection of ourselves.

There was only one significant glimpse in my study of participants engaging in shadow integration. That was Louise’s insights regarding her shadow and that of the CMHPT counselling field revealed through her imaginal sense-making of the Pied Piper image, where she identified that she and the CMHPT counselling field were child abductors (Pied Piper) and therefore, archetypally, they were villains. Louise’s subsequent reported change to her practices that included inviting parents into her therapeutic space (physically and metaphorically) hints at the transcendent function. The Pied Piper example offers a preview perhaps of the territory that critical reflexivity in the CMHPT counselling field could expand to next. That is, the field could adopt a more open and active approach to meeting one’s shadow (and that of the field), and integrating the shadow through a deliberate process of engaging the transcendent function through the union of opposites and other theoretical thinking tools to assist the integration. It also provides a path to activating the higher self archetype discussed in Chapter 3, which was notably missing from the archetypal influences on participants’ relational practices with parents.

### 7.7.2 Unexamined dimensions of participants’ and my shadow

To further explore and crystallise core aspects of participants’ shadow as well as to identify my own shadow blind spots, I created my own imaginal product via the Blind Image Card Technique discussed in Chapter 4. With the question: *Is there an aspect of participants’ shadow I have overlooked?* in mind, I drew a card from Hakanson’s (1998) *Oracle of the dreamtime* deck (cards face down). Figure 7.7 depicts the card I randomly chose and turned over.
My imaginal sense-making process highlighted three core dimensions of participants' shadow that shaped their understandings of their relational practices with parents: (1) objectification and depersonalisation, (2) idealisation, and (3) grief. Below is part of the transcript from my imaginal sense-making process that illustrates how the thread of the dialogue commenced and how these three dimensions were identified. I have used abbreviations for my right hand (RH) and left hand (LH) dialoguing:

RH: Describe what you see.
LH: Interesting. Willy wagtail, which is one of my favourite birds. I love the way the bird wags its tail and always seems to be dancing, but I don't like this image. This bird doesn't really look like a willy wagtail.
RH: Why not?
LH: Well, the bird looks spaced out. He looks almost zombie-like. Like there's no real substance to him.
RH: How would you describe this bird to someone who couldn’t see him?
LH: It’s an image of a bird but it’s more like a stencil. A prototype of sorts. A generic bird. Not an actual bird.
RH: What is it about the bird that indicates it’s a generic bird?
LH: Its eye. It’s robotic-like. There’s no real personality.
RH: What would you say is the purpose of something generic or stencilled without personality?
LH: It provides a very basic outline of what something is. It outlines what essential features something should have. It doesn’t emphasis personality because that’s not what’s important. What’s important is that the essential features are there.
RH: Why is that important?
LH: Because to be able to use it properly, you have to have all the necessary bits.
RH: What would the consequences be of having a prototype without the necessary bits?
LH: It would be useless.
RH: How do you think this might relate to further identifying participants’ shadow as well as your own blind spots?
LH: I guess how parents have been approached and discussed is a bit like describing a bird species like a willy wagtail, in that when they’re talked about they’re described in generic terms or according to categories like “challenging parents” and “ideal parents” but not really acknowledging their individuality like clients (children) would be. The clients are the ones whose individuality and personality are celebrated and encouraged but not the parents. I guess there’s an objectification of parents and I’m guilty of this too.

It was at this point that the dialoguing reached a resonance in that the word objectification really struck a chord with me and I had identified my own blind spot. I first explored how the concept featured in the literature and then returned to my text sets to further explore the texts with the concept in mind.

Objectification and depersonalisation

The concept of objectification was first introduced by Immanuel Kant (1920/1997), who proposed that objectified people are seen primarily as instruments for another’s desires or needs, a means to an end, and in the process are de-humanised. The concept of objectification features prominently in the feminist literature where it has been further expanded by feminist theorists (e.g., Fredrickson & Roberts, 1997; Loughnan et al., 2010; Nussbaum, 1995). Nussbaum (1995) contends that, in addition to instrumentality, objectification undermines one’s ethical attitude to the other. Nussbaum (1995) argues that, when we see people as a means to an end (e.g., parents
as a means to transporting the child to and from therapy sessions), we stop asking ethics-based questions such as “What is this person likely to feel if I do X? What does this person want, and how will my doing X affect her with respect to those wants? And so on” (p. 265). Similarly, Loughnan et al. (2010) argue that objectification is associated with depersonalisation, whereby the person objectified is denied an ethical status in that they are considered not worth thinking and acting ethically about.

With the concepts of objectification and depersonalisation in mind, I returned to my text sets and discovered that both the participants and myself used language that objectified and depersonalised parents. For example, the participants typically referred to children by their name or a pseudonym but when referring to parents they invariably referred to them as “the mum”, “mum”, or “this woman” rather than using names. Similarly, although I had used names in the form of pseudonyms for my participants, I had not considered using them for parents and had also referred to them using common nouns. I reflected this was also a part of many CMHPT counselling practices I participated in as an educator and supervisor, where children’s names (or pseudonyms) were used but parents were often depersonalised and simply referred to by common nouns such as mum, mother, dad, father. This suggests that the objectification and depersonalisation of parents via language is a practice shared among CMHPT counsellors. I also contend that objectification and depersonalisation are features of participants’ and the CMHPT counselling shadow, as they are the main characteristics participants identified with parents they found challenging (i.e., not considering their children as autonomous, unique beings), yet counsellors engaged in this very behaviour in their approach to parents and were unaware of it. The inherent irony in this mirrors the Pied Piper example discussed in Section 7.6, in that the qualities participants found challenging in parents (e.g., objectifying and depersonalising children) are qualities that form part of participants’ and the CMHPT counselling field’s shadow.

Apart from my role as researcher in this study, I also reflected on other ways in which I have unknowingly contributed to the CMHPT counselling field’s shadow. For example, one of my roles as a CMHPT counselling supervisor is to assist counsellors identify threats to their emotional and psychic health and in turn engage in effective self-care strategies to prevent burnout. Given my main area of clinical specialisation is trauma and many CMHPT counsellors including those I provide supervision for have a
high trauma caseload, I have no doubt that on many occasions I have been firmly entrenched in the trauma field discussed early in the chapter, and embodied a strong warrior archetype that has contributed to fostering the parent complex by approaching and discussing parents primarily as a group (that is, depersonalised) that potentially poses a threat to counsellors’ wellbeing. Although arguably this is required on some level and in some circumstances, particularly regarding parents who abuse their children and are hostile towards counsellors, it undermines the possibility of new ways of being for both the parent and the counsellor. Picking up on Bourdieu’s contention regarding the generative nature of habitus and fields, without critical reflexivity, an entrenched warrior habitus unconsciously continues to recreate and generate the trauma field and vice versa.

Additionally, even when I have assisted counsellors work through their countertransference issues with parents, I have conceptualised parents as a group who offer an opportunity for counsellors to explore aspects of their shadow. I reflect that viewing parents as an opportunity is simply the flip side of viewing them as a threat, as this too is a form of depersonalisation and objectification in that parents are viewed primarily as an opportunity for counsellors’ benefit (their personal and professional becoming) rather than also approached, appreciated, and celebrated as individuals to meaningfully connect with at whatever level they require at the time. In other words, approaching parents how counsellors typically approach children.

Similarly, when I have suggested and discussed with counsellors the need for particular parents to have their own individual counselling in order to work on their unresolved psychological issues impacting on their parenting, I reflect that this is primarily based on the notion that parents do this to be better parents so that they can in turn meet the needs of their child. Although this is clearly a worthy goal with benefits for the parent and child, it could still be mainly approached as a means to an end with the child as the main focus. Going deeper still, it implies a shadow side to child-centred practice (a defining feature of CMHPT counselling) if parents are not afforded the same deeply personalised and person-centred approach that children are.

**Idealisation**

The overwhelming majority of the literature on objectification and depersonalisation (which mostly focuses on the human body) associates objectification and
depersonalisation with idealisation (e.g., Flynn, Park, Morin, & Stana, 2015; Monro & Huon, 2005). In this literature, the ideal is typically referred to as something romanticised, and in turn unattainable. I returned to my texts and considered whether and how idealisation related to my research phenomenon and research question. I found that the concept of idealisation shed further light on the ideal parent habitus discussed in Section 7.4.1, namely, the ideal parent habitus was something participants strived for (romanticised) but rarely encountered (it was largely unattainable). I argue that objectification of parents, and the ensuing depersonalisation of them, facilitates the idealisation of a (singular) parent ideal which all parents are then compared to. This singular ideal was very rarely achieved, so I returned to my text sets with the question: If the ideal is largely unattainable, why do counsellors still strive for it? The answer came via the healer archetype. That is, the healer archetype was responsible for the notion that participants’ primary focus and role is to heal children from their mental health issues, and parents’ role is to facilitate this primarily via the healer’s assistant archetype (discussed in Section 7.3.1). Additionally, the notion of parents ideally embodying the healer’s assistant archetype was at odds with parents who wanted the counsellor to be their assistant (e.g., middle-class parents discussed in Chapter 6), and parents who embodied other archetypes such as the villain (e.g., parents who abused their children). Although having ideals can be useful in guiding practice, there is a danger that they facilitate objectification and depersonalisation of people, and Jung warns they frequently form part of our unexplored shadow:

To be ideal is impossible, and remains therefore an unfulfilled postulate. Since we usually have keen noses in this respect, most of the idealisms that are preached and paraded before us sound rather hollow and become acceptable only when their opposite is also openly admitted. Without this counterweight the ideal exceeds our human capacity, becomes incredible because of its humourlessness, and degenerates into bluff, albeit a well-meant one. Bluff is an illegitimate way of overpowering and suppressing others and leads to no good. Recognition of the shadow, on the other hand, leads to the modesty we need in order to acknowledge imperfection . . . it is just this conscious recognition and consideration that are needed whenever a human relationship is to be established. (Jung, 1957/2010, pp. 56–57)

I further considered what emotions are generated when ideals are not achieved and arrived at grief as the primary emotion, which I discuss in the following section.
Studies on burnout, particularly in the helping professions, have found that not realising one’s ideals leads to unacknowledged and unprocessed grief, which is often masked by frustration and anger. For example, Schaufeli, Leiter, and Maslach (2009), who reviewed 35 years of burnout research, concluded that burnout is closely associated with “frustrated idealism”, which is frequently found “within professions dedicated to lofty goals to help and serve others” (p. 206). I argue that participants’ frustrated ideals concerning parents are a form of unacknowledged and unexplored grief. In the bereavement literature, the absence of a person one wishes to be present in one’s life is sometimes referred to as “the presence–absence dialectic” (Wyatt & Adams, 2014, p. 4) where who (or what) is missing is often both present and absent at the same time. Wyatt, Tamas, and Bondi (2016) highlight that these absent presences haunt us and give “a constant sense that all is not as it seems, that what’s missing, or unheard, or occluded, is what’s most telling and most demanding” (p. 38). In the context of my research, I contend that the absent presence that haunted participants was the healer archetype and all the unrealised ideals that are attached to it.

Additionally, the association of unacknowledged and unexplored grief with burnout further crystallised the role of participants’ emotional and psychic health as important influences on their relational practices with parents. Specifically, participants’ emotional and psychic health were undermined by their frustrated ideals concerning parents and the ensuing unexplored grief that it facilitated, rather than being undermined by the parents per se. This further assisted in contextualising the largely negative tone and mood participants expressed toward parents. That is, it was participants’ grief regarding the healer archetype not being fully realised that influenced their frustration and anger toward parents, and in turn shaped their relational practices with parents. I argue that CMHPT counsellors projecting their unowned shadows onto parents forms part of the CMHPT counsellor habitus and is a form of symbolic violence in that it is considered the natural order of things. This is an archetypal symbolic violence generated by a frustrated healer archetype. In turn, CMHPT counsellors’ unowned shadow is misrecognised as part of the CMHPT counselling doxa. This leads to diminished relational opportunities for parents as CMHPT counsellors are focused primarily on building the child–counsellor relationship rather than the parent–counsellor relationship. This was illustrated by participants’ understanding of the use of time and the material environment where their focus was
primarily on using time and space for healing clients (children), and the use of time and space for parents was largely an adjunct to this. That is, parents did not have their own therapeutic frame. In archetypal terms, the healer archetype is primarily interested in establishing and maintaining a relationship with the wounded child, not the healer's assistant. Consequently, I argue that shadow integration is an important aspect to include in counsellors' critical reflexivity, as it assists them to minimise projecting their shadow onto parents. From a Jungian perspective (discussed in Chapter 3), owning our shadow by not projecting it onto others is an integral part of developing an ethical attitude and ethical practice.

In this section, I have identified three core dimensions of participants' shadow that were largely unacknowledged and unexplored as influences on participants' relational practices with parents: (1) objectification and depersonalisation, (2) idealisation, and (3) grief. These unacknowledged and unexplored aspects of participants' shadow revealed a congruence with Bourdieu's concepts of doxa, misrecognition, and symbolic violence in that they contribute to accepted sayings, doings, and relatings in the CMHPT counselling field that undermine ethical relational practices.

7.8 Conclusion

From the distanciated exploration of my research phenomenon, I revealed five main findings. First, participants were only minimally aware of the broad and intricate number of personal, social, and collective unconscious influences on their relational practices with parents. Participants' limited awareness of most of these unconscious influences was found to be a function of their limited critical reflexive tools. Participants who demonstrated more critical reflexivity and awareness were those who actively and deliberately employed archetypes as a tool to unveil collective unconscious influences on their practices.

Second, participants who used critical reflexive tools such as archetypes in conjunction with their imaginal product-making and imaginal sense-making processes were able to deepen their understanding of influences on their practices. This suggests that using archetypes as a critical reflexive tool gave these participants the language to articulate aspects of the collective unconscious influencing their practices. Specifically, the imaginal product-making in conjunction with the gestalt distanciation unpacking of the images (imaginal sense-making) I employed as the researcher were found to
effectively assist in unearthing deeper layers of unconscious structural influences on participants’ relational practices with parents.

Third, to effectively work with parents, CMHPT counsellors need to consciously embrace and develop healthy manifestations of the healer, teacher, and warrior archetypes, and create a conscious working relationship with all three. Additionally, this finding suggests that CMHPT counsellors need to develop a flexible and temporally sensitive habitus that can activate different archetypes at different times for different practices. By more consciously working with and harmonising these archetypal influences, counsellors are less likely to experience archetypal hysteresis, which will in turn positively impact on their relational practices with parents.

Fourth, participants’ critical reflexivity only minimally included shadow integration (via the wounded healer archetype), which suggests that participants’ mostly negative mood and tone associated with parents was a function of projecting their unexplored shadow onto parents. The core dimensions of participants’ shadow that were found to influence participants’ relational practices with parents but were unexplored by participants were: (1) objectification and depersonalisation of parents, (2) idealisation of parents via the ideal parent habitus, and (3) unexamined grief pertaining to the healer archetype not being realised and participants not encountering their ideal parent habitus (healer’s assistant). My findings suggest that these dimensions should be central to CMHPT counsellors’ critical reflexivity regarding influences on their relational practices with parents.

Lastly, a thought partnership between Bourdieu and Jung assisted in revealing the interconnection between personal, social, and collective unconscious influences on participants’ relational practices with parents. Bourdieu and Jung’s theoretical thinking tools mostly unearthed the same unconscious influences, just on different dimensions of unconsciousness – Bourdieu the social unconscious and Jung the personal and collective unconscious. Most notable was that archetypes were found to be associated with all of Bourdieu’s theoretical thinking tools, suggesting the concept’s centrality in exposing unconscious influences on practices. Table 7.4 provides a summary of my research findings based on the thought partnership between Bourdieu and Jung.
The findings discussed in this chapter have several implications for professional practice capabilities required by CMHPT counsellors to effectively engage in critical reflexivity regarding their relational practices with parents. I include a discussion of these implications in the following concluding chapter.
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8 Imaginal appropriation of findings and final conclusions

In the spirit of Pinkola-Estés’ quotation, this final chapter focuses on how my research findings offer guidance regarding enhancing CMHPT counsellors’ understandings and critical reflexivity regarding their relational practices with parents, opening possibilities to enrich parent–counsellor relationships, and improve outcomes for children. I begin by reviewing the findings and answers to the research sub-questions I posed in the initial understanding, deeper understanding, and distanciation moments of my research presented in Chapters 5, 6, and 7 respectively. I then discuss the meta-synthesis of the findings from these three moments, which I achieved via the imaginal appropriation moment of understanding the research phenomenon. The main findings of this thesis, developed through the appropriation moment, are drawn together in my Critical Imaginal Reflexivity Model. This model can be used to guide the development of CMHPT counsellors’ critical reflexivity practices and capabilities, and in turn to minimise the adverse impact of personal, social, and collective unconscious influences on their relational practices with parents. I follow with a discussion of the unique contributions of my research to the CMHPT counselling field and beyond. I then discuss my critique of my study and recommendations for future research. I conclude the chapter with final reflections.

8.1 Review of findings from initial, deeper, and distanciated moments of understanding

The aim of my research was to explore the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents. I did this with the overall goal of informing the professional
practice capabilities required by CMHPT counsellors to create the best outcomes for children through relational practices with parents. My main research question was: What is the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents? My research revealed three distinct yet interrelated layers of participants' understandings of the influences that shape their relational practices with parents. These layers were revealed via engaging in the first three moments of my Critical Imaginal Hermeneutic Spiral based on Ricoeur's critical hermeneutics: initial understanding, deeper understanding, and distanciation moments.

8.1.1 Findings from the initial understanding moment

Participants' initial understandings of their relational practices with parents were presented in Chapter 5. These initial understandings, explored using the research sub-question: How do CMHPT counsellors understand personal influences on their relational practices with parents?, illuminated participants' understandings of personal influences on their relational practices with parents. My findings revealed that participants' understandings of personal influences on their relational practices with parents primarily involved conscious influences rather than unconscious influences. With the exception of transference and countertransference, participants did not employ personal unconscious reflexive tools to identify personal influences on their relational practices with parents.

The participants identified six main personal influences: four parent-driven influences and two counsellor-driven influences. The four parent-driven personal influences that participants understood to shape their relational practices with parents were: (1) parents’ conceptualisations of mental health, counselling, and the counsellor’s role, (2) parents’ responses to the counsellor’s boundary setting, (3) parents’ willingness to change themselves, and (4) parents’ conceptualisations of child and parent. Participants also identified that these four parent-driven influences impacted most on two counsellor-driven personal influences: (1) the counsellor's emotional health, and (2) the counsellor’s psychic health, and that it was the quality of their emotional and psychic health that most determined the nature of their relational practices with parents. For instance, if participants’ emotional health and psychic health were undermined, this typically led them to feel more frustrated and angrier with parents. Consequently, these feelings of frustration and anger often led
participants to engage in relational practices that were less congenial in nature, such as being less flexible with parents’ demands, more instructive with parents, and generally less accommodating. In sum, participants’ initial understandings of the influences on their relational practices with parents primarily centred around how they understood parents’ sayings, doings, and relatings, and how participants’ understandings influenced their emotional and psychic health, which in turn influenced the nature of their relational practices with parents.

8.1.2 Findings from the deeper understanding moment

Participants’ deeper understandings of their relational practices with parents, discussed in Chapter 6, centred around how they understood sociocultural influences shaped their relational practices. These understandings were explored through the research sub-question: How do CMHPT counsellors understand sociocultural influences on their relational practices with parents? Compared to participants’ initial understandings, these deeper understandings were achieved via a more co-constructed process, that is, with more probing questions from me the interviewer. My findings revealed that participants’ understandings of sociocultural influences on their relational practices with parents primarily involved conscious influences rather than unconscious influences. That is, participants did not employ social unconscious reflexive tools to identify sociocultural influences on their relational practices with parents.

Participants identified six sociocultural influences they understood to be the main shapers of their relational practices with parents: (1) class, (2) professional identity, (3) Medicare, (4) referrers, (5) time, and (6) the material environment. My findings showed that participants’ understandings of these sociocultural influences were intricately related to the personal influences they identified in their initial understanding. That is, these sociocultural influences shaped one or more of the six (four parent-driven and two counsellor-driven) personal influences identified in their initial understanding. As with their initial understandings, participants’ focus was mostly on the sayings, doings, and relatings of parents (as well as third parties), rather than their own. For instance, in identifying class as shaping their relational practices with parents, participants focused on the parents’ class as the influence rather than their understanding of their own class in relation to the parents’ class.
8.1.3 Findings from the critical and imaginal distanciation moment

Participants’ understandings of unconscious structural influences on their relational practices with parents, discussed in Chapter 7, centred around the nature of their critical reflexivity. The research sub-question I explored in Chapter 7 was: *What is the nature of CMHPT counsellors’ critical reflexivity regarding unconscious structural influences on their relational practices with parents?* The distanciation moment of understanding, discussed in Chapter 7, revealed that participants’ critical reflexivity was largely a function of the reflexive tools they used. Transference and countertransference were the main personal unconscious reflexivity tools used (by five of the seven participants) to identify personal unconscious influences on their relational practices, none of the participants used social unconscious reflexive tools to identify social structural influences on their relational practices, and three participants used archetypes as a collective unconscious reflexive tool to identify collective unconscious structural influences on their relational practices with parents.

My findings revealed the important role of the imaginal product-making and imaginal sense-making processes in unearthin structural unconscious influences on relational practices – both participants’ use of the imaginal as well as my own. The critical and imaginal distanciation moment included my application of Bourdieusian and Jungian theoretical thinking tools, discussed in Chapter 3, which assisted in revealing an intricate web of personal, social, and collective unconscious influences on participants’ relational practices with parents. Additionally, a tight congruence was found between the Bourdieusian and Jungian thinking tools. Most notable was how Jung’s concept of archetypes was found to be associated with all the Bourdieusian thinking tools, and how different archetypes were found to shape all six of the personal influences discussed in Chapter 5. Thus, the personal, social, and collective unconscious influences were found to be tightly interconnected. Additionally, my findings suggest that influences on CMHPT counsellors’ relational practices with parents have an archetypal core.

Another finding from my critical and imaginal distanciation moment was that participants’ understandings of their relational practices with parents were a function of participants’ unacknowledged and unexplored shadow. The main aspects of CMHPT counsellors’ shadow that influenced their relational practices with parents were participants’ objectification and depersonalisation of parents, participants’ idealisation
of parents’ role in CMHPT counselling, and participants’ unacknowledged and unexplored grief pertaining to not realising their ideals.

8.1.4 Trajectory of participants’ understandings and critical reflexivity

The change in participants’ understandings over the three moments (and ultimately my understanding of their understandings) highlighted how understanding is deepened and enriched by co-constructive processes, particularly processes that engage the imaginal to unearth unconscious influences on relational practices. Similarly, in my in-depth exploration of participants’ understandings of their relational practices with parents via the three different yet interrelated moments of understanding, my research also provides valuable insights into how participants engaged in relational practices with parents, and the trajectory of how the parent–counsellor relationship is formed. It demonstrates that, while this trajectory is influenced and shaped by a range of personal, social, and collective unconscious influences, it can also be influenced and shaped by participants’ agentic impetus stimulated by their critical reflexivity. This was evidenced throughout the interview process where most participants reported consciously and deliberately changing their relational practices based on the processes of critical reflexivity they engaged in via the research interview process. Participants did not undertake this as a condition of my study or because of any instruction from me, but rather as a spontaneous, organic response to critically reflecting on their practices.

8.1.5 Summary of the nature of participants’ understandings and critical reflexivity

Considering the findings revealed from exploring the three sub-questions discussed earlier, in answering my main research question: What is the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents? I distilled the following main conclusions:

- CMHPT counsellors’ understandings of their relational practices with parents are multilayered.
- CMHPT counsellors’ understandings of their relational practices with parents change and develop over time and can be influenced by co-constructed exploration of the phenomenon.
**CMHPT counsellors’ understandings of their relational practices with parents are a function of their critical reflexive tools.**

Critical reflexive tools can assist CMHPT counsellors to move from focusing on conscious influences to identifying more hidden, unconscious influences on their relational practices with parents.

**CMHPT counsellors’ critical reflexivity is enhanced by imaginal product-making and imaginal sense-making processes.**

**CMHPT counsellors’ relational practices with parents are shaped by their unacknowledged and unexplored shadow.**

The quality of CMHPT counsellors’ critical reflexivity influences the quality of their relational practices with parents.

**CMHPT counsellors’ critical reflexivity organically facilitates conscious, deliberate changes to their relational practices with parents.**

### 8.2 Imaginal appropriation of research findings

To arrive at a meta-synthesis of the findings from the three moments of understanding discussed above, I engaged in the appropriation moment of my Critical Imaginal Hermeneutic Spiral, and what Ricoeur (1981/2016a) refers to as revealing “the mode of being unfolded in front of the text” (p. 53). With the questions: What stands in front of the text? What does it refer to? in mind, I drew a card from Hakanson’s (1998) Oracle of the dreamtime deck using the Blind Image Card Technique discussed in Chapter 4 (cards face down). Figure 8.1 depicts the card I randomly chose and turned over.

Below is part of the transcript from my imaginal sense-making process that illustrates how the thread of the dialogue commenced. I have used abbreviations for my right hand (RH) and left hand (LH) dialoguing.
RH: Describe what you see.
LH: An opal in the centre emanating a rainbow of colours.
RH: How would you describe the image to someone who could not see it?
LH: It’s multi-coloured but the colours are not blended, they stand out distinctly to form a pattern. At the centre of the image is an opal emanating a rainbow of colours which make these different patterns.
RH: How would you describe what an opal is to someone who did not have knowledge of opals?
LH: It’s a precious stone that is mined from the Earth and is defined by its colour, or more specifically its array of colours.
RH: What’s the opal’s main function or purpose?
LH: It’s regarded for its beauty.
RH: How does it differ from other beautiful stones?
LH: Its colour, or more specifically its combination of colours. That’s what makes it unique. Other gems I guess tend to be one colour, whereas the opal has many.
*RH: How would you say your description of the image of the opal relates to your question regarding appropriating your findings and what stands in front of the text?*

*LH: My bricolage approach. Like the different colours in the image, the different elements I have drawn on have not been blended into one; they are still distinct but considered together they create a more valuable whole. For example, this relates to the different moments of my hermeneutical spiral. They’re distinct but they make up a greater whole, a greater understanding. I also see Bourdieu, Jung, and Ricoeur as distinct yet complementary theorists contributing to a greater understanding. I guess all aspects of my bricolage approach could be described in this way.*

*RH: If any element of the image could speak, what would speak to you and what would it say?*

*LH: The black centre. Interesting because I didn’t notice it until now. Only the other colours. The black centre represents the shadow. It would say: “Don’t forget me. I am at the centre of understanding.”*

My imaginal product-making and ensuing imaginal sense-making process provided a beautifully poignant symbol that captured the bricolage sensibility which characterised my research approach, as well as the centrality and importance of CMHPT counsellors’ unacknowledged and unexplored shadow. I decided to further distanciate the image by exploring the Aboriginal dreamtime story outlined in the book that accompanied the card pack to determine whether there were further insights to be mined from the distanciation process. The dreamtime story told is about the world before people on Earth knew how to live ethically, as they had no laws or sacred ceremonies to guide their practices. Eventually, the Great Spirit came to Earth on a rainbow to instruct the people about the laws and sacred ceremonies to follow so they could live “moral correct” lives (Hakanson, 1998, p. 21). Once the Great Spirit imparted his teachings, he left Earth on the great rainbow. Where the rainbow had rested on the ground is where the people found rocks of the rainbow, or what we now know to be the first opals. The opals served as a reminder of the Great Spirit’s teachings.

The author’s commentary following the dreamtime story states that the image of the rainbow and opal symbolise two previously opposing worlds being bridged: “the rainbow bridges the two realms, uniting the spiritual and material dimensions” (Hakanson, 1998, p. 22). Aside from yet another message regarding the centrality of ethical practice, the dreamtime story also offers a metaphor (via the rainbow) of the bridging of worlds. This served to crystallise the importance of bricolage and liminality.
in my research, and how important they were in bridging conceptual, theoretical, paradigmatic, methodological, and disciplinary worlds and making accessible what would otherwise not have been. In sum, “the mode of being unfolded in front of the text” (Ricoeur, 1981/2016a, p. 53) was the importance of adopting and systematically applying multiple, complementary concepts, theories, methodologies, methods, and disciplines with the aim of facilitating greater understanding of the phenomenon. I used the findings from my appropriation moment to assist in developing and designing my Critical Imaginal Reflexivity Model, which I discuss in the following section.

8.3 Critical Imaginal Reflexivity Model

Based on the findings of my research, I developed a Critical Imaginal Reflexivity Model to guide the development of CMHPT counsellors’ critical reflexivity practices and capabilities. The main aim of the model is to guide the development of personal, social, and collective unconscious literacy among CMHPT counsellors. That is, the aim is to discourage CMHPT counsellors from primarily focusing on conscious influences on their relational practices and to assist them to identify a systemic web of unconscious influences on their practices. This is based on my contention that, to enhance CMHPT counsellors’ critical reflexivity and mitigate unconscious influences that undermine the quality of their relational practices with parents, CMHPT counsellors need a range of critical reflexive tools to inform their practices. That is, the quality of CMHPT counsellors’ critical reflexivity influences the quality of their relational practices with parents, and in turn the quality of the parent–counsellor relationship.

The Critical Imaginal Reflexivity Model combines the fundamental components of critical reflexivity with the fundamental processes (the trajectory) involved in critical reflexivity. The model consists of two related spirals. The outer spiral (in colour) represents the trajectory of understanding from conscious to unconscious influences on relational practices, and includes the Bourdieusian and Jungian theoretical thinking tools in a hermeneutical spiral of deepened, enhanced understanding (see Figure 8.2). That is, the theoretical thinking tools used for methodological purposes in my research (discussed in Chapter 3 and explored and developed further in Chapter 7), have become part of the final research product where they play a central role in assisting CMHPT counsellors develop critical reflexivity capabilities. The inner spiral (in white) represents how engaging the imaginal using the Jungian and gestalt imaginal product-making and sense-making processes (discussed in Chapter 4), assists in the movement
toward deepened, enhanced understanding depicted in the outer spiral. That is, the Critical Imaginal Hermeneutic Spiral used to guide my text construction and text interpretation process, has become part of the final research product where it guides the trajectory of CMHPT counsellors’ critical reflexivity.

The model's spiral starts with identifying conscious influences on our relational practices (e.g., personal influences and sociocultural influences). This is followed by identifying personal unconscious influences, which are explored via engaging with corresponding thinking tools such as transference and countertransference. Next is the identification of social unconscious influences, which is achieved by applying thinking tools...
tools such as the cultural complex, habitus, field, capital, and hysteresis. The subsequent part of the spiral represents collective unconscious influences, which are revealed by applying thinking tools such as archetypal habitus, archetypal field, archetypal capital, and archetypal tensions. The shadow part of the spiral involves utilising tools to expose the field’s shadow projections as well as our own. This process of critical reflexivity is aided by thinking tools such as archetypal symbolic violence, archetypal doxa, archetypal misrecognition, and tension of opposites. The final and central part of the spiral represents shadow integration, and draws on thinking tools such as synchronicity, union of opposites, and the transcendent function to assist us to identify, explore, and integrate the different aspects of our unacknowledged and unexplored shadow. It is important to note that shadow integration is synonymous with Jung’s concept of individuation; however, I have chosen to use the term shadow integration rather than individuation to emphasise the ongoing (lifelong) process of personal and professional becoming rather than a fixed endpoint or place of having arrived.

The inner, parallel spiral (white background) incorporates the four moments of the Critical Imaginal Hermeneutic Spiral discussed in Chapter 4 which includes the role of the imaginal in the critical reflexivity process and how the final process of imaginal appropriation typically facilitates spontaneous, organic changes in our relational practices. Although spontaneous, organic changes to relational practices can occur at any time throughout the critical reflexivity process, the appropriation moment more readily facilitates these changes due to the moment’s focus on synthesising and mining the gems unearthed by the critical reflexivity process built upon in the preceding moments.

Both spirals purposefully indicate a linear progression to deepened, enhanced understanding, as each of the moments along the spirals offers a scaffold to assist the trajectory of understanding. Comparable to a story or narrative, understanding can be compromised if we do not start at the beginning or if we skip sections of the story. Thus, I recommend that the spirals indicated in the model be approached as a narrative or journey to deeper, critical understanding, where the story or journey commences at the beginning and follows the trajectory depicted in Figure 8.2. However, this does not assume a smooth, even-paced progression. Rather, it assumes that we frequently get stuck at particular moments of a journey, that we often need to revisit moments, and
that journeys are frequently iterative. Although I acknowledge that the model encompasses many tools, I contend that CMHPT counsellors are accustomed to working with theoretical tools by way of their respective theoretical orientations. The model offers opportunities for CMHPT counsellors to extend their tool kit to include more comprehensive tools for critical reflexivity, and to do so using a clear trajectory that facilitates the development of professional practice capabilities as well as an ongoing engagement with professional and personal becoming.

8.4 Contributions to the CMHPT counselling field

My research makes a significant contribution to new knowledge to CMHPT counselling practice, education, and supervision; other related professions working with children and their parents; as well as the broader fields of practice. I have generated new knowledge pertaining to the nature of CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents.

8.4.1 Contributions to CMHPT counselling practice, education, and supervision

My study was driven by several gaps in the CMHPT counselling literature, which centred around relational phenomena being largely de-contextualised, unconnected to CMHPT counsellors’ understanding of them, and studied without consideration of personal, social, and collective unconscious influences that shape them. My study addressed these gaps by providing a contextualised exploration of relational phenomenon, extending the conceptualisation of relational to include social and collective influences (rather than simply personal influences), focusing on the role of CMHPT counsellors’ understandings of influences on their relational practices as central to how the parent–counsellor relationship is formed, and exploring the integral role of unconscious personal, social, and collective influences on relational practices. The Critical Imaginal Reflexivity Model I developed encompasses all these elements to provide a unique, systemic guide for CMHPT counselling practice, education, and supervision in developing CMHPT counsellors’ critical reflexivity, and in turn minimising the adverse impact of unconscious influences on their relational practices with parents.
8.4.2 Theoretical contributions

My research findings contribute to addressing gaps in the CMHPT counselling literature pertaining to the theoretical landscape that has overwhelmingly been shaped by the disciplines of psychology and psychotherapy. My research contributes to expanding and enriching the theoretical landscape by including other disciplines. I drew on sociology to extend the conceptualisation of relational beyond person-to-person interactions (e.g., sociological relationalism), as well as to extend conceptualisations of the unconscious to include the social unconscious as per Bourdieu and his suite of theoretical thinking tools. I drew on the discipline of professional education and development by placing CMHPT counselling practice in the broader context of professional practice. I also drew on philosophy to develop my philosophical framework and methodological approach based on Ricoeur’s critical hermeneutics. Additionally, I engaged with these disciplines in an interdisciplinary fashion by coalescing their commonalities to form theoretical and methodological partnerships. For example, the thought partnership I formed between Bourdieu and Jung provided an enriched and enhanced understanding of the unconscious influences on CMHPT counsellors’ relational practices with parents.

8.4.3 Methodological contributions

My research findings contribute to methodological gaps in CMHPT counselling research, where relational phenomena have largely been studied by research situated in the positivist paradigm using quantitative methods. I situated my research in both the social constructivist and critical paradigms, which enabled me to explore multiple ways of knowing, including social constructivist and critical meaning-making. I also developed a unique method of text construction and text interpretation via my critical imaginal hermeneutic approach, which incorporated aspects of Jungian imaginal product-making and sense-making with Ricoeur’s critical hermeneutics. This approach facilitated a deeper engagement with the unconscious, and in turn assisted in the determination of its influences on practices.

My research findings also address a surprising gap in CMHPT counselling research, where using play therapy techniques and mediums as research methods is largely absent. My research findings address this gap via my adoption of a hybrid, practice-based strategy that involved the transplantation of play therapy mediums and activities used in the CMHPT counselling setting into the research setting. My research findings
highlight how imaginal tools and processes used in CMHPT counselling can enrich and enhance research exploring unconscious influences on practices. With my bricolage approach I constructed new interdisciplinary theoretical and philosophical frameworks that open up new possibilities for understanding relational practices.

8.5 Contributions to other fields, practices, and research

Although my research was situated in the CMHPT counselling field and focused on contributing new knowledge in the field, it also has relevance to other fields, areas of practice, and research. In this section I highlight the contributions to other professions working with children, critical social science and methodologies, and interdisciplinary and bricolage research.

8.5.1 Other professions working with children

My research findings have relevance to other professions working with children, particularly those that have also emphasised the importance of the relationship between parents and practitioners, for instance, paediatric nursing (e.g., Nethercott, 1993; Smith, Swallow, & Coyne, 2015), primary school education (e.g., Gonzalez, Moll, & Amanti, 2009; Price-Mitchell, 2009), and early childhood education (e.g., Ceppi & Zini, 1998; Clarke, Sheridan, & Woods, 2010; Knopf & Swick, 2007; Rinaldi, 2006). Like the CMHPT counselling field, the literature in these fields has overwhelmingly focused on “strategies” to develop better quality relationships with parents; however, these approaches have not emerged from critical explorations of personal, social, and collective unconscious influences on practices. In fact, critical approaches are overwhelmingly absent from studies exploring parent–practitioner relationships. My research offers a critical reflexive approach that facilitates changes to practices that arise from exploring personal, social, and collective unconscious influences on practices, and in turn the quality of the parent–practitioner relationship. Additionally, looking beyond parent–practitioner relationships, my Critical Imaginal Reflexivity Model can also be translated and adapted to other fields of practice that focus on better understanding relational practices with others.

8.5.2 Critical social science and methodologies

My research findings reveal the integral role the interrelated dimensions of consciousness (personal, social, and collective) play in shaping practices, and in turn
the importance of considering all three dimensions when exploring unconscious influences. My Critical Imaginal Reflexivity Model offers a new approach to researching the unconscious by systematically and systemically incorporating all three dimensions of the unconscious. This addresses an important gap in the critical social science literature which neglects the systematic and integrated exploration of personal, social, and collective unconscious influences on practice issues. In terms of critical methodologies, my research addresses a gap concerning effective methods to identify and explore unconscious influences. The use of the imaginal to systematically uncover the interplay between personal, social, and collective unconscious influences is largely absent from the critical literature, including critical arts and visual research methods as well as the critical hermeneutic literature (Romanyszyn, 2013). Specifically, the distanciation function of the imaginal is neglected. My research findings address these gaps via the development of my Critical Imaginal Hermeneutic Spiral, which facilitates the distanciation of images and provides a systematic and systemic way to engage and explore the unconscious and its influences on practices.

### 8.5.3 Interdisciplinary and bricolage research

Commentators on the complexities involved in the provision of and research on health services have frequently stressed the need for an interdisciplinary approach that involves drawing on two or more distinct disciplines throughout multiple stages of the research process, rather than simply one aspect of the research (Aboelela et al., 2007). My research provides an exemplar of an interdisciplinary approach woven through multiple stages of the research process. In my research this included the conceptual treatment of my research phenomenon by drawing on the disciplines of psychology, sociology, professional practice, and philosophy; developing a thought partnership between a sociologist (Bourdieu) and psychologist (Jung); positioning my research at the juncture of two paradigms (social constructivist and critical paradigms); utilising a methodology that drew on two paradigms (critical hermeneutics based on philosophical hermeneutics and critical theory); and developing a hybrid practice-based research strategy (verbal dialogues combined with imaginal product-making and imaginal sense-making processes). Although I concede adopting an interdisciplinary approach has challenges (e.g., the volume of stimulating literature to wrestle with multiplies), it is immensely enriching. I contend that boundary crossing between disciplines can be made less challenging by focusing on common threads. For instance, Bourdieu, Jung, and Ricoeur all had the commonality of surpassing binaries,
embracing the liminal, and exploring unconscious influences as a central focus of their respective approaches. I used these core features as the foundation for developing partnerships between them.

### 8.6 Critique of my study

A paradox exists in my research in that one of its strengths is potentially one of its limitations. The strength I refer to is the uncensored, honest, and often raw responses elicited from my participants. This feature not only strengthened the credibility and authenticity of my study but was also fundamental in revealing core aspects of the CMHPT counselling field’s shadow, which is an important yet neglected feature of the CMHPT counselling literature. However, a possible limitation of participants’ candid responses is that not only participants but also the CMHPT counselling field can be left feeling exposed and vulnerable, particularly in the context of the field’s focus on demonstrating the efficacy of play therapy according to Evidence Based Practice criteria discussed in Chapter 2. Fawkes (2015) cautions how a typical response by professions that have had their shadow exposed and in turn feel vulnerable, is to employ “defensive strategies” and “shut down alternate perspectives” (p. 198). I contend that this is likely to take place in the event that participants’ responses are decontextualised from the aim of my study, which was to ultimately improve outcomes for children by revealing hidden, unconscious influences on CMHPT counsellors’ relational practices with parents. I concur with Fawkes (2015) who suggests that the tensions created by revealing a profession’s shadow (and I would add a person’s shadow) may need to for a time “be ‘held’ rather than resolved” (p. 196).

An additional and related paradox of my study is that although my familiarity with the field and my past professional relationships with most of the participants assisted me achieve authentic participant responses, I suspect it may have hindered participants candidly identifying the influence of CMHPT counselling supervisors and educators due to the inherent power differential I hold in these roles. For example, I noted that none of the participants identified supervisors as an influence on their relational practices with parents beyond identifying them as a positive influence on their emotional and psychic health, that is, supervisors assisting them with self-care and working through parent countertransference issues. My own reflexivity regarding my shadow as a CMHPT counselling supervisor and educator discussed in Section 7.7.2, suggests that supervisors and educators likely play a more integral role in influencing
CMHPT counsellors’ relational practices with parents where their own shadows and that of the profession are unconsciously seeded and nurtured through the socialisation and pedagogical functions of their roles. Indeed, my own critical reflexivity continues to explore the point where I ended my study – how CMHPT counsellors’ and my own unacknowledged and unexplored shadow influences relational practices. In my postdoctoral research, I aim to explore the influence of my own shadow and the unique role of CMHPT counsellor educators and supervisors in shaping CMHPT counsellors’ relational practices with parents.

8.7 Recommendations for future research

In this section I discuss five main recommendations for future research. These recommendations are based on either aspects of the research phenomenon not covered within the scope of my study or aspects of the CMHPT counselling context discussed in Chapter 2 that did not feature in my findings, and therefore may warrant further exploration.

8.7.1 Parents’ and children’s understandings of CMHPT counsellors’ relational practices with parents

My research specifically explored CMHPT counsellors’ understandings of influences on their relational practices with parents and, in doing so, deliberately did not consider parents’ and children’s views. This was undertaken with the awareness that this was one of many steps in exploring and unpacking the complexity and richness of my research phenomenon. The next step I recommend is to explore parents’ and children’s understanding of CMHPT counsellors’ relational practices with parents. This will further inform the overall phenomenon of the parent–counsellor relationship. Given that my research revealed that many of my participants’ child clients suffered from unresolved trauma, often perpetrated by their parents, any research exploring parents’ and children’s experiences would need to be sensitive to this and designed and carried out with pertinent ethical issues in mind. For example, to minimise the risk of research adversely impacting on the child’s CMHPT counselling treatment, research involving children could be conducted as a retrospective study where children who have previously engaged with or completed CMHPT counselling treatment are recruited and interviewed regarding their past experiences. These experiences could be explored using the critical imaginal hermeneutic approach developed in this study in
combination with any number of appropriate play therapy mediums and techniques. Prospective studies involving parents could explore parents' experiences from the beginning of their contact with CMHPT counsellors through to the end of their engagement with the counsellors using the critical imaginal approach developed in this study in combination with any number of appropriate play therapy mediums and techniques. The methods for collecting data would need to vary depending on whether the data is collected retrospectively or closer in time to the practice episodes. For example, studies could incorporate the critical imaginal hermeneutic approach with solicited diaries as one of the data collection methods, as solicited diary data is generally recorded closer to the relational practice episode than retrospective interviews or questionnaires (Mackrill, 2008). This is an important consideration as my study revealed that parent dropouts typically occur in the early stages of engaging a CMHT counsellor and often immediately following a challenging interaction with the counsellor.

8.7.2 Group understandings of CMHPT counsellors’ relational practices

An implied focus of my study was exploring individual CMHPT counsellors’ understandings and critical reflexivity regarding influences on their relational practices with parents. Given one of my research findings revealed that understanding is a co-constructed process, and considering CMHPT counsellors typically discuss issues with colleagues informally at work as well as formally in group supervision, I recommend that future research explore the nature of CMHPT counsellors’ understandings in group contexts such as the workplace and/or group supervision. Changing the setting from individual to group can provide additional and valuable knowledge regarding the research phenomenon. This could be achieved by employing methodological approaches other than or in addition to critical hermeneutics, such as ethnographic and participatory action research approaches. Group understandings could also be explored in a professional practice development context where the researcher explores the Critical Imaginal Reflexivity Model with a group of CMHPT counsellors over a set number of meetings. Titchen’s (2003) concept of critical companionship could be drawn on in this context. For instance, the researcher could

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28 I would not recommend research involving groups of parents or children as this could pose confidentiality and privacy issues for parents and children with mental health issues. An exception to this would be research involving parents and/or children who were participants in group counselling.
become a critical companion by guiding participants through the model and participants could provide insights into their understandings, experiences, and application of the model in their practices. If the research is situated primarily in the critical paradigm with an emancipatory agenda, the role of the critical companion could be extended further with the aim of enabling groups of CMHPT counsellors to inquire into their own relationships with parents and bring about changes more systematically. This could include changes to participants’ own relational practices but also more widely include bringing about sociocultural change in the CMHPT counselling field and beyond such as to referrers and Medicare. This approach would create a bricolage of professional practice development and professional practice research in one project with mutual benefits for the researcher and participants.

8.7.3 Exploration of gender and cultural and linguistic diversity influences

Considering that such a large percentage of mental health counsellors are female, and given the rich cultural and linguistic diversity (CALD) in Australia, I was surprised that gender and CALD were not identified by participants as major influencers on their relational practices with parents. These influences may be identified by exploring the phenomenon with parents and children as discussed in Section 8.7.1. Regarding the CALD background of both parents and participants, it is not clear if participants who did see parents from CALD backgrounds (different or similar to their own) simply did not identify CALD backgrounds as an influence on their relational practices, or whether parents from CALD backgrounds were not accessing CMHPT counselling due to a range of barriers, and therefore were not considered by participants because they do not see these parents to begin with. I contend that exclusion from or inaccessibility of service provision is a type of relational practice in which groups of people are not able to access a service, and therefore warrants exploration. To explore exclusion and accessibility of service issues, Smith (2010) suggests a participatory action research approach that includes the collaboration of local community members. Future research could include local community members and services that do work with children and parents from CALD backgrounds, and explore exclusion and accessibility issues regarding CMHPT counselling services with them. Thus, I recommend future research consider exploring the influence of gender and cultural and linguistic diversity on CMHPT counsellors’ relational practices with parents by adopting methodological approaches that best facilitate this inquiry.
8.7.4 Exploration of rural versus metropolitan influences

My study did not purposefully recruit participants from either rural or metropolitan areas. Only one of my participants (Josephine) practised and lived in a rural area, and her understanding of class as an influence on her relational practices with parents differed significantly from the other six participants, who lived and practised in or close to a metropolitan city area. This suggests that the geographic areas counsellors practise and live in shape their understandings of some influences on their relational practices with parents. Similarly, my observations of the town Josephine practised in (see Appendix F) suggest that exclusion from CMHPT counselling due to social disadvantage may be more pronounced in some rural areas than many metropolitan areas. My observations and speculations regarding social issues in the town where Josephine practised were supported by comments Josephine made in an email she sent me about 18 months after her last interview. In the email, Josephine mentioned some of the issues the town was facing and how she decided to cease her direct client work with children as a way of managing her emotional and psychic health:

*Community Health and Mental Health services have had a mass exodus in the last 6 months and basically have no staff and keep advertising with no luck. Sadly our little town has had an enormous amount of suicides in the past 12 months – children as young as 12. Government agencies and Pollies [politicians] have come to town to hold meetings, but no-one has thought of actually putting services in on the ground. We have dozens of employment agencies for a town with no jobs and dozens of referral services and case managers but no [counselling] clinicians to deliver the services... I have dodged many bullets last year by pulling back [from work]... Many clinicians in NGO’s [non-government organisations], private practice, and NSW Health have been swept up in the unhealthy drama, hence the mass exodus of staff. I think the teen interviewed in the [recent media] report summed it up well: “suicide has become normal for teens in this town”. Talk about community psychic trauma...* (Josephine)

Josephine’s comments highlight a few pertinent features of rural towns with pronounced social disadvantage. Firstly, Josephine’s account of what she describes as “community psychic trauma” illustrates that the trauma field is not simply an “imagined community”, in Anderson’s (1983/2006) usage, where the field and its players are spread out over an elastic geographic distance. Rather, in certain geographic areas, such as rural towns suffering from a multitude of issues, the trauma field can be contracted and concentrated to such an extent that it absorbs a whole town.
Secondly, Josephine’s comments suggest that counsellors attempting to protect themselves emotionally and psychically in this environment may face unique challenges that are not shared with those working in metropolitan settings. Namely, to avoid burnout (or to recover from it), counsellors either cease working in the mental health field or leave the town altogether. The implication of this is that children who often have the highest mental health needs cannot access treatment because counsellors are not available to offer a service. The unique challenges of burnout and retention among counsellors based in rural areas has been explored in the general mental health counselling literature (e.g., Earle, 2017; Kee, Johnson, & Hunt, 2002); however, such an exploration is absent in the CMHPT counselling literature.

My recommendation is that future research study the unique influences on the relational practices of rural-based CMHPT counsellors, particularly those practising in areas characterised by social disadvantage such as high unemployment and poverty, and areas with high rates of child abuse and mental health issues such as youth suicide. Considering the high level of marginalisation and disempowerment in these settings, I recommend future studies employ a research design that has a strong emancipatory agenda such as participatory action research, and one that facilitates prolonged engagement with the community over a time frame that maximises the benefits of the research to the community.

**8.7.5 Further exploration of shadow influences**

Although my study has ended, the Critical Imaginal Hermeneutical Spiral is continuous and does not cease because my study has. Thus, further immersion into the Critical Imaginal Hermeneutical Spiral and therefore further understanding of the research phenomenon could be the focus of future studies, particularly focusing on the role of CMHPT counsellors’, supervisors’, and educators’ shadows on relational practices with parents. As discussed in my critique of my study in Section 8.6, my own critical reflexivity continues to explore the point where I ended my study – how my own unacknowledged and unexplored shadow influences relational practices. In my postdoctoral research, I aim to further explore how my shadow may mirror the core dimensions of the participants’ shadow revealed in my study, by employing an autoethnographic research design combined with a critical imaginal hermeneutic approach. This research aim and design could also be adopted by researchers who are CMHPT counselling supervisors and/or educators.
Future studies could also explore the relevance and applicability of my Critical Imaginal Reflexivity Model, particularly the role and nature of shadow integration in the critical reflexive process and ensuring changes to practices. This could be achieved by employing any number of critical research approaches (e.g., critical imaginal hermeneutics, critical ethnography, participatory action research) depending where on the social constructivist/critical paradigm continuum the research is positioned.

8.8 Final reflections

As I was writing this final section of the final chapter and was deciding how to encapsulate the impact three and a half years of marinating myself in relational thinking has had on my professional and personal life, I experienced what Jung would describe as a synchronistic event. I received an email notification for an upcoming presentation at the Brisbane Jungian Society. The presentation blurb outlined that the speaker would be talking about Joseph Campbell’s “new myth of our time”. Although I was familiar with Campbell’s work on myths, I was not familiar with this reference to a new myth of our time. I looked this up and discovered it referred to Earthrise – the photograph of Earth taken by astronaut Bill Sanders in 1968 during the Apollo 8 mission around the moon, and lauded as the first image humans had of Earth in space.

The experience of seeing Earth from this non-Earthly, cosmic perspective had an unexpected impact on the astronauts as well as those who viewed the footage. White (1998) was one of the first to study the impact of the image on people’s sense of relatedness to one another and our planet. After interviewing 29 astronauts and studying the impact of seeing Earth from this perspective had on them, he coined the term the overview effect. The overview effect refers to the emotional impact the sight of Earth from space produced, characterised by “an expected and sudden feeling of being swept off one’s feet” (Siebenpfeiffer, 2017, p. 114), and in turn transforming the astronauts’ understanding of themselves and the world. Campbell argues that the feelings and realisation of the interconnectivity of all our lives needs to be at the centre of the new myth of our time (Campbell & Moyers, 2011). Myth in Campbell’s usage refers to the stories and narratives we use to make sense of our lives. Intrigued, I located the short documentary titled Overview (Reid, 2012) and, part-way through watching it, I was simultaneously taken aback and amused by what I interpreted was at the centre of this synchronistic occurrence. One of the images of Earth at night showed off a
spectacular montage of rich colour illuminated by lights and electricity generated by thunderstorms. It was a magnificent opal in space (see Figure 8.3).

Figure 8.3. Earth: Opal in space.29

Whether it was the astronauts’ poetic description of their first-hand experience of seeing Earth as a wholistic, living entity suspended in space; the documentary’s moving background music; or simply the beauty of the image; I viscerally related to the overview effect. I was swept off my feet. I watched the documentary a few times and reflected on why I found it so powerful. In addition to the association with the symbol of the opal that had emerged from my imaginal sense-making process, the image of Earth’s quiet totality crystallised for me the interconnectivity of our lives. In the context of my research, this mostly related to unconscious influences, particularly shadow projections, how they influence relational practices, and ultimately how damaging they can be to relationships. Indeed, this is what has consumed my own reflexivity in recent months, regarding both my professional and personal relationships, and appears to be the topic that has now claimed me, as it were.

29 Image from Planetary Collective (http://weareplanetary.com/collective/)
Returning to the new myth of our time, Campbell (in Campbell & Moyers, 2011) argues that the narratives we develop to guide our existence on Earth need to have our interrelatedness at the heart and centre, and this interrelatedness needs to encompass more than the personal, but also the social, the collective, and even beyond. My hope is that my research has contributed to this narrative.
References


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Appendix A: Invitation to participate

Hello APT member,

My name is Rosa Bologna and I am undertaking a doctorate at Charles Sturt University’s Education for Practice Institute (EFPI) in Sydney, Australia.

I would like to invite you to participate in my dissertation research exploring relational practices in child mental health play therapy counselling. The aim of this study is to gain a deeper understanding of how qualified mental health play therapy counsellors facilitate and interpret relational practices with parents.

I have attached a Participant Information Sheet outlining details of the study. If you would like to participate, please contact me at your earliest convenience.

Thank you for your time, consideration, and interest in this study.

Cheers,

Rosa

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Rosa Bologna
PhD Candidate
School of Community Health
Charles Sturt University
Postal address: Locked Bag 450, Silverwater NSW 2128
Tel: 0411160411
Email: rbologna@csu.edu.au
Appendix B: Participant information sheet

Participant Information Sheet

Relational practices in child mental health play therapy counselling

Principal Researcher:
Rosa Bologna
Ph: 0411160411
Email: rabologna@csu.edu.au

1. Introduction
You are invited to take part in my dissertation study titled Relational practices in child mental health play therapy counselling. The aim of this study is to gain a deeper understanding of how qualified mental health play therapy counsellors facilitate and interpret relational practices with parents.

This Participant Information Sheet tells you about the research project. It explains what is involved to help you decide if you want to take part.

Please read this information carefully and ask questions about anything that you don’t understand or want to know more about. Participation in this research is voluntary. If you don’t wish to take part, you don’t have to.

If you decide you want to take part in the research project, you will be asked to complete 2-4 semi-structured interviews. By completing these you are indicating that you:

- understand what you have read
- consent to take part in the research project
- consent to be involved in the procedures described

2. What is the purpose of this research project?
This study is located in the field of child mental health play therapy counselling, which like general child mental health counselling, experiences a high client dropout rate. Research indicates that one of the main reasons parents take their children prematurely out of mental health counselling is due to the quality of their relationship with the counsellor.

Despite research and various policy and reform initiatives emphasising the importance of the parent-counsellor relationship, it is largely neglected in research of child mental health play therapy counselling. Particularly neglected in the research is counsellors’ perspectives and interpretation of the parent-counsellor relationship. As such, the purpose of this study is to gain a deeper understanding of how qualified mental health play therapy counsellors facilitate and interpret relational practices with parents.

3. Who will be participating in this research?
Participants for this research study will be selected based on meeting the following criteria:

- Participants hold an accredited qualification in play therapy (from a Registered Training Organisation or University)
- Participants hold registration/membership with a clinical board in Australia (e.g. Psychology Board of Australia, Australia Association of Social Workers, Australian Register of Counsellors and Psychotherapists, Australian College of Mental Health Nurses, Australian Association of Occupational Therapists as a Mental Health Occupational Therapist or Royal Australian and New Zealand College of Psychiatrists)

www.csu.edu.au
CRICOS Provider Numbers for Charles Sturt University are 00005F (NSW), 01947G (VIC) and 02606B (ACT). ABN: 83 878 798 551
Participants provide play therapy counselling to preschool or primary school aged children (3-12 years)
Participants are based in Australia

4. What does participation in this research project involve?
Your participation in the study will involve 2-4 semi-structured, in-depth interviews. The first interview will last approximately 1 hour and where practically possible will be conducted face-to-face. If you are based in NSW, Victoria or Queensland, I am available to conduct the initial interview at your workplace or if you prefer, the interview can be conducted at the Education For Practice Institute’s Sydney Olympic Park office or via Skype. I am available to conduct interviews during or after business hours.

At the end of the first interview, I will ask you to nominate 3 play therapy texts or DVDs that have informed and influenced your relational practice and/or which you believe represent exemplary relational practice. You will also be invited to take photos or produce images of objects that symbolise your relational practice with parents (e.g. photo elicitation technique) for discussion in the follow-up interview(s). Photos or images you produce will not be of identifiable people or workplaces but rather symbolic representations of your relational practice with parents.

A follow-up interview(s) will be conducted over a 3 months’ time frame after the first interview and will be between 30-60 minutes in duration and be conducted either face-to-face or via Skype. The intent of the follow-up interview(s) is for me to clarify any questions from the initial interview, engage in deeper conversation with you about the topic, and to give you an opportunity to provide additional information pertinent to the research.

All interviews will be audio recorded for transcription and data analysis purposes. From the beginning of the study, you will be assigned a pseudonym that will be used for all your data; therefore, your interview data will be anonymous. If necessary, details that seem likely to identify you or your practice will be de-identified or withheld; for example, if you or your workplace has unique characteristics such that a description of these features would mean that those familiar with the Australian play therapy practice would be likely to identify you or your workplace.

5. What are the possible benefits for me?
There are a few possible benefits for you as a participant of this study:

- You will be able to claim professional development hours with your mental health clinical board/association (for example, the Psychology Board of Australia and the Australian Association of Social Work) as participation in research is considered a professional development activity by most boards and associations.
- You may gain greater understanding and insight into your relational practice patterns and values.
- You will receive a $100 book voucher from Dymocks Bookstore for your participation in the study.

6. What are the possible benefits of the research for the wider community?
I envisage that in gaining an in-depth understanding of counsellors’ relational practices with parents, new knowledge will be generated that can assist mental health play therapy counsellors to improve the parent-counsellor relationship and in turn address the high dropout rate of children receiving mental health counselling.

7. What are the possible risks?
It is not anticipated that significant risk is posed by participating in this research. All participants in this study are 21 years of age or over.

8. Do I have to take part in this research project?
Participation in any research project is voluntary. If you do not wish to take part, you do not have to. If you decide to take part and later change your mind, you are free to withdraw from the project at any time without penalty. Your decision whether to take part or not, or to take part and then withdraw, will not affect your relationship with me. It is important that you understand that you are free to withdraw your participation in the research at any time, and that if you do you will not be subjected to any penalty or discriminatory treatment. Interview participants who wish to withdraw their contribution from the study can do so by contacting me as soon as possible and within one fortnight of having taken part in an interview.
9. What will happen to information about me?

Any information obtained in connection with this research project that can identify you will remain confidential and will only be used for the purpose of this research project. In any publication and/or presentation, information will be provided in such a way that you cannot be identified. At the end of the project, online data will be permanently deleted. Data will be stored in a locked cupboard or on a password protected computer only accessible by the researchers.

10. Can I access research information?

In accordance with regulatory guidelines, the information collected in this research project will be kept for at least 5 years. Australian privacy laws stipulate that you have the right to access the information collected and stored by the researchers about you. Participants may access a copy of the final report by requesting a copy from the researchers. Excerpts from collected data may be used in written publications or presentations. It is expected that this research project will be completed by the end of 2018. Should you be interested in accessing the final report, please contact me on 0411160411 or email me at rbologna@csu.edu.au

11. Is this research project approved?

Charles Sturt University’s Human Research Ethics Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee through the Executive Officer:

The Executive Officer
Human Research Ethics Committee
Office of Academic Governance
Charles Sturt University
Panorama Avenue
Bathurst NSW 2795
Tel: (02) 6338 4628
Email: ethics@csu.edu.au

Any issues you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

12. Who can I contact for further information?

If you would like any further information concerning this project or if you have any problems, which may be related to your involvement in the project (for example, feelings of distress), you can contact the principal researcher, Rosa Bologna or Lifeline. Participants who wish to seek alternative independent counselling services are encouraged to access their local community counselling services.

Contact details are as follows:

Rosa Bologna
The Education For Practice Institute
Charles Sturt University
Locked Bag 450 Silverwater NSW 2126
Telephone: 0411160411
Email: rbologna@csu.edu.au

To access Lifeline from anywhere in Australia call 131114 (24 hours, 7 days a week).
Appendix C: Ethics approval

13 May 2015

Ms Rosa Bologna
Charles Sturt University Sydney
Locked Bag 450
SILVERWATER NSW 2128

Dear Ms Bologna,

Thank you for the additional information forwarded in response to a request from the Human Research Ethics Committee (HREC).

The CSU HREC reviews projects in accordance with the National Health and Medical Research Council’s National Statement on Ethical Conduct in Research Involving Humans.

I am pleased to advise that your project entitled “Relational practices in child mental health play therapy counselling” meets the requirements of the National Statement, and ethical approval for this research is granted for a twelve-month period from 13 May 2015.

The protocol number issued with respect to this project is 2015/069. Please be sure to quote this number when responding to any request made by the Committee.

Please note the following conditions of approval:

- all Consent Forms and Information Sheets are to be printed on Charles Sturt University letterhead. Students should liaise with their Supervisor to arrange to have these documents printed;
- you must notify the Committee immediately in writing should your research differ in any way from that proposed. Forms are available at: http://www.csu.edu.au/research/ethics_safety/human/hrec_forms (please copy and paste the address into your browser);
- you must notify the Committee immediately if any serious and or unexpected adverse events or outcomes occur associated with your research, that might affect the participants and therefore ethical acceptability of the project. An Adverse Incident form is available from the website: as above;
- amendments to the research design must be reviewed and approved by the Human Research Ethics Committee before commencement. Forms are available at the website above;

www.csu.edu.au

Last updated: March 2015
Next review: March 2016
• if an extension of the approval period is required, a request must be submitted to the Human Research Ethics Committee. Forms are available at the website above;
• you are required to complete a Progress Report form, which can be downloaded as above, by 18 March 2016 if your research has not been completed by that date;
• you are required to submit a final report, the form is available from the website above.

YOU ARE REMINDED THAT AN APPROVAL LETTER FROM THE CSU HREC CONSTITUTES ETHICAL APPROVAL ONLY.

If your research involves the use of radiation, biological materials, chemicals or animals a separate approval is required from the appropriate University Committee.

The Committee wishes you well in your research and please do not hesitate to contact the Executive Officer on telephone (02) 6338 4628 or email ethics@csu.edu.au if you have any enquiries.

Yours sincerely

Julie Hicks
Executive Officer
Human Research Ethics Committee
Direct Telephone: (02) 6338 4628
Email: ethics@csu.edu.au
Cc: Dr Nicole Patton Associate Professor Franziska Trold

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007)
Appendix D: Consent form

PARTICIPANT INFORMATION AND CONSENT FORM

I……………………………………………………………..consent to participate in the research project titled:

‘Relational practices in child mental health play therapy counselling’

Researcher:
Rosa Bologna
Ph: 0411160411
Email: rbologna@csu.edu.au

I acknowledge that:

I have read the participant information sheet [or where appropriate, ‘have had read to me’] and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s. I have been given the opportunity to ask questions about the research and received satisfactory answers. The purpose of the research has been explained to me, including the (potential) risks/discomforts associated with the research. I have also read and understood the written explanation given to me.

I consent to the semi-structured interview, which will be audio-taped for accuracy of transcription. I consent for the information I provide, including photographs and/or artefacts to be published in reports, papers, books and/or book chapters and presented at conferences and seminars. I understand that any information or personal details gathered in the course of this research about me are confidential and that neither my name nor any other identifying information will be used or published. I understand that I am free to withdraw my participation in the research at any time, and that if I do I will not be subjected to any penalty or discriminatory treatment.

Signed: ........................................................................

Name: ...........................................................................

Date: ............................................................................
Appendix E: Interview guide

SEMI-STRUCTURED INTERVIEW GUIDE

(Relational practices in child mental health play therapy counselling)

Thank you for agreeing to participate in this semi-structured interview. This interview will be recorded and take no longer than 60 minutes. Your contributions will remain anonymous, as detailed in the participation consent form you have read and signed. If you need to discontinue this interview at any point in time, please let me know.

(Introductory statement read to participant once recording has started)

1. How did you come be involved in child mental health play therapy counselling?
   a) What are the most rewarding/enjoyable aspects of child mental health play therapy counselling?

(child mental health play therapy context/opening question)

2. What have been your general experiences regarding parents of children you see for counselling?

(scope)

3. What has been your most positive experience with parents?
   a) Can you describe a memorable, positive experience with a child’s parent?
   b) What contributed to making this a positive experience?

(Memorable impression)

4. What has been your biggest obstacle in working with parents?
   a) Can you describe an interaction with a child’s parents that didn’t go so well?
   b) Why do you think this interaction didn’t go so well?

(Memorable impression)

5. How do you facilitate development a working relationship with parents?
   a) How does your relationship with parents evolve?
   b) What do you do to foster the development of this relationship?

(Detail of relational practices)

6. How does your relationship with parents affect your work with their children?
   a) Which types of practice/procedures do you find the most valuable for these interactions?
   b) Why do you think these have been valuable?
   c) Which types of practice/procedures have you found to be the least valuable for these interactions?
   d) Why do you think these have not been effective?

(Detail of interrelationships/value and interpretation of practice)

7. If you could change anything about your practice or the system you work in, in order to develop a better relationship with parents, what would that be? Why?

(Detail of prospective practices)

8. What has specifically encouraged and/or discouraged you from facilitating a relationship with parents?
• How were you introduced to facilitating relational practices with parents?
  
  (Detail of how relational practices were initiated, implemented etc)
  
9. From your observations, how have children responded to your relationship with their parents?
  
  (client context)
  
10. Is there anything else you would like to discuss or share in relation to your relational practices with parents which we haven’t discussed?
  
  (Space for participants to share other insights/closing question)

Please Note: Questions for subsequent interviews will evolve from my engagement with photos/artefacts, seminal texts and participants’ responses in proceeding interviews. Depending on participant responses and timing, all of the questions outlined above may not be asked in the first interview. For example, questions 6 & 7 may be best suited for subsequent interviews.
Appendix F: Extract from research journal

Friday 17th July 2015
1st interview with Josephine, NSW.

Pre-interview reflections

Arrived at Airport 8.15 am. Man on plane next to me helped me with my overhead luggage. He looked like a farmer. Hat, jeans, flannel shirt. I also noticed his very rough leathery hands. I wondered how he would make sense of counselling let alone play therapy? Does rural living impact on people’s understanding and perceptions of counselling? History of counselling/therapy originates from cities (I think).

8.30. Airport terminal. One of the smallest I’ve ever been to. Man behind the counter seems to do everything at the airport (tickets, baggage processing, communicating with the pilot, etc). He offers to call me a taxi. Initially I had trouble understanding him. I then realised he only has one tooth (or at least I could only see one). This really shocks me. Why? I’ve seen dental problems before. Maybe because in places like Sydney it would be a barrier to employment, particularly where customer service is involved. Wonder what socio-economic situation is in . While waiting for the taxi, saw a man in his 20s with a Pit Bull puppy in a crate he was sending off on the next flight out. He looked like he was either half asleep or under the influence of something. He seemed indifferent to the puppy. He didn’t say goodbye to the pup just handed it to the man with one tooth and left. My thoughts race to puppy farms and dog fitting rackets. I was about to get up to go sit with the pup but the man behind the counter whisked him away somewhere at the back.

9.00am Taxi took a while to arrive but I was early for the interview so got taxi to drop me off at coffee shop. Taxi driver tells me there’s one in the mall. At a coffee shop in mall. Coffee is pretty bad. Watching people walk by. Just going by surface appearance, appears to be a lot of socioeconomic disadvantage here. Saw one man walk out of Big W with a singlet top and no shoes yet it’s 7 degrees! He looks pretty dishevelled. Is he on drugs? Wondering what the drug situation is like in . The drug ice has hit epidemic levels in many country areas in Australia. Wonder if it’s a problem here in ? Try to look it up on the internet but can’t get wifi. I notice that the stores in this small mall are very budget or low cost. More people walking by in thongs and shorts and it’s 7 degrees!!!

A number of elderly people in the mall. Wonder what their situation is economically, i.e. pensioners or retirees? Also, very Anglo looking population but population is supposed to have a high Aboriginal population. Try to look up census data on the internet but still can’t get wifi connection. Going by appearance only, doesn’t appear to be any ethnic or racial diversity, at least not in the mall. What’s the history of this area? Ie: how do most people come here? Is it a generational or transient? Immigration? As I’m typing this, I see another person, a woman, in a singlet top and thongs. Her arms are covered in
tattoos. Isn’t she cold?! Mix of ages – young parents, middle aged people and elderly. Seems to be same amount of men and women. Would be interesting to see the employment stats for this area and what the main employment industries are. Haven’t seen any primary or high school aged children - probably at school.

Walking to the interview, I asked an elderly woman for directions. She was very helpful and even after she had told me where the cottage was, she ran back after me to double check I had understood. Very helpful and hospitable. Country town hospitality?

Arrived at Josephine’s practice.

Josephine showed me rooms in the cottage she was hoping to take over in coming months to expand/improve her practice.

Post-interview reflections

Directly after interview went to get some lunch. A café in what Josephine described “the good part of town.” Original art works hanging on the walls some of which I think are for sale. Mostly middle aged and elderly women having coffee. Seemed like a different demographic to that of the mall.

After lunch, got a bit lost finding the taxi rank. Found myself at the back of the mall near a park. Rang for a taxi. While waiting saw a heavily intoxicated man stumbling in the park. He looked Aboriginal. I remembered Josephine saying the town was divided socially - North and South and the social disadvantage was more pronounced on the south side. I was on the north side and it looked pretty disadvantaged so can’t imagine what the south side is like. Taxi arrives. I ask the taxi driver to point out South to me on the way to the airport. He does and gives me a running commentary on the town. Told me his family moved to many years ago from Sydney because of the cheap real estate. Said he used to work in the and started to drive taxis once the closed. Driving through South and notice many of the houses look quite rundown. Although there are aspects of that look uniquely Australian, there’s something about it that reminds me of places I’ve been to in the deep south of the United States. Half expecting to see Huckleberry Finn and Tom Sawyer any minute.

Lots stood out to me probably because of the juxtaposition between Sydney/city and rural town. Wonder what would stand out to a rural-based researcher coming to Sydney? What would stand out to them that I don’t see? So much open space in yet I felt claustrophobic. Felt a very heavy energy there. Trauma-related energy. Wonder what the Aboriginal history is in the area. Whether there were massacres. I’ve been to regional areas where I’ve had the same feeling and always felt it was associated with past trauma in the area. It’s like the energy lingers or forms an energetic membrane around the
town. Would be interesting to speak to an Aboriginal elder about their take on the energy in [Town].

Blind Pick:

Haven’t transcribed the interview yet but reflecting on the overall feel/message from Josephine’s interview. She has put a lot of thought, energy and care into creating a healing environment for her clients. Seems like she’s creating a temple where there’s a set of rules, decorum etc and only people who know and accept these rules and codes of conduct can enter her temple. Metaphorically I think of missionaries who set up churches throughout the world. They vary their practice very little. I.e. The countries/cultures they go to have to adapt to them rather than the other way around. I reflect that counselling is like this. I could walk into any counselling space anywhere in the world and recognise it as a counselling space. I think my Blind Pick refers to this. Using the metaphor of a church, it’s as if Josephine is constructing and creating a representative of the “counselling” religion in the town of [Town]. Great healing can take place there however it is only available to
those of the “faith” and who believe in its practices. Thinking of the people I saw at the airport, mall and park today, how would they make sense of counselling and its tenets? This contrast highlights for me how much counselling is a type of implant and is more foreign in some contexts (e.g. disadvantaged country town) than others.

In Josephine’s interview, she expressed a lot of frustration regarding parents not respecting her counselling policy and procedures but not much reflection regarding counselling as a cultural artefact and how foreign it may be to many of these parents in the context of their sociocultural background. Josephine expressed more reflection on how parents’ sociocultural background impacts on their parenting practices. E.g. farming parents expecting their children to work on the farm at a very young age, very practical in their parenting and generally not very emotionally-focused. With the exception of the café society I saw at lunch, I can’t imagine many people in the town being indoctrinated in the ways of counselling. Or maybe more specifically private practice? Looking at the Blind Pick card, the building is being constructed above ground. Josephine’s practice is like this in the sense that it feels removed from the ground-level, grimy coal face vibe of the town. To me her practice feels like a refuge and haven and a good healing space but I wonder how accessible it is for all members of the town?

**Active Imagination dialogue with Blind Pick Image**

Me: What are you doing (to the gnomes)
Gnomes: We’re working.
Me: At what?
Gnomes: [They laugh]. What does it look like?
Me: It could be anything.
Gnomes: A frame [more laughter].
Me: Why is it so funny?
Gnomes: Frame, frame, frame [laughing and mocking me I think?].
Me: [Epiphany]. Oh, is it the therapeutic frame?
Gnomes: [They don’t respond. Just more laughter].
Me: Can you tell me about the love heart you’re cutting out of the door of the frame?
Gnomes: [No response. Ignoring me].
Me: Can you tell me about the frame you’re building? What are its main qualities and functions?
Gnomes: [Still no response. Continue to ignore me].
Me: Do you have a message for me?
Gnomes: [All four look at me. Grinning]. Look at us. Where do we come from? [They all laugh].
Me: What do you mean where you come from?
Gnomes: [No response. Not even laughter this time].

*Can’t get more out of the image. Or more specifically, can’t get more out of the gnomes!
What do they mean where they come from? My initial thought is England e.g. Enid Blyton and land of fairy folk. I do a google search of “Origins of gnomes.” From Wikipedia: “A gnome is a diminutive spirit in Renaissance magic and alchemy, first introduced by Paracelsus in the 16th century and later adopted by more recent authors including those of modern fantasy literature. Its characteristics have been reinterpreted to suit the needs of various story tellers, but it is typically said to be a small humanoid that lives underground.” Never heard of Paracelsus so look him up. Lived in the 15th/16th century and was a “Swiss physician, alchemist, and astrologer of the German Renaissance.”

Interesting. In this context, the words “Swiss” and “German” immediately have me thinking of Jung and Freud who I symbolically associate with the origins of counselling/therapy. Depth therapists such as Jung and Freud who focus on the unconscious I guess can be thought of as “living underground” (i.e. the unconscious). I don’t think either Freud or Jung coined the term “the therapeutic frame” (that was Lang or Langs I think?) but nonetheless, the message I get from the card is the importance of the therapeutic frame. How does this relate to Josephine’s interview? I guess with Josephine there was a lot of emphasis on providing a safe, protected space and place (therapeutic frame) for the client (child) and annoyance at parents who threaten the integrity of the frame by not respecting her policy and procedures e.g. child’s confidentiality, coming to appointments on time and not interrogating the child about what they’ve done in the session. In the literature, I don’t think there’s an equivalent of the therapeutic frame for parents (i.e. non-clients). Josephine didn’t have a waiting room so parents are quite literally excluded from the space - they have to either wait outside on the porch or in their car. Only able to enter the sacred space when they meet with the counsellor every so often. Thinking about the origins of counselling/therapy, it was for adults so an emotional and physical space for third parties such as parents was never really a consideration for founders such as Freud and Jung. I’ve never come across any references to the therapeutic frame and/or its equivalent for parents in the literature but will have a look and see what I find.

*Follow up: literature regarding therapeutic frame and parents.*