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THE WINTER EDITION

Reflecting on Clinical
Training During a
Pandemic

The Evolution of
Self-Care: From
Explicit Techniques
to Implicit
Awareness

An Exploration of
Body-Centred
Countertransference
in Irish Therapists

Exploring the
Relationship between
Childhood Trauma and
Psychosis: A Review of
the Literature

The Experience of
Grief in Special
Education: Support
for Staff on
Deterioration and
Death of Students

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FOREWORD

Clinical Psychology Today

Happy Holidays & Welcome to the Seventh Edition of Clinical Psychology Today!

It has been a tough year for our community, both in our personal and professional lives. The challenging and unpredictable nature of our worlds has provided little respite for reflection. In this regard, we are pleased to present a number of thought-provoking articles on a range of timely and valuable topics.

The first three articles of this edition highlight the importance of checking in with our emotional and physical reactions as clinicians. The edition begins with an engaging and honest reflective piece on the personal experience of training as a psychologist during the current pandemic. A qualitative research study subsequently examines the experience of self-care within psychologists in Ireland, identifying the different forms of self-care and the importance of clinician awareness. An interesting research study with a large sample of therapists explores the topic of body-centred countertransference, identifying the different types of therapist reactions and arguing for the need to interpret these reactions as part of the therapeutic process.

The final two articles of this edition provide a discussion of two distinct and important topics. A literature review explores the link between childhood trauma and psychosis, highlighting the complex interaction between environmental and biological factors. The edition concludes with a discussion of grief in special education and identifies the supports needed for staff to manage this difficult process.

Do also check out the accompanying podcast (video here <https://youtu.be/NRbOSBuF8AA> or audio version here <https://soundcloud.com/user-204176533/cpt-interviews-dr-malie-coyne/s-8JRCcl2OWkk>) with Dr. Malie Coyne, Clinical Psychologist. In this engaging podcast, Malie gives her experience of working in the media as a psychologist and discusses her motivation for writing her new book, *Love In, Love Out*.

Finally, a sincere thanks to all the individuals that made this edition possible; the authors, the reviewers, the journal's working group. We would like to give special thanks to Siobhán O'Neill for her wonderful editing work and Chloe Costello for helping with the online edition.

Wishing you and your family a wonderful Christmas!

Edition Co-Editors: Patrick McHugh, Charlotte Wilson

REFLECTING ON CLINICAL TRAINING DURING A PANDEMIC

CLODAGH CREMEN



history. As a trainee clinical psychologist this comes with its own specific set of concerns; namely: placement competencies, placement days, placement locations, the placement “counting”, etc.

MARCH 12TH 2020

Where were you the day the schools and colleges closed? March 12th. A new flashbulb memory for many. I was in class being taught about Positive Behaviour Support by a wonderfully interesting and witty lecturer. Our course director came in to give us a much needed and comprehensive update on the situation. He mentioned redeployments, health care assisting, contact tracing, the colleges closing by the end of the week and our teaching being moved online. There have only been a few times in my life where I have lost my hearing because of shock and this was one of them. Time stopped, my vision tunnelled, and the room started

“The strangest of times”

“Stay safe”

“We are living through history”

Things we have all heard so often that they may be starting to sound cliché. I personally recoil now when I hear stay safe, but I have always been averse to a cliché. However, my own personal views on the matter aside – this has been a strange time. It has been a really scary time. We are very much so living through

to spin. I recall people asking questions, but I cannot remember what they were. I remember getting up and leaving the room abruptly, moving to the bathroom to go and cry. I met three other people from my class crying there too. Within (what felt like) minutes, we had received the Redeployment Policy from our employers. We anxiously questioned where we would be redeployed to – most of us anticipating contact tracing. By the end of the day the Taoiseach had announced the closure of schools and colleges. Our new reality had begun.

REDEPLOYMENT

We spent two weeks being sent reading materials online, as the universities also tried to rapidly adapt to what was happening. One by one we started to receive phone calls from the placement coordinators: contact tracing, health care assisting, back to old placements, swabbing, etc. etc. etc. I personally was sent Health Care Assisting. What an interesting experience it was. I kept a reflective diary throughout and let us just say I was not exactly the noble hero

running into battle the media may have been portraying at the time.

And so, on March 30th, I started the strangest placement of my life; one which was not part of the plan, which was filled with uncertainty, and which I initially resented. I had originally been expecting to do an Intellectual Disability placement, where I would be working in a residential home for people with Intellectual Disabilities. In normal times I would be doing group work, interacting with day services, supporting individuals, their families, and dealing with a wide range of professionals from different disciplines. Instead, I found myself doing a mixture of Health Care Assisting and Psychology work. This involved supporting people with their intimate care needs, whilst also supporting their emotional and physical wellbeing too.

I was angry. I was very angry. I was angry that I had not been listened to. I was angry that this was my placement. I was angry that I (initially) did not have PPE. I was angry that I had to move across the country. I was angry that I had to move

away from my family. I was angry that people were clapping. I was angry that we were lighting candles. I was angry that I was on my own. I was angry that I still had to find cases and clients to work with – that I had to somehow turn this experience into a placement that would meet my training requirements. I was angry that I got moved onto shift work. I was angry that I still had to apply for ethics for my research project. I was angry that I had to somehow find a case study still. I was angry that I had to still complete a placement contract and a logbook.

It is fair to say that my anger and emotional response was not grounded in reasonable or rational thought. I was angry that my life had to continue as normal. Things that I would normally do on any placement, such as logbooks and placement contracts, suddenly seemed to be huge requests. Things that are standard practice, like ethics applications, suddenly appeared as mountainous tasks that I was unable for. Everything had spun out of control and yet, I somehow had to keep going with all the normal things in

life too. I wanted to freeze (and in many ways I was frozen), but at the same time I wasn't allowed to be, and I reacted with a lot of anger.

It took me a month before I could even begin to think about my placement requirements. This left me in a position where I had to somehow squeeze a 3-month placement into roughly 8 weeks. I found clinical work where I could; I completed dementia screening assessments, behaviour support plans, and updated care plans. I completed individual interventions with some of the residents that focused on building relationships. A fellow trainee and I developed support materials for the staff in relation to minding their wellbeing during the pandemic. I was so lucky to have met some amazing nurses and health care assistants on the way who were incredibly patient and supportive of me, which I am so thankful for. We received weekly check-ins from our employers throughout, which afforded us the opportunity to express our concerns. I was also beyond fortunate to have had an incredible supervisor who was honest and

genuine with me about what was going on – something I needed tremendously throughout.

This is not something anyone signed up to, and it was certainly not something I signed up to either.

THE HERO EXPERIENCE

This brings me to the “hero” narrative. It was an interesting experience to say the least. As a trainee clinical psychologist, I very rarely have found myself being considered as a “hero”. What even is a hero: noble, brave, patient, selfless, caring, honest? At that time, I certainly did not feel patient, noble, or brave. I felt selfless in some ways, but only because I was forced into it. I was certainly honest with anyone who would listen to me complain. I absolutely did not identify with the heroes being depicted in the news or on social media. I felt really scared, really angry, and I cried a lot.

I only share this experience because it is important. We have all made huge sacrifices and suffered tremendously both

collectively and individually. Clapping for our healthcare workers was important. It helped people; I have no doubt. What helped me was having an incredible flatmate with whom I shared the experience, who allowed me to be angry. Equally, my family did the same (albeit via Zoom). This experience was not fair. Nobody signed up to it, including our health care staff. The people around me did not try to correct or change my narrative but listened patiently instead and validated what I was saying.

If being a hero means being noble and brave, that can also mean being stoic. We need to be so careful collectively about this narrative, not because what we are seeing is not heroic, but because humans need to be allowed to express how they feel. Anger is important. This experience has not been fair to anyone. Fear is important. There is so much uncertainty around us all the time now. Sadness is important. We have lost our world.

We need to be allowed to share these experiences, which can be challenging when you are also being cast into the role

of the brave, noble, and stoic hero society needs you to be. We are all just humans.

THE LEARNING EXPERIENCE

In terms of my clinical competencies I learned a huge amount about the importance of boundaries, something I had not previously valued in a meaningful way before. I learned to say no to people and to compromise where I had to. I learned to express my anger in a way that was assertive, to communicate it in a healthy way. It is difficult being told you have to do something and that you have no choice in the matter, I think most humans tend to react to this with anger. I learned that this anger can burn you, over and over again in an insidious way. It can be exceptionally painful to hold over long periods of time and it is important to learn how to let go of it, I am thankful that I did. I am thankful that I learned to focus on what I have control over, which was largely around meeting my placement competencies to the best of my ability and respectfully communicating my thoughts to those in charge. Learning to be both flexible and assertive at the same time with those around me was a challenge

and one that I am now grateful for; these are skills I will carry forward with me.

Working as a Health Care Assistant whilst also carrying out psychological assessments/interventions was complicated and stressful. I came to realise how important self-care is and had to develop my own resilience throughout the placement. This is something we often ask of our clients and whilst I thought I had an appreciation of how challenging this is, I now know that I did not. Learning to use worry time to contain my ruminations was difficult, as was building mindful moments into my day. It was a frustrating process, reflecting in action at times where stress is high is hugely difficult. It is easy to reflect when things are calm, as they often are when you are a psychologist sitting across from a client. It was really frustrating having to hold myself to account in this way and take responsibility for my thoughts, to accept them as opinions (not facts) and to work towards letting them go. I think as I move forward in my career. I will need to remember these lessons, to appreciate and understand how incredibly

demanding the requests we make are. I believe I will move slower, afford more patience, and be more empathic to those I am working with. This stuff is really hard. I have much more appreciation for being allowed to vent, without the narrative being corrected or reframed; being seen and validated was the most priceless intervention I could have asked for at that time.

These learning experiences were hugely beneficial and ultimately what has helped consolidate them for me has been the process of reflecting on them independently, in my own space, and in my own time. Validating my own anger and asserting it helped me to process what had happened and allowed me to move on from the experience in a beneficial way.

Whilst obviously still anxious, I am also hopeful that my experiences will 'count' towards my training still and that I will be on track to qualify on time. I am hopeful that my career will not be affected and that others will value my experiences in the future.

The rest (as they say) is history.

I have never been very good at endings.

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THE EVOLUTION OF SELF-CARE: FROM EXPLICIT TECHNIQUES TO IMPLICIT AWARENESS

AARON FARRELLY AND LOUISE HOPPER



ABSTRACT

Background: Research focusing on self-care has typically examined the effectiveness of specific interventions within unique samples. This has culminated in a dearth of exploratory research surrounding the area of stress and self-care. Coupled with this, a lack of investigation within an Irish clinical population was apparent. The current study aimed to address the exploratory gap via investigation of the experience of stress from the clinician's perspective,

focusing also on self-care within this sample.

Method: Semi-structured interviews were conducted with seven Clinical Psychologists (3 males and 4 females) currently practicing in Ireland. Data was analysed via Inductive Thematic Analysis.

Results: A superordinate theme of Clinician Awareness emerged. This describes the awareness necessary on the clinician's part to initiate healthy behaviour conducive to safe long-term practice. Analysis also identified three sub-themes; Physicality, Relationships and Work/Life Balance.

Conclusion: Findings of this research point towards the evolving nature of self-care within the sample of clinical psychologists. More than just techniques, clinician awareness adds a novel layer to self-care research and provides new scope for future research in this area.

INTRODUCTION

There is a dearth of research investigating the meaning of self-care to practitioners. To date, the focus has been on the specific effects of stress mitigation interventions.¹ Research lacks an in-depth understanding of the impact of stress and the need for self-care from the perspective of the caring professional.

Compassion fatigue has been conceptualised as a general 'cost to caring'.³ Much research has considered how to ameliorate this cost to caring and emphasised self-care. This is the process of a practitioner caring for their own physical and mental health via different techniques in their own time.² Research on the meaning of self-care to clinical psychologists is necessary to guide future interventions.

'Cost to caring' broadly examines the effects of stress for practitioners and various concepts have emerged demonstrating the nuanced manifestations this cost can take. Secondary Traumatic

Stress is a condition that mimics Post-Traumatic-Stress-Disorder (PTSD) and develops through the indirect transmission of traumatic material in a clinical encounter.⁴ Conversely, compassion fatigue is a non-clinical term describing the cost of caring for traumatised individuals.³ Vicarious traumatisation details the transformation of therapists' cognitive schemas related to identity, spirituality and worldview resulting from chronic exposure to clients' trauma.⁵ Finally, 'burnout' is conceptualised as a state of physical, emotional and mental exhaustion caused by long-term involvement in emotionally demanding situations, rather than exposure to the trauma and suffering of a specific client.⁶

Experiencing the 'costs of caring' can result in increased depression and anxiety⁷, decreased job satisfaction⁸, reduced self-esteem⁹, disrupted personal relationships¹⁰ and loneliness.¹¹ 'Costs of caring' also affects professional effectiveness, but more specifically this is due to effects on attention, concentration and the therapeutic relationship.¹² These outcomes may demonstrate the damaging influence

of unchecked compassion fatigue on the clinician.

It was determined that there was a dearth of research evaluating approaches to stress reduction in clinical psychologists.¹³ Although this realisation has been a catalyst for research on self-care interventions,¹⁴ the associated studies have focused exclusively on the effectiveness of self-care interventions and approaches, to the detriment of gaining a contextual understanding of stressors and self-care techniques. As a result, existing research illustrates the multiple manifestations of the impact of stress, but our understanding of self-care is left wanting in comparison.

Research has presented a four-factor model of self-care that includes intrapersonal, interpersonal, professional and physical domains.¹⁵ This model was further built upon by including a category dedicated to maintaining balance in the clinician's life; a key sentiment throughout the literature in this field.¹⁶ Proceeding from this need for balance, researchers concluded that more holistic approaches

to the mitigation of stress via self-care were necessary, and that these should incorporate a seven-day awareness to caring for self.^{17,18} With this emerging factor of awareness held as a key aspect of self-care, further research has proposed that this awareness is essentially knowledge of the self.¹⁹ Others suggest that awareness is knowledge of one's thoughts, emotions and behaviours. Therefore, it can be considered a state.²⁰

Similar to this awareness, mindfulness has been consistently defined as maintaining awareness of oneself and one's environment.²¹ Although research has identified subtle differences between mindfulness and self-awareness, these factors have also been found to be significantly positively correlated.²³ This awareness also ties into spiritual self-care; an outlook of self-care incorporating the importance of balance and awareness in a clinician's life.²³ However, these various conceptions of self-care are limited due to a lack of exploration. The literature lacks the ability to contextualise reported stress and self-care approaches within professionals' overall lived experience.²⁴ As

a result, there is a need for more research investigating the context in which self-care exists.

Such research represents an important step in bridging the exploratory gap between understanding why clinicians need to self-care, and what this act looks like from the clinician's point of view. As proposed by Maslach & Leiter,²⁵ the power of this research and its approach rests on the fact that it will essentially function as an organisational check-up, which is needed considering the nature of the job and the risks professionals are vulnerable to simply as a result of carrying out their role. Consider for example, 73% of qualified clinical psychologists in the USA reported clinically significant levels of stress. Similar levels of stress have been found among clinical psychologists in the UK.²⁶ A lack of support for self-care in mental health workers has been proposed.²⁷ It was concluded that a primary challenge for psychology was to build a more robust knowledge base regarding stress and burnout.²⁸

The current study explores the meaning of self-care in a previously unexplored sample of Irish Clinical Psychologists. This research will examine daily stressors experienced and provide an exploration of self-care from the perspective of clinicians. Findings will inform future research on stress and self-care in this population.

METHOD

Design

A qualitative approach took place by means of semi-structured one-to-one interviews. This methodology was chosen as it has been demonstrated as most appropriate for research concerned with the meaning of phenomena as experienced by individuals.²⁹ Semi-structured interviews were conducted using prompts to structure the interview and to reduce investigator influence.³⁰ The resulting data was analysed using Inductive Thematic Analysis (ITA).³¹ Ethical approval was obtained from the Research Ethics Committee (REC) in Dublin City University prior to initiating data collection.

Participants

Purposive sampling was used to recruit seven clinical psychologists. The minimum

qualification held by each participant was at Doctorate level. The average age of the sample was 42 years (SD =13.60). Hours spent practicing per-week (M = 37; SD =10.55) and average caseload per-week (M = 17; SD = 7.00) varied between participants. All participants were Irish clinical psychologists currently operating within multidisciplinary teams.

Data Collection

Upon demonstration of interest, potential participants were informed about the study. All participants then provided informed consent. Subsequently, a face-to-face interview was arranged in the clinician's place of work. A total of seven interviews were conducted in different clinical settings around Ireland. The interviews lasted from 30 to 48 minutes (M = 31mins, SD = 17mins). All interviews followed the semi-structured interview schedule. Interviews were audio-recorded and transcribed verbatim by the researcher. This transcription including non-verbal sounds such as laughter, which added to the depth of information obtained.³² Post transcription, participants were emailed a copy of their transcript to review. Once conformation was obtained

that each transcript was an accurate reflection of the participant's experience, data analysis began.

Data Analysis

An inductive thematic key was created to organise ITA³¹ which incorporated various phases.³³ The initial phase included familiarisation with the data via transcribing all interviews verbatim. Phase 2 was focused on the generation of initial codes from interview transcripts. In phase 3, initial codes were reduced into more manageable code extracts via the grouping of similar codes. In phase 4 new codes were collated with interview data and subsequent analyses of emerging themes was also conducted. The final phase hinged on defining and naming each theme - capturing the aspect of the data corpus that it represented. These themes and associated sub-themes represented the results of the thematic analysis.

RESULTS

Thematic analysis of interview data revealed three themes; Physicality, Relationships and Work/Life Balance. These aforementioned themes formed the super-ordinate theme of 'Clinician

Awareness'. Clinician awareness aids clinicians by alerting them to stressors and the need to care for their own physical and mental health.

Clinician Awareness – The pre-condition for optimum self-care

More than any specific technique, self-care emerged as an overarching awareness of specific needs that were central to the maintenance of physical and mental health. "Clinician awareness" encapsulates this emergent principle of self-care. It can be described as maintaining awareness of one's emotional and physical needs while conducting oneself as a clinical psychologist. Participants felt that this awareness could be utilised to foster positive self-care habits.

Physicality – The importance of body awareness in clinicians

Clinicians consistently reported self-care in terms of physical techniques and these were seen to have a consistently cathartic effect.

"spending time doing things physically, because I find so much of our work is sedentary, that it's, it's like a total contrast

to even be like, mowing the lawn, going to the gym". [P1]

"Meditation, mindfulness, yoga, daily swimming in the sea, cooling off in cold water, exercise. [P2]

Physical actions were mentioned by all participants as well as "grounding techniques" and hobbies such as reading. An awareness of the sedentary nature of a clinician's job meant it must be balanced with adequate physicality. However, some clinicians may lose this awareness of the importance due to the demands of their post.

"when I was in college I used to sing, and I stopped it, bad decision, because singing was great self-care for me and helped with stress". [P4]

This dropping off of a physical outlet due to work demands is one example of how a lack of awareness can impede self-care. Clinical awareness arose from the understanding of how everything the clinician did affected them in some way.

"I noticed that if I drop some of those things, that's when I notice". [P6]

Balance & Boundaries – Awareness as a bulwark to stressful potentialities

An awareness of the work/life divide was very important to all participants.

“it’s just really important to make sure other aspects of your life aren’t put on hold” [P5]

“scheduling in that balance, that balance with self, balance in lots of areas” [P7]

Clinician awareness did not just have ramifications for work-life balance; participants suggested that it radiated into many aspects of their job. A lack of awareness meant increased potential for the accumulation of stressors.

“If we’re not checking in with that (stress), and we don’t have that self-awareness, we’re in big trouble. Because we don’t know what’s going well for us and we don’t know how to make sure that stays, and then we don’t know what isn’t going well for us, and how we can reduce that”. [P1]

Awareness was considered a pre-requisite for superior performance as a clinician. It was not considered an in-the-moment fix, but a tool to guide clinicians on the right overarching trajectory of self-care.

“It’s about checking in, seeing what stresses you, and staying checked in with that, and how that changes over time”.

[P1]

Being self-aware enabled one participant to pursue work in an area suited to their personality, thus reducing stress.

“well it’s good that you learn either way, you either learn you hate it, or you learn that that’s where you want to go, trying to find a job that has the least emotional stress associated with it”. [P4]

Participants described self-care as active awareness; the ability to pragmatically analyse their situation and to not only mitigate stress in the moment, but to change their ongoing actions in order to function better. Finding their voice and creating healthy boundaries was key to this.

“I was quite newly qualified still, and wasn’t as able as I am now to manage boundaries with what I was expected to do, whereas I’ve learned to have realistic expectations and to be able to say no to managers”. [P5]

Relationships – How awareness sculpts a safety network

Hopes Situated within the personal and work life of the clinician, relationships emerged as a potent avenue for self-care.

“A lot of it is about spending time with my family, spending time with friends”. [P1]

“it would be very hard, to be, doing this kind of work if you didn’t have friends and family”. [P2]

These statements show the importance of keeping up relationships and socialising when it comes to sustaining practice for clinicians. An important aspect of this self-care mechanism is the escapism provided by the contrasting nature of relationships.

“none of my friends or family are in psychology, so actually its lovely, like going out, brunch, dinner, you know, its brilliant, because it’s never about psychology”. [P3]

Many participants spoke of the restoring and redemptive side to nurturing relationships.

“taking some time in the evening to do something that restores you, that’s socialising for me”. [P4]

“nurturing the important relationships in your life, and, the important emphasis on how they’re a two-way street, you’ve got

to put into those people you care about in order to get it back, making sure you have time for them”. [P7]

Relationships were described as providing a safety network for the clinician, allowing their stress load to be either shared with colleagues, or forgotten with friends. Awareness allows the clinician to realise this importance of relationships and the role they play in not just escaping for a while, but actively benefitting practice via colleague alliances.

“I used to organise a monthly lunch with colleagues in the building...to keep connected in life”. [P7]

This simple act had sustaining and redeeming effects resulting from this particular clinician understanding the positive effects of work relationships. Awareness of the benefits of relationships was imperative to clinician health for all participants, not just for personal and work life. Awareness of the nurturing qualities of relationships also emerged from the importance of personal therapy for the clinician. Personal therapy was described as “vital” for practicing clinicians and it was seen as both a vehicle to achieve increased clinician awareness, and also as a

relationship that takes an initial level of awareness to form.

“the idea that was the greatest help was individual therapy, I knew what it was like to be a patient, I think that was the most helpful, it gave me insight, insight into my own blind-spots, my own limitations”. [P2]

This insight was intrinsic to awareness and provided the clinician with a more wholesome view of themselves. One of the most experienced participants suggested when speaking of trainee’s that:

“they should all do a certain amount of personal therapy - of a psychodynamic nature, they need to understand their own defences, their own blind-spots, their own weaknesses”. [P2]

A number of this participant’s students had not carried out their own personal therapy. One participant felt it was an extreme oversight, or in other words a lack of awareness to not foster the important relationship of personal therapy.

“I think people should practice what they preach, you see there are a lot of people doing this kind of work who really still have a lot of unresolved baggage”. [P2]

This participant felt that unresolved conflicts caused clients to remind clinicians

of their own shortcomings, thus causing anxiety. The exploration as a result of initial awareness on behalf of the clinician to seek out personal therapy ultimately allows the clinician to develop greater awareness of themselves.

DISCUSSION

This research investigated qualitatively the stressors faced and techniques used for their mitigation in a sample of clinical psychologists working in Ireland. The findings support the view that there is a significant amount of stress involved with carrying out the role of clinical psychologist. The primary finding in this instance was understanding the emergent principle of clinician awareness. It was found that clinician awareness provides a foundation for subsequent actions aimed at stress mitigation.

Self-awareness involves obtaining knowledge relating to markers of the self, such as emotions and triggers, via reflection. This reflection then allows a person to act more in accordance with their inherent values at a future time-

point.¹⁹ In line with findings presented here and in previous research, there must be an attempt made to achieve a 'seven-day awareness' in clinicians.¹⁷ From the data, it was demonstrated that actions involving physicality, relationships and work-life balance could be described as stemming from an awareness on the clinician's part that appeared as the precursor to subsequent positive action.

Physicality

Participants spoke about the broad importance of physicality and its role in self-care. More specifically, exercise was a form of physical self-care. Previous research has demonstrated the psychological impact of exercise in other populations. Aerobic exercise has been associated with positive clinical outcomes for those with anxiety disorders.³⁴ Six 20-minute aerobic exercise sessions over two weeks has been shown to alleviate symptoms in those with PTSD, Generalised Anxiety Disorder and Depression.³⁴

One study has suggested that the anxiolytic effects of exercise are a result of the distraction from stressors while the

exercise is being carried out.³⁵ This may help to explain why participants cited exercise and physicality as important to self-care. These findings support the argument that exercise is an excellent self-care tool due to its efficacy and ease of implementation.³⁴

Some participants ceased their physical outlets due to work demands, thus losing their beneficial effects. This cessation resulted in increased stress for the clinician. Self-awareness has been significantly associated with recognising the importance of self-care;²² if exercise had to be stopped due to a busy schedule, a clinician with higher self-awareness may have attempted to find a less time-consuming substitute to exercise, rather than just completely lose out on self-care.

Relationships

Relationships in the workplace have been directly linked to occupational stress and burnout.³⁶ Evidence from this study supports the important function of relationships and how they can act as a safety net for each individual clinician. There is evidence that supervisors are important in helping to decrease stress³⁷, this finding lending credence to the

importance of relationships. With relationships being so important to clinicians, it could be demonstrated that awareness of this, and active work on behalf of clinicians to form alliances inside and outside of work is an active form of self-care. Work related sources of social support can take the form of supervisors or co-workers, whereas non work-related sources can take the form of family and friends.³⁸ The onus is on the clinician to have the awareness to know of the important role of relationships in practice and then use this to actively sculpt a safety network. With the current pandemic actively limiting a clinician's physical network and thus safety net, research should aim to investigate how clinicians dealt with this extraordinary change in events.

Relationships may also become stressed if not managed correctly. Low social support at work has been linked with helping professionals' intentions to leave their profession,³⁹ and sometimes relationships at work can cause stress due to the existence of power hierarchies within organisations.⁴⁰ Overall, relationships can

have a positive outcome on health and well-being, ultimately helping workers deal with occupational stress.⁴¹ Findings point to the importance of being aware of how relationships mediate stress; another potential avenue for future research on self-care.

Work-Life Balance

Another critical component of self-care was the development of a sustainable work-life balance²³ which emerged as imperative to participants in this study. While clinicians may perceive their professional and personal lives as separate, self-awareness is needed to ensure healthy boundaries exist between these two aspects of life.⁴² This conclusion is key in the realisation of the significance of clinician awareness and the role it plays in practitioner well-being.

Greater awareness from the clinician can aid in the promotion of a healthier work-life balance. This plays into previously mentioned activities. Essentially, with more awareness a clinician can build a work-life balance that allows the

actualization of both personal and professional aspirations. Focus on this work-life balance is another novel route for future research.

Strengths & Limitations

Findings should be interpreted in light of specific strengths and limitations of this research. Research concerning the experiences of clinical psychologists in Ireland in relation to stress and self-care is limited. This research has therefore provided an initial investigation of their experiences using qualitative methodology.

This study has a number of limitations. Semi-structured interviews were used to provide a framework for the discussion. This structure was mostly beneficial, but some participants limited their answers strictly to the questions rather than elaborate on their broader experience. Therefore, investigator influence³⁰ may have played a part via the construction of prompt questions used with all participants. Future research should establish a less structured approach to the

interview. It would also be helpful to include an additional step in which the interview schedule could be piloted, which was not possible in this instance due to time constraints. The transferability of the findings to other applied psychology roles is limited due to the homogeneity of the sample in this instance. It would be beneficial for future research to focus on other applied disciplines within psychology to begin elucidating consistent factors relating to self-care across populations.

CONCLUSION

The current research provided an initial understanding of the stressors and self-care techniques employed by Irish Clinical Psychologists. The elucidation and construction of the role clinical awareness plays in Irish clinical psychology is an important step towards enhancing self-care within the profession.¹⁴ Clinicians are aware that they are at risk due to the stressors inherent in their job (costs), and of the need for self-care, but self-care does not appear to be embedded in their role to the extent it should in light of ethical considerations. Self-care should not just be

a 'tick the box' exercise. There is still much progress to be made before a holistic approach to caring for the self can be achieved.²⁴

However, the literature²³ and research presented here provides some initial steps towards a new understanding of self-care embedded in an awareness that acts as the pre-cursor to relevant and positive action. The findings of this research imply that the evolution of self-care from explicit techniques to implicit awareness is not to the detriment of any techniques. Rather, the awareness seems to complement the usage of techniques. Future research can investigate this process in more detail, such as whether clinical training influences a clinician's outlook on self-care or whether it is an inherent attribute of some people to seek out healing activities more than others. There is a need to question clinician supports and education surrounding self-care so that we can consistently supply clinicians with the tools and knowledge to keep themselves both physically and mentally well.

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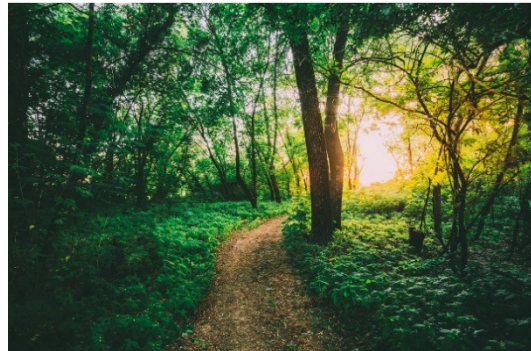
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AN EXPLORATION OF BODY-CENTRED COUNTERTRANSFERENCE IN IRISH THERAPISTS

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ABSTRACT

This paper aims to assess the frequency of Body Centred Countertransference (BCT) in a large sample of therapists (N=175; 122 Females) using the Egan and Carr Body Centred Countertransference Scale. BCTs are bodily responses of the therapist towards the client's story. Understanding how the body reacts and if gender or therapeutic approach has an impact on the presence of BCTs will help in the management of these symptoms. The most commonly reported BCTs in the current study included: muscle tension (80.6%), tearfulness (77.7%), sleepiness (72%), yawning (69.1%) and throat

constriction (45.8%). Descriptive statistics showed a higher occurrence of muscle tension and aches in female therapists while a higher occurrence of sexual arousal was seen in male therapists. The sample size did not allow for comparison across therapeutic orientation. These theoretical understandings of countertransference will aid in the awareness of BCTs, internal supervision of what this means in session, and its management within the supervisory relationship.

INTRODUCTION

Body-centred Countertransference

The original term Body-centred Countertransference (BCT) comes from a description given by Pearlman and Saakvitne.¹ They stated that: "We hold our affects physically and we will respond unconsciously through our bodies to the material and the presence of our clients. It

is not unusual for a therapist to experience somatic symptoms that parallel her client's body experience".^{1(p.91)} Much of the research on BCTs has used different terms that equate to BCT. Some of the terms used within the literature include embodied CT^{2,3} somatic CT⁴, somatic resonance⁵ and embodied empathy⁶.

Shaw⁷ reported that understanding this bodily phenomenon aided relational engagement with clients when the therapists used their BCT reaction in an attuned way. If the timing was right and if the therapist was acting in the interests of the client, rather than out of a personal CT reaction, then their understanding and use of their BCT aided engagement with clients. Blackburn and Price's⁸ description of 'presence in therapy' supports the notion that a therapist being both present and having a mindful dual awareness related to the relationship helps the therapeutic outcome. Being fully present to the client, bringing one's whole self (knowing what is mine and what is thine from moment to moment) into the relationship.

These reactions can have negative consequences to the therapist's health, for example, aches in joints,⁹ so the awareness of the factors attributing to the presence of BCTs is essential for the management of the therapist's health. Hayes, Gelso, Goldberg, and Kivlighan¹⁰ completed three meta-analyses in their review of countertransference (CT) and its management in psychotherapy. They found small to medium effect sizes in relation to the relationship between CT reactions, management of the CT and therapeutic outcome, with management factors diminishing CT reactions and resulting in better therapy outcomes. This is important in relation to supervision considerations and practice. They called for further focused research in relation to the effects of different types of CT on therapeutic outcomes, as well as how latent variables such as gender, ethnicity and therapists' qualities also impacts these outcomes.

An Irish study of body-centred or somatic CT in 78 clinical psychologists¹¹ found that the majority of the psychologists reported high levels of BCT when in session with

their clients in the previous six months (as measured on the Egan and Carr Body-Centred Countertransference Scale⁹). This level of somatic CT was very similar to that found by Egan and Carr¹² in a sample of 35 female trauma therapists working with adult survivors of childhood abuse and neglect. Higher levels of BCT were found to be related to higher levels of sick leave in female trauma therapists, but this relationship was not found in Booth and colleagues' sample of psychologists who were not primarily working with trauma survivors¹¹. The six most common symptoms reported in more than half of the samples were sleepiness; yawning; muscle tension; unexpectedly shift or movement of part of the therapist's body (hypnic jerk), tearfulness and headaches. These symptoms all occurred in the previous 6 months during a clinical session with a client.

From an Affect Phobia perspective¹³ the inability of a therapist to effectively engage with their own affective state, or the client activating previously unmet needs in the therapist, might result in the manifestation of defensive care-giving.¹⁴ This can

develop into a self-sacrificing style of caregiving in the long-term. Either process may activate the threat or inhibition system (fight/flight/freeze/flag/faint) where muscle tension is likely to occur, without access to a real physical or emotional escape. A therapist's unconscious defences when (automatically) deployed, might include reactions such as; defensive tiredness (switching to immobilization when anger cannot be asserted), somatization (commonly headaches or GI upset¹⁵) and dissociation (hypnic jerks such as unintended bodily shifts or mind drifting into a trance like state).

In a study by Hayes, Nelson and Fauth, 18 therapists were investigated about their experiences of CT reactions and how this impacted therapeutic outcomes.¹⁶ Half of the therapists reported their CT reactions to be 'successful' in the therapeutic outcome. The other half judged their reactions to be 'not successful'. Hayes and colleagues did not find reports of somatic reactions in the therapists studied. However, the interview schedule that they used did not specifically ask the therapists

about reactions in their bodies. Their research found that therapists who reported successful outcomes tended to be better at managing their CT reactions.

Egan and Carr recommended taking a moderate stance in relation to therapists' somatic or BCT responses to their clients,¹² assessing any occurrence in the last 6 months as well as investigating when there was a high occurrence of BCTs in the past 6 months. They found that the therapists reported dissociative responses to clients such as a loss of voice and throat constriction in approximately a third of therapists. McGrath and Egan¹⁷ in a randomised control design of 50 therapists, found that somatic countertransference occurred at the same time as both cognitive and emotional countertransference in response to a video clip of a narcissistic client compared to a neutral control video. These self-report measures showed evidence for somatic responses but did not correlate with the galvanic skin response and heart rate of therapists measured.

A further exploratory study looked at the frequency of occurrence of BCT in clinical psychologists from a variety of therapeutic approaches¹¹ using the same measure. Clinical psychologists ($N= 87$) were sampled to assess whether there was a relationship between BCT and a range of variables including: primary client group and therapeutic orientation; clinical supervision; client session hours per week, age, marital status, sick leave, number of children and number of years post-qualification. Results showed that there was no significant relationship between BCT and these key variables. Booth and colleagues¹¹ suggested that future research needs to replicate their study's findings, thereby providing further support for their results and additionally exploring whether there is a gender effect across frequency and type of BCT occurrence.

Several studies have suggested that there are gender differences in CT. Studies have shown that male therapists are more likely to withdraw from clients when their CT is evoked.^{18,19,20} Female therapists, on the other hand, are more likely to become over-involved with their clients when their

CT is aroused.¹³ The two previously mentioned Irish studies in relation to BCT in female trauma therapists and clinical psychologists did not assess gender effects.^{19,20}

Analytic Case Studies

There are a number of published analytic case studies which explore the topic of BCT.^{21,22,23,24,25,26,26} Of particular interest is the work of Dosamantes-Beaudry²³ who explains the importance for therapists to attend not only to their clients' nonverbal somatic communications, but also their own. She argues that this knowledge then enables therapists to understand an evolving intersubjective relationship between themselves and their clients more fully and accurately. According to her, the therapist's somatic CT is an additional source of information for the therapist which, to be employed most usefully, needs to be integrated with cognitive and emotional CT as well.

According to modern attachment theory the ability of the therapist to assuage the unmet needs of insecurely attached clients is achieved by the attunement of the therapist to the clients' elicited help

seeking behaviour, which is often non-verbal and is expressed in micro glances and other verbal and non-verbal signs displayed to a care-giver.¹⁴ Affect Phobia Theory¹³ adds to Heard and colleagues stance by stating that adaptive affect and closeness needs which have been un-responded to, or inconsistently responded to, or in some cases verbally or physically punished, may result in an unconsciously phobic resistance to approaching adaptive affect and sharing distress with potential care-givers. In O'Laoide, Osborne and Egan,²⁷ in a large sample of young Irish adults (N= 761), insecure attachment was assessed in relation to depression, anxiety and stress. This relationship appeared to be mediated by levels of current depersonalisation. Those who experienced emotional maltreatment and neglect had significantly higher levels of depersonalization than those who reported experiencing childhood physical or sexual abuse.

Stone⁵ suggested that there are three conditions that are most likely to lead to embodied CT. He proposed that if the client has a borderline or psychotic

personality structure, they are more likely to project their embodied feelings onto the therapist. Also, if the client has instinctual problems, childhood, or severe pre-verbal trauma, the therapist may pick this up in their body. And finally, if the therapist has a particular typology, that is, has introverted intuition as the superior function, they are more open to experiencing bodily CT responses. Stone's work has not been validated by longitudinal models.

BCT has also been explored in qualitative studies.^{2,7,28,29} Shaw^{7(p.271)} concluded that "psychotherapy is an inherently embodied process", and that the therapist needs to use their body as part of the psychotherapeutic process. According to Shaw, therapists who experience bodily phenomena note a stronger connection with the client, they are more emotionally involved. Participants in this study indicated that the bodily phenomena of BCT was not addressed in their therapeutic training and that this was a detrimental gap. Booth and colleagues¹¹ also recommended that being conscious of BCT 'as it arises in the moment' during a

therapy session, and whether it affects the connection with the client, is important to explore in clinical supervision. This approach is in keeping with Hayes and colleagues' review of CT, its management and clinical outcomes.¹⁰

METHOD

The current study will use BCT as defined by Pearlman and Saakvitne¹ and utilised by Egan and Carr^{12,20} and Booth and colleagues¹¹ who all used 'The Egan & Carr, Body-centred Countertransference Scale'⁹ as a dependent measure. This study aims to build on previous research, assessing 'The Egan & Carr, Body-centred Countertransference Scale'⁹ in a larger, more diverse population of therapists, taking into consideration the impact of gender and therapeutic approaches.

Design

This study was conducted using a cross-sectional design in order to investigate the Egan and Carr Body-Centred Countertransference Scale.⁹ This research aimed to investigate if there was a

difference in the presence of the 16 BCT symptoms in this scale, with regard to gender and therapeutic approaches.

Procedure

Participants were recruited through various professional bodies including the Irish Council for Psychotherapy; The Irish Association for Counselling and Psychotherapy and the Division of Counselling Psychology of the Psychological Society of Ireland. Therapists were contacted by their organization via e-mail, giving them information about the study and instructions on taking part. They were also contacted by the Research Ethics Committee with approval from Trinity College, Dublin. Each participant received a survey link to an online Survey Monkey™ platform.

Participants

One hundred and seventy-five therapists took part in the study, of which the majority were female (n = 122, 70%). The participants ranged in age from 35 to 72 (Mean = 54.9 years, SD = 9.80) with post qualification experience ranging from 3 to

30 years (Mean = 10.84 years, SD = 6.65).

Table 1 below summarises the distribution of the different therapeutic orientations used by the participants.

Table 1: Breakdown of Participant Therapeutic Approach/Orientation

Therapeutic Orientation	Percentage	Frequency
Psychodynamic	8.00	14
Humanistic	22.86	40
Integrative	56.57	99
Cognitive Behavioural	2.29	4
Systematic	5.14	9
Other	5.14	9
Total N = 175	100	175
Female	70	122

Note. Psychodynamic = Jungian, Object Relations (and the other specialities mentioned); Humanistic = Person Centred and Gestalt; Integrative = Working from more than one therapeutic approach

Measures

The measure used for this study was the Egan & Carr Body-centred Countertransference Scale.⁹ This scale was originally based on the Trauma Symptom Inventory (TSI),³⁰ a scale commonly used to assess trauma symptoms in adults. The Egan & Carr Body-centred Countertransference Scale⁹ is a 16-item scale that was used to evaluate the

frequency of various forms of BCT experienced by therapists in their sessions with clients in the previous 6 months. The frequency of each symptom was responded to on a Likert scale questionnaire. Participants indicated 0 (“never”) if the symptom had not occurred in the previous six months, 1 (“this has happened to me at least once in the last 6 months”), 2 (“this has happened a few times in the last 6 months”) and 3 (“often”) if the symptom has occurred quite frequently in the past six months. The Body-Centred Counter Transference Scale has good internal consistency with a Cronbach’s alpha of .74.

Data Analysis

Quantitative data were analysed using the SPSS Statistics 25.0³¹ programme. Preliminary analysis was used to check that all of the assumptions had been met. Test-retest reliability was used to assess the scale’s reliability. A Cronbach’s alpha of .84 was calculated. One item (numbness) was positively skewed but no improvement in reliability was seen when this item was

removed. Following this, characteristics of the participants were investigated. Responses were assessed to investigate the frequency with which participants experienced the various BCTs in response to clients in the last six months. BCTs were meant to be examined across gender and therapeutic approach but the numbers were inadequate for inferential statistics.

RESULTS

In Table 2. below it shows the percentage frequency with which the sample reported experiencing each type of BCT. The five most common forms of BCT were muscle tension, with just over 80% of the sample reporting this form of BCT in the last six months. This was followed by: tearfulness (78%), sleepiness (72%), unexpectedly shifting body (70%) and yawning (69%) as the most commonly experienced BCT reactions for the sample in the last six months. The least common occurrences of BCT, as reported by the participants were dizziness (20%) and genital pain (7%).

Table 2: Descriptive statistics of sample by gender where BCT occurred at any time in the previous six months

	Female Therapists (N = 122)		Male Therapists (N = 53)		Total Sample (N = 175)	
	Frequency	Percentage (%)	Frequency	Percentage (%)	Frequency	Percentage (%)
Muscle Tension	105	86.1	36	67.9	141	80.6
Tearfulness	94	77	42	79.2	118	77.7
Sleepiness	87	71.3	39	73.6	126	72
Yawning	83	68	38	71.7	121	69.1
Throat Constriction	64	52.5	16	30.2	80	45.8
Headache	53	43.4	22	41.5	75	42.9
Stomach Disturbance	55	45.1	20	37.7	75	42.8
Unexpectedly Shifting Body	87	71.3	36	67.9	123	29.1
Sexual Arousal	29	23.8	21	39.6	41	28.6
Raised Voice	34	27.9	15	28.3	49	28
Aches in Joints	36	29.5	9	17	45	25.8
Nausea	32	26.2	10	18.9	42	24
Numbness*	29	23.8	10	18.9	39	22.3
Dizziness	29	23.8	6	11.3	35	20
Genital Pain	11	9	2	3.7	13	7.5

*Numbness was removed from the final scale due to skewness

DISCUSSION

The current study replicated the findings of Egan and Carr Body Centred Countertransference Scale⁹, Egan and Carr⁴ and Booth, Trimble and Egan¹¹, highlighting the presence of 16 core BCT symptoms in therapy sessions. The sample size of therapists in this study was much larger, however, the problem of gender and therapeutic orientation comparisons still remained due to small number of participants in these sub-samples. The numbers were too small for a comparison among therapeutic approaches, but descriptive statistics showed some differences in the frequency of BCTs between genders. A higher proportion of female therapists appeared to experience muscle tension, aches, throat constriction and dizziness. In comparison, a higher proportion of male therapists appeared to have experienced sexual arousal. Without an analysis of statistical significance, this can only suggest the need to look further into this. Different gendered reactions to BCTs have been noticed in Hayes and Gelso²⁰ as well as Latts and Gelso.¹⁹ A study with a balanced gender profile needs to be conducted to examine these trends.

Supporting Dosamantes-Beaudry²³ and Shaw,⁷ there was a high frequency of BCT in the participants of this study, highlighting the power of bodily reactions for therapist and client. Similarly to Shaw,⁷ nausea and aches in the body were common experiences for the therapists. Building on Blackburn and Price⁸ and Hayes and colleagues¹⁰, confirming the commonality of these reactions, one can see how this knowledge can enhance the presence of the therapist within session and therefore influence the therapeutic outcome.

Strengths and Limitations of the Present Study

The limitations of the present study include the relatively small sample size, as this did not allow for comparison across gender or therapeutic approach. Future research might seek to explore this further. As per Hayes and colleagues¹⁰ recommendation, future research needs to address whether the presence of BCT has an effect on clinical outcomes and also whether its management improves same.

Separately, the relationship between BCT and vicarious traumatization and burnout have not yet been studied. With larger sample sizes, the use of factor analysis might prove beneficial in addressing whether certain items in the scale cluster to identify, for example, somatization in a therapist and its correlates (See Abbass et al., 2008 for a discussion¹⁵).

As this study used a cross-sectional design, future research needs to include a longitudinal analysis of therapists' BCT and related variables over time. Using in-vivo video analysis of BCT¹³ would also be suggested, evaluating micro-seconds of relational patterns between the therapist and client in order to facilitate the deconstruction of both clients' and the therapists' defences in an ever-maturing dynamic corrective relationship.¹² How BCT affects the attunement/misattunement of a therapist with the client would also be an important area of study.^{13,14,35}

Finally, Hayes's and colleagues¹⁰ called for the management of CT in supervision with therapists. The findings in this current cross-sectional study appear to have

supported their stance. However, analysing the clinical utility and acceptability of this measure with therapists (and clients) needs to be assessed in the future.

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THE RELATIONSHIP BETWEEN CHILDHOOD TRAUMA AND PSYCHOSIS: A REVIEW OF THE LITERATURE

MARK CECCHETTI



ABSTRACT

Although the exact physiological processes that result in the experience of psychosis remain unclear, the literature consistently demonstrates that a combination of neurobiological and environmental factors contribute to the development of the illness. One such environmental factor that represents a significant risk factor for the development of symptoms across the extended psychosis phenotype is exposure to traumatic experiences in childhood. This paper explores the wealth of epidemiological research to support this

position. The nature of this relationship is complex, with genetics, brain physiology and various environmental factors including childhood trauma each playing a role in the development of psychosis. Psychosis treatment outcomes have also been shown to be poorer in individuals reporting a history of childhood abuse. However, several methodological limitations have been identified in the body of literature, including issues with definition and measurement that need to be addressed in order to fully establish the nature of the relationship between childhood trauma and psychosis. Though a relationship between the two exists, childhood adversities are neither necessary nor sufficient to trigger the onset of psychosis. Key clinical implications arising from the research are also discussed.

INTRODUCTION

Although the exact physiological processes that result in the experience of psychosis remain unclear, the literature consistently reports that a combination of neurobiological and environmental factors contribute to the development of the illness¹. One such environmental factor frequently highlighted in the body of research is exposure to childhood trauma. The term 'trauma' refers to a large variety of negative experiences including emotional, physical or sexual abuse and neglect. There is much epidemiological research to support the position that exposure to traumatic experiences in childhood represents a significant risk factor for the development of psychotic disorders and symptoms across the extended psychosis phenotype^{2,3,4}. Though there is a general consensus that a link does exist between childhood trauma and psychosis, there is some debate surrounding the significance of this relationship as well as the types of trauma associated with an increased risk of developing psychotic symptoms. In addition, much of the research in this area is cross-sectional in nature, with the

majority of studies relying on self-reported retrospective accounts of traumatic experiences. There are also numerous inconsistencies in the research regarding other biological and environmental factors that may mediate this relationship. This paper aims to review the literature exploring the link between childhood trauma and psychosis, and comment on the clinical implications of this relationship. Due to the paucity of research specifying the onset age of psychosis as being before 18 years⁵, this paper will focus primarily on early onset psychosis and psychosis being experienced in early adulthood.

TRAUMA

Childhood trauma can be broadly defined as the harm, potential for, or threat of harm to a child often resulting from the commission of abuse or the omission of sufficient care⁶. This definition captures a wide range of adverse experiences including emotional, physical or sexual abuse, emotional and physical neglect, bullying and parental separation or loss⁷. In a large-scale study of adverse childhood experiences involving 9,508 participants,

50% of respondents reported having been exposed to at least one adverse experience before the age of 18⁸. This study also provided support for the hypothesis that childhood adversities tend not to occur in isolation, with 25% of respondents being exposed to 2 or more categories of abuse. Interestingly, it has been noted that accurate prevalence rates of childhood trauma are difficult to obtain due to the systemic under-reporting of experiences⁹, suggesting that the true prevalence rate may be even higher than the current estimates. This high prevalence rate of abuse and maltreatment among children poses significant challenges for survivors and for health care providers¹⁰. Exposure to abuse during childhood serves as a significant risk factor for maladjustment and the development of psychopathology later in life¹¹. Negative childhood experiences have also been associated with impairment in a range of functional domains¹², as well as with the development of many specific psychological disorders including anxiety, personality and dissociative disorders¹³.

The significant body of research that has emerged over the past few decades has

greatly enhanced our understanding of the relationships between childhood adversity and subsequent psychological difficulties. Historically, trauma research has tended to focus on physical and sexual abuse, largely overlooking other types of adversities^{5,14}. More recent research has expanded the conceptualisation of trauma to increasingly include emotional abuse¹⁵, neglect¹⁶, parental loss, separation or disharmony¹⁷ and bullying¹⁸. Understanding the breadth and complexity of the traumatising experiences children can be subjected to allows researchers to more accurately investigate the extent of the relationship between childhood trauma and psychological difficulties later in life.

PSYCHOSIS

The DSM-5¹⁹ characterizes disorders as psychotic or on the schizophrenia spectrum if they involve auditory or visual hallucinations, delusions, disorganized thinking or a variety of negative symptoms such as apathy or lack of emotion. The term psychosis is often used to describe the range of experiences people may have that include any combination of these

symptoms in varying degrees of severity²⁰. Psychotic experiences in the body of research are often defined broadly and are discussed using terminology such as schizophrenia, schizoaffective disorder, first episode psychosis, and delusional disorder².

There is also a general consensus among researchers that the psychosis phenotype can be expressed at levels significantly below its clinical manifestation, commonly referred to as sub-threshold psychotic experiences, psychosis proneness, schizotypy or persons at risk of psychosis^{21,22,23}. This concept of a psychosis continuum implies that the same symptoms observed in patients with psychotic disorders can also be measured in non-clinical populations. This is an important development in understanding psychosis and exploring its relationship with childhood trauma. Experiencing symptoms of psychosis such as delusions and hallucinations may only be considered a disorder depending on symptom characteristics such as frequency, intensity or intrusiveness, and personal characteristics such as one's use of coping strategies and distress tolerance²³.

Therefore, even though the prevalence of the clinical disorder may be relatively low, the prevalence of the symptoms among the general population at sub-threshold levels may be much higher.

A lack of clarity has been highlighted in the research base concerning the terminology and definition of both psychosis and childhood trauma. Inconsistencies in the literature regarding what experiences constitute a trauma and what severity level of psychotic symptoms constitutes psychosis can lead to discrepancies between research studies and issues with replicability²⁴.

EXPLORING THE ASSOCIATION BETWEEN CHILDHOOD TRAUMA AND PSYCHOSIS

The evidence demonstrating an association between childhood trauma and psychosis has been consistent. In one meta-analysis, 87% of individuals identified as being at ultra-high risk of transitioning to psychosis reported having prior exposure to childhood trauma²⁵. Another meta-analysis concluded that individuals experiencing psychosis were significantly more likely to

have been exposed to a wide range of childhood traumas including sexual, physical and emotional abuse or neglect, than healthy controls⁴. Furthermore, a recent meta-analysis involving 23,668 participants from 10 studies revealed that victims of childhood bullying were over twice as likely to develop psychotic symptoms later in life²⁶. In addition, exposure to cumulative adversities have been shown to increase the risk for psychotic disorders significantly more than those exposed to a singular type of trauma^{27,28}.

Relatively little research has been conducted exploring the relationship between childhood trauma and psychotic symptoms being experienced before the age of 18. One longitudinal twin study involving 2,232 participants found that children who had experienced severe maltreatment were more likely to report psychotic symptoms before the age of 12 than children who did not experience such maltreatment²⁹. The higher risk of experiencing psychotic symptoms was observed regardless of whether the traumatic experiences occurred early in life or in later childhood. In addition, the

increased risk associated with childhood trauma remained significant when controlling for other potential mediating biological and environmental factors such as gender, socioeconomic deprivation, and IQ. Similarly, in a study following 2,230 adolescents from age 10 to 16 years, a history of childhood trauma was found to be associated with subclinical experiences of psychotic symptoms³⁰. This evidence suggests that a similar association is observed between childhood trauma and the development of psychosis, regardless of whether the onset of the disorder occurs in childhood, early adulthood or later in life.

However, several limitations that have been identified in the body of literature exploring the relationship between childhood trauma and psychosis. Loewy et al.²⁴ highlight the controversial issue that many clinical cohort studies rely on the retrospective self-reporting of childhood trauma, obtained after the onset of psychotic experiences. They suggest that self-report data from individuals experiencing psychotic symptoms may be unreliable. Conversely, research conducted

by Fisher et al.³¹ demonstrated that self-reports are stable over time and unaffected by current psychopathological symptoms. Hardt and Rutter³² attempted to address this limitation by evaluating the validity of self-report data, comparing disclosures with independent court or clinical records and collecting the retrospective reports of multiple siblings. The authors found that the self-reports of childhood trauma by individuals experiencing psychosis are under, rather than over-reported.

Research has demonstrated that specific kinds of childhood adversities may lead to specific psychotic symptoms. Exposure to childhood physical and sexual abuse have been found to be strong predictors of positive psychotic symptoms³³. Childhood trauma has been proposed as a causal factor for certain positive symptoms of psychosis including voice hearing and command hallucinations³⁴. Most consistently, research has indicated that a history of childhood adversities may increase the severity of positive symptoms of psychosis, specifically auditory hallucinations and delusions³⁵. One study involving 184 participants diagnosed with a

variety of schizophrenia spectrum disorders concluded that childhood adversities may influence the severity of delusions and hallucinations in a dose-response relationship³⁶. Additionally, in a study involving in depth interviews with 61 severely maltreated children, it was found that the content of their hallucinations strongly resembled the nature of the trauma they were subjected to³⁷. A recent systematic review and meta-analysis supported this position, concluding that traumas in childhood may lead to an increased severity of hallucinations and delusions within psychotic disorders³⁸. Similarly, experiences of childhood neglect have been associated with paranoia and negative symptoms³⁹. A study involving 2,765 patients with psychosis provided further support for this position revealing that neglect was significantly more associated with negative symptoms of psychosis⁴⁰.

The often limited evaluation of the nature and degree of childhood trauma is a methodological issue consistently identified in the body of literature⁵. Many studies rely on the endorsement of a single question to consider a particular category

of trauma as present or not. Important aspects of childhood trauma that may mediate the relationship with psychotic disorders, such as age of exposure and relationship to the perpetrator, are also not addressed in many studies³¹.

Though there is significant evidence in the body of literature demonstrating an association between childhood trauma and psychosis, there is also research reporting conflicting findings that do not fully support this association. In a 4 year longitudinal study involving 105 patients at ultra high risk of developing psychosis, no evidence was found to suggest that childhood adversity was associated with transition to psychosis⁴¹. Similarly, a study involving 764 individuals identified as being at clinically high risk of developing psychosis concluded that childhood trauma was not a reliable predictor of later transition to psychosis⁴². A more recent meta-analysis involving patients at ultra-high risk of psychosis, found that only sexual abuse and not other types of childhood trauma was significantly associated with transition to psychosis⁴³. This suggests that exposure to childhood trauma alone may not be sufficient to

bring about a higher transfer to psychosis rate among ultra-high risk individuals. The research indicates that childhood trauma may interact with other genetic and environmental risk factors to result in an increased risk of developing a psychotic disorder.

BIOLOGICAL MODELS LINKING CHILDHOOD TRAUMA AND PSYCHOSIS

It has long been hypothesized that there is likely to be a biological influence on the development of psychotic disorders²⁰. Twin studies from around the globe have played a vital role in establishing a genetic contribution to the aetiology of schizophrenia and psychosis spectrum disorders^{44,45}. The biopsychosocial model of psychosis is a model that looks at the interplay between biology, psychology, and socio-environmental factors in the development of psychosis and schizophrenia spectrum disorders. Research into the aetiology of psychotic disorders consistently demonstrates a complex interaction between genetic and environmental factors⁴⁶. The evidence

indicates that stressful life events may influence critical periods of brain development, triggering the onset of psychosis later in life⁴⁷.

The traumagenic neurodevelopmental model of psychosis³ emerged as an attempt to explain this process, highlighting the impact trauma can have on the developing brain. Research has demonstrated increased stress sensitivity among individuals experiencing psychotic symptoms⁴⁸. The traumagenic neurodevelopmental model attributes this observation to trauma-induced neurodevelopmental changes during crucial periods of brain development in childhood.

Psychosocial stress, in particular childhood trauma, is hypothesized to interact with one's predisposing genetic vulnerability or in certain cases alter gene expression via epigenetic mechanisms to contribute to the development and maintenance of psychotic disorders⁴⁹. Interestingly, one review found that the role epigenetic dysregulation plays in the onset and development of psychosis and schizophrenia-spectrum disorders is

becoming increasingly recognized⁵⁰. Several biological mechanisms have been proposed attempting to explain this interaction between psychosocial stress, trauma and the experience of psychosis.

The Hypothalamic-Pituitary-Adrenal (HPA) axis response

The HPA axis is a neuroendocrine unit comprising of the hypothalamus, pituitary gland and the adrenal glands. It plays a vital role in basal homeostasis and in regulating the body's stress response processes. A main function of the axis is the production and secretion of cortisol, a hormone released during times of stress increasing heart rate, blood pressure, respiration and blood glucose⁵¹. Substantial evidence indicates that individuals diagnosed with schizophrenia spectrum disorders or experiencing psychotic symptoms exhibit HPA axis dysregulation. It has been reported that individuals experiencing psychosis are characterized by elevated morning cortisol levels⁵², higher diurnal cortisol levels⁵³ and reduced cortisol response to stress⁵⁴.

The experience of trauma during childhood results in the activation of the stress

response and HPA axis, with prolonged or repeated trauma resulting in sustained over-activation of the system. The traumagenic neurodevelopmental model hypothesizes that long-term exposure to such stressors and activation of the HPA axis may result in elevated levels of glucocorticoids such as cortisol. This disruption to the normal functioning of the HPA system has been linked to the increased likelihood of developing psychosis and schizophrenia spectrum disorders.

The experience of psychosis has also been demonstrated to accompany other physiological brain abnormalities. A meta-analysis revealed higher pituitary gland volumes in individuals at risk of psychosis and first episode psychosis patients when compared with healthy controls at trend level significance⁵⁵. In addition, research has demonstrated that a history of childhood trauma may be associated with lower amygdala and hippocampus volumes in patients experiencing psychotic symptoms⁵⁶. In one study involving 60 patients with a psychotic disorder, sexual abuse, but not other types of childhood trauma, was associated with lower total volume of grey matter when compared

with healthy controls⁵⁷. These findings support the results of previous research suggesting that higher levels of stress hormones may be associated with lower brain volumes in abuse victims⁵⁸.

Comprehensive biological models such as the traumagenic neurodevelopmental model offer a description of the potential biological mechanism linking trauma, stress and psychosis vulnerability. Other biological models linking childhood trauma to the experience of psychotic symptoms include brain-derived neurotrophic factor⁵⁹, immune-inflammatory mechanisms⁶⁰ and metabolic dysregulation⁶¹. There is a general consensus that significant environmental stressors such as childhood trauma may have detrimental effects on brain development and physiological structure, resulting in the increased likelihood of experiencing psychotic symptoms⁶². Many of these biological models aim to identify a clinical biomarker associated with the deleterious effects of childhood maltreatment on brain plasticity, leading to the experience of psychotic symptoms.

PSYCHOSIS TREATMENT OUTCOMES IN PATIENTS WITH A HISTORY OF CHILDHOOD TRAUMA

Research has consistently demonstrated that previous exposure to childhood trauma is related to the clinical manifestation of psychotic symptoms, however, relatively few studies address how trauma may impact on response to treatment in this clinical cohort. A study measuring early response indicators to antipsychotic treatment in first episode patients found that those who displayed poorer response to treatment more frequently reported a history of childhood trauma⁶³. Further evidence suggests that a history of childhood adversity, in particular emotional abuse, may be associated with a poorer response to anti-psychotic medication in patients experiencing first episode psychosis⁶⁴. Similarly, in a study involving 186 participants diagnosed with schizophrenia spectrum disorders, it was demonstrated that treatment-resistant patients report experiencing emotional abuse and neglect, as well as sexual abuse more frequently than the patients responding positively to anti-psychotic treatment⁶⁵. These findings suggest that

the experience of childhood trauma may mediate the effectiveness of anti-psychotic treatments, leading to poorer clinical outcomes for clients with a history of childhood adversities. Interestingly, one study involving 50 participants evaluating the effectiveness of an acceptance and commitment therapy intervention for individuals with a diagnosis of a psychotic spectrum disorder found that that trauma severity did not moderate the effectiveness of the intervention⁶⁶. This finding highlights the different mediating roles childhood trauma may play in patient response to anti-psychotic medication versus psychological therapy treatment pathways.

MEDIATION ENVIRONMENTAL FACTORS

In addition to childhood trauma, a variety of environmental insults have been associated with an increased risk of developing a psychotic disorder. Cannabis use has been consistently highlighted in the body of research as being associated with the development of psychosis and

sub-threshold psychotic experiences. One meta-analysis concluded that a relationship exists between cannabis use and the development of schizophrenia spectrum and other psychotic disorders⁶⁷. This finding supports the position of previous research suggesting that cannabis use can result in the chemical disruption of brain development, resulting in the experience of psychotic symptoms. This relationship appears to be particularly strong if cannabis is used during important phases of neurological maturation such as adolescence⁶⁸. Similarly, research indicates the possibility of an additive interaction between cannabis use and childhood adversities. In a study of 211 adolescents aged between 12 and 15 years, it was found that both cannabis use and childhood trauma were significantly associated with the risk of experiencing psychotic symptoms⁶⁹. The presence of both childhood trauma and early cannabis use significantly increased the risk for experiencing psychotic symptoms beyond the risk posed by either risk factor alone, indicating that there was a significant additive interaction between childhood trauma and cannabis use. Additionally, the effect of sexual trauma on psychosis

development has been demonstrated to be significant only for those who used cannabis under the age of 16⁷⁰. Several studies have also explored the interaction between childhood trauma and socio-economic status in order to provide a broader insight into the influence of environmental factors on the development of psychosis. A study involving 168 cases concluded that social inequity at birth was associated with a greater risk of developing a schizophrenia spectrum disorder in adulthood⁷¹. This finding is in support of previous research indicating that social deprivation during gestation and early life can increase the risk of developing a psychotic disorder⁷². One study involving 3,021 adolescents reported an additive effect of urbanicity, cannabis use and childhood adversities on the risk of experiencing psychotic symptoms⁷³. Gender differences⁷⁴ and lack of social support⁵ have also been identified as potential factors mediating the relationship between childhood trauma and psychosis. In a study of 202 individuals, women who experienced childhood trauma and had low social support were the most at risk group of developing a psychotic disorder⁷⁵.

The evidence suggests that though there is a well-established association between childhood trauma and the development of psychosis, there are numerous other environmental factors that may mediate this relationship.

CLINICAL IMPLICATIONS

There are numerous clinical implications arising from an enhanced understanding of the relationship between childhood trauma and psychosis. In terms of assessment, the research supports the inclusion of childhood trauma as a key risk factor for clinicians to explore when assessing for risk of experiencing psychotic symptoms. This may assist clinicians to conduct more robust and clinically accurate assessments, resulting in the earlier identification of clients at risk of developing psychotic symptoms. In terms of intervention, understanding the nature of the relationship between childhood trauma and psychosis may enable clinicians to develop more tailored treatment strategies for clients. Research is beginning to emerge regarding what interventions may be particularly effective

for clients with a history of childhood trauma who experience psychosis. A recent meta analysis⁷⁶ revealed that trauma focussed interventions have a small effect on the positive symptoms of psychosis immediately post treatment. However, these improvements were not maintained when measured again at follow up, suggesting that alternative strategies may be necessary to result in lasting positive change.

A history of childhood trauma may also be related to poorer clinical outcomes following treatment than clients who do not have a trauma history. Schäfer and Fisher²⁶ found that clients with a diagnosis of psychosis who had previously experienced childhood adversities had a more severe clinical profile, lower levels of cognitive functioning and increased relapse rates following treatment. Similarly, Hassan and De Luca⁷⁷ found that higher levels of adversities including childhood trauma increased the likelihood of clients being resistant to antipsychotic treatment. Augmenting antipsychotic treatment with psychosocial interventions such as Cognitive Behavioral Therapy has been demonstrated to be effective in improving the mental state and reducing

symptom severity in treatment resistant clients experiencing psychosis with a history of childhood trauma⁷⁸. This has significant clinical implications, as it suggests that multi-dimensional approaches may be more effective when treating clients with a history of childhood trauma. The research suggests that for clinicians, routine assessment of trauma histories combined with an individualized bio-psycho-social formulation and multi-dimensional individualised intervention strategies are key areas to continue to address in order to improve client outcomes.

CONCLUSION

In conclusion, there is significant evidence to suggest an association exists between the experience of childhood trauma and the later development of psychosis. However, there is some conflicting evidence surrounding the extent of this relationship and the types of trauma that may be associated with psychotic symptoms. The quality of the current research base suffers from several methodological issues including definition

and measurement issues that need to be considered when evaluating the reliability of findings. Increased methodological rigor is necessary to further establish the complex relationship between childhood trauma and psychosis. Misiak et al.⁵⁹ in their systematic review of the literature conclude that although a relationship exists between a history of childhood trauma and psychosis, childhood adversities are neither necessary nor sufficient to trigger the onset of psychosis. This statement captures the complexities of the relationship between childhood trauma and psychosis highlighted in the research base. The traumagenic neurodevelopmental model of psychosis demonstrates this complex interaction between genetic factors, biological mechanisms and environmental insults and the experience of psychotic symptoms. The research suggests that though there is a well established genetic vulnerability increasing the likelihood of psychosis, the differences in brain structure and function resulting from childhood trauma and other environmental factors play a crucial role in the onset and development of psychotic symptoms. Key clinical implications arising from the research include the importance

of routine assessment of trauma histories and the delivery of multi-dimensional individualised treatment strategies in maximising client outcomes.

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THE EXPERIENCE OF GRIEF IN SPECIAL EDUCATION: SUPPORT FOR STAFF ON DETERIORATION AND DEATH OF STUDENTS

KATE O'BRIEN, MARIA GOMES



ABSTRACT

Staff in special education settings commonly experience the deterioration and death of students. An inability to cope with anticipatory grief while observing the deterioration of a student can cause burn-out or compassion fatigue which can lead to an overattachment or detachment from the student. Subsequently, an inability to appropriately grieve a deceased student increases the risk of complicated grief

which can negatively impact the work of staff. Despite the frequency of death in special education and the risks that grief poses to special educators in their work with remaining students, grief management is not common practice in their training.

This article makes recommendations for school wide actions in supporting grieving staff members which include (i) in-service workshops, (ii) the development of a grief plan (iii) the development of staff support initiatives and (iv) guidelines on support for surviving students after the death of a classmate. Specific strategies are also suggested for staff on coping with anticipatory grief and grief. Such strategies include the five realms of self-care and the cultivation of supportive interprofessional relationships.

INTRODUCTION

The advances in life-saving and life-extending technology has seen staff in special education encountering more children with life-threatening conditions¹ and more special educators now find themselves providing services to students who have a Do Not Resuscitate Order¹. It would appear that experiencing the deterioration and death of a student is inevitable to special education staff (teachers, special needs assistants, administrators etc.).

The most readily available research suggests that between 59% to 70% of educators teaching students with significant impairments have experienced the death of at least one student^{2, 3}. Many of the interviewed professionals had experienced multiple student deaths, and one professional had experienced the deaths of 20 children³. The most recent research in this field notes a potential increase in the number of student deaths experienced by teachers in special education settings⁴.

Although much is written about supporting children and families when a child dies, a search of the nursing, medical, psychological, counselling, and educational literature reveals few guidelines for supporting bereaved professionals. Although special education personnel frequently experience grief, the death of a child is not within their normal range of expectations or training⁵ and they often lack substantial training and support to deal with grief^{6, 7}. Special educators do report an increase in education in terms of pre-service or in-service training regarding dealing with death and grief (see Figure 1), however research beyond 2000 is scarce, and over the last twenty years since this published research, the advances in life-saving and life-extending technology has seen staff in special education encountering more children with life-threatening conditions⁸. Therefore, we must question if we are providing substantial information and support for those teaching and supporting society's most vulnerable children.

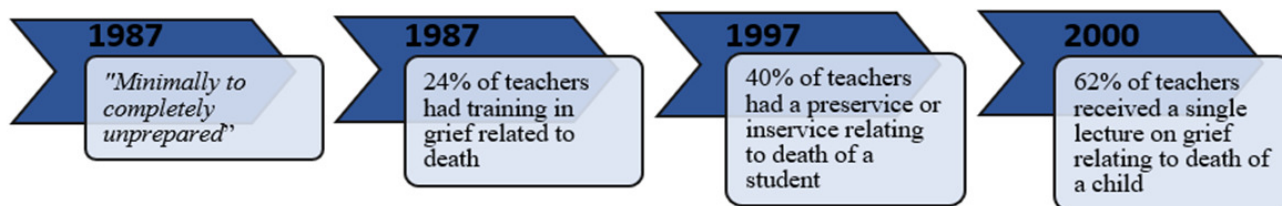


Figure 1: Progression of teachers' education of death and grief^{2, 3, 7, 9}

Moreover, the school community often lacks a formal support system for staff when the death of a student occurs¹⁰ and few schools are reported to have a proactive protocol or plan for dealing with a death¹⁰. This lack of a formal system is compounded by the lack of pre-service or in-service education about grief and the grieving process. Educators report receiving more support from colleagues than administrators after the death of a student³, and 83% of educators who have experienced the death of a student report no known source of support².

The purpose of this article is to provide information regarding the unique grief experienced by special education staff teachers as a result of the deterioration and death of students and to offer suggestions for special schools to support

members of staff and the surviving students.

DETERIORATION OF STUDENTS AND ANTICIPATORY GRIEF

With more children with life-threatening conditions attending schools⁸, it is plausible that their teachers and supporting staff anticipate their death, which can cause Anticipatory Grief (AG)¹¹ a term coined by American psychiatrist Eric Lindemann¹². Lindemann observed that wives of soldiers at war rejected their returning husbands after the war¹². This rejection was interpreted in light of Freud's psychoanalytic theory in which emphasis was placed on "grief work"¹³. Accordingly, the bereaved inevitably had to work through the emotional pain of the loss and eventually relinquish the bonds with the deceased to avoid adverse bereavement

outcome¹³. Lindeman's description of AG built on the assumption that the wives had begun their *grief work* before the loss as the threat of losing their husbands had made them detach their bonds to their husband¹². Hence, the concept of AG rose from the notion of Freud's *grief work* hypothesis and the necessity of

relinquishing emotional bonds seated within a psychoanalytic theoretical frame. Although AG has received substantial interest from clinicians and researchers alike, it remains a little understood psychosocial construct which is seldom recognised¹⁴⁻¹⁶, the most commonly cited effects are outlined in Table 1.

Characteristic	General presentation of characteristics	Potential presentation of characteristics in special education staff
Sadness and tearfulness	Sadness and tears tend to rise rapidly and often when least expected. Even small things, such as a television commercial may be a sudden and painful reminder that the individual is dying; almost as if it is again the first time one is aware of the impending loss.	Special education staff may become upset when they are reminded of the deteriorating student's illness, or when the deteriorating student is absent due to the illness and their name appears during a class game or the absent student is requested by peers.
Fear	Feelings of fear are common and include not only the fear of death but fear about all of the changes that will be associated with losing the dying individual.	Special education staff may fear how the surviving students and staff will respond to the death.
Irritability and anger	Anger may be experienced due to the "injustice" of why a loved individual is dying.	Anger may be experienced by special education staff member due to the injustice of a dying child. It may also be difficult coping with a dying student's family's anger.
Loneliness	A sense of intense loneliness is often experienced by those around someone dying.	In addition to experiencing a sense of loneliness due to being around the dying student, special education staff may feel that is not socially acceptable to express anticipatory grief, which can further add to feelings of isolation.
Guilt	For some people, the time prior to a close individual's death can be a time of great guilt—especially if the individual is suffering. They may also be experiencing survivor guilt.	At the same time that staff members may long for the student to be free of pain (and hence, die), they may fear the moment that death will actually happen. Staff may also experience survivor guilt
Intense concern for the dying individual	Individuals may become increasingly concerned for the dying individual and this concern can revolve around emotional, physical, or spiritual issues.	Special education staff may find themselves extremely concerned about the student.
Rehearsal of the death	Individuals find themselves imagining the death/being informed of the death and what it will be like once the death has occurred. Many people feel guilty about these thoughts, but they are very normal and are part of accepting the inevitability of death.	Staff may find themselves visualizing what it will be like when the student is gone. Many people feel guilty about these thoughts, but they are very normal and are part of accepting the inevitability of death.
Physical problems	Physical problems such as sleep difficulty and memory problems.	Physical problems such as sleep difficulty and memory problems.

Table 1: Characteristics of Anticipatory Grief^{15, 17, 18}

Staff who work with deteriorating students and experience AG are at risk for burn-out or compassion fatigue¹⁹. Burnout is a response to chronic work-related interpersonal and emotional stressors, and it is measured on three general scales: emotional exhaustion, depersonalisation and lack of perceived personal accomplishment¹⁹. Compassion fatigue involves an excess of empathy and undue identification with the dying individual's suffering, resulting in an inability to maintain a healthy balance between objectivity and empathy¹⁹, which is described as the delicate balance of mutually conflicting demands of simultaneously letting go of, and drawing closer to the dying individual¹⁶. Certain professionals develop strong interpersonal relationships with a dying individual and experience a sense of bereavement similar to the family when the individual dies²⁰ whereas other professionals detach themselves from the experience and the dying individual in an attempt to avoid the pain of grief²¹. Such overattachment or detachment with students is not conducive to a healthy relationship with the deteriorating student. Furthermore, a high AG score (as measured via factor analysis

of an composed of thoughts, feelings, and behaviours) is associated with acute anxiety¹¹, high level of post-loss depressive symptoms^{22, 23}, high self-rated stress²²⁻²⁴, complicated grief^{25, 26} and post loss avoidance²⁴, all of which negatively impact the work of staff.

DEATH OF STUDENTS AND GRIEF

The grief experienced by special education after the death of a student is influenced by many factors²⁷. Among these determinants of grief are (i) the relationship between the member of staff and the deceased student, (ii) the mode of death of the student, (iii) the age of the deceased impacts the grieving, given it is usually easier to accept the death of a person ripe in years than that of a young person¹¹ (iv) the presence of a support system in the staff member's life, (v) the religious, social, ethnic, and cultural background of the member of staff, (vi) the staff member's coping behaviours, and (vii) the staff member's previous experience with loss, (death/divorce/job change etc).

William Worden's work with bereaved persons resulted in a move from looking at grief as a stage or phase framework²⁸ to

what he considered a more practical approach¹¹ and the grief of staff members and larger school community can be approached as this series of tasks to be faced (see Figure 2)^{11, 29}. There is no set timeline to completing these tasks,

although they generally occur over months or years, not days or weeks. Worden points out that while it is essential to address these tasks to adjust to a loss, not every loss we experience challenges us in the same way.

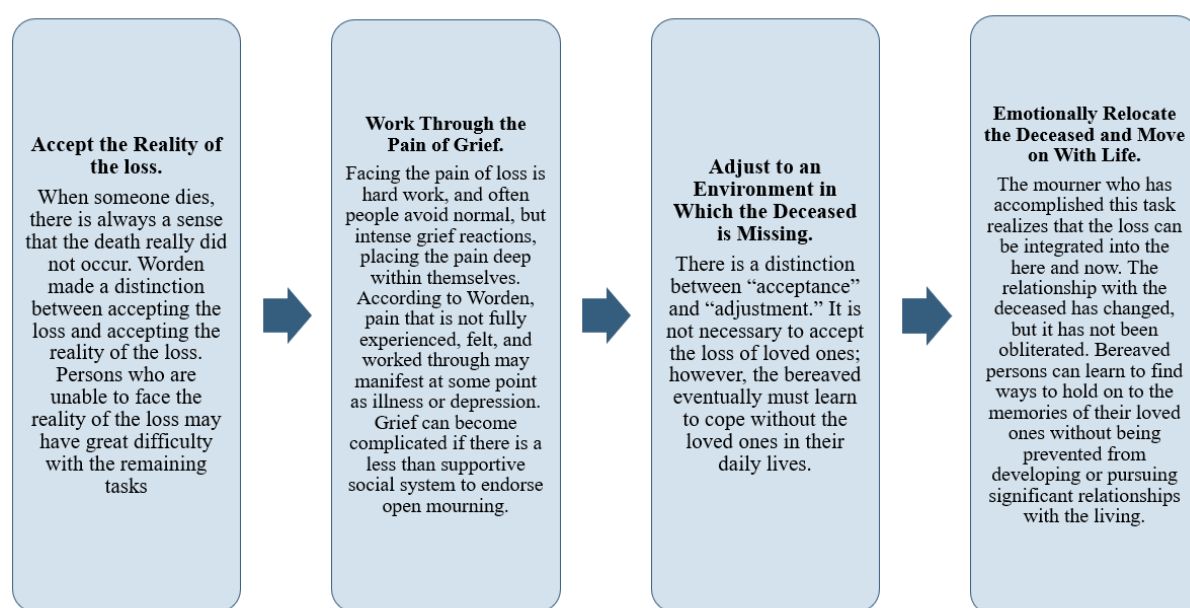


Figure 2: Worden's Tasks of Grief^{11, 29}

Those in grieving often do not give themselves permission or time to grieve²⁷ and special education staff may often be required to put their own grief on hold while helping others³⁰. When members of staff experience the death of a student, they must not only cope with their own grief and its accompanying reactions (e.g. anger, guilt, frustration) they may also be

expected to support the family of the student³¹. Moreover, the staff member's relationship with the student may have failed to be recognised by others or the staff member themselves³⁰. If the bereaved member of staff has failed fully to perform the tasks of mourning identified by Worden, they are at risk of unresolved or complicated grief^{11, 27}, which

evidently negatively impacts the work of staff³⁰.

SURVIVING STUDENTS IN GRIEF

In special education settings, staff must support other students who may not fully understand the implications of death and may only know that a classmate is missing³². Given a limited cognitive capacity does not indicate a limited emotional capacity, the surviving students may experience an emotional response through grief when a classmate dies³³. The remaining students may present with somatic complaints, relationship difficulties, social withdrawal, increased compulsivity, intensified frustration, and self-injurious behaviour³⁴. It is the responsibility of staff to remain cognizant that such 'challenging behaviour' may be expressions of grief rather than an attribute of the intellectual disability^{35, 36}. The challenge to staff is recognising that increased frequency and severity of these maladaptive behaviours indicates recognition that something has changed and the child is attempting to cope with that change³⁷. There can be significant consequences for people with intellectual

disability if they do not understand dying and death³⁸.

RECOMMENDATIONS

Many of the Cognitive Behavioural Therapy (CBT) strategies employed in the treatment of anxiety disorders and depression, such as graded exposure to avoided or feared situations, increasing pleasant events and challenging unhelpful thoughts, can be modified for working with bereaved people³⁹. Moreover, CBT has been found to be more effective than other commonly practiced therapies when working with bereaved individuals^{40, 41} and is becoming a commonly employed mode of therapy when working with bereaved⁴². Therefore, CBT strategies are incorporated into this article's recommendations for informing school grief practices and supporting bereaved members of staff⁴³. Such strategies include providing information about grief; provision of a structured framework for how to deal with difficulties in the school; basing classroom decisions on evidence not emotions; self-care strategies and ways to challenge negative thoughts.

School Recommendations

Special educators experiencing grief require support from their school in order to continue to work with surviving students without becoming overburdened by loss⁴⁴. Schools can support staff to cope with the deterioration and death of students through (i) providing in-service grief workshops (ii) developing a grief plan (iii) developing staff support initiatives and (iv) providing guidelines on support for the surviving students after the death of a classmate. Addressing the support needs of the school community could improve job satisfaction and prevent compassion fatigue^{45, 46}.

(i) Provide Grief In-Service Workshops

Individuals working in special education need to acknowledge the possibility of the death of a student¹⁻³, therefore there is benefit to the provision of proactive in-service grief workshops. Such a workshop could focus on the material outlined in this article to include recognizing signs of grief, understanding its impact and guidance as to how special educators can best support themselves and the remaining students after the death of a student⁴⁷. William Worden's Tasks of Grief (see Figure 2)^{11, 29}

may be a particularly helpful approach. In-service workshops should acknowledge and respect differences in staff member's responses to death, noting the determinants of grief²⁷. Annual in-service workshops may help to establish a culture of openness to talking about death and grief.

(ii) Develop a Grief Plan:

Schools can support staff by being proactive prior to a death rather than reactive after the death of a student. Members of staff working with students, along with administrators and counsellors could develop a grief plan with procedures to be implemented following the death of a student. The plan must include support for all staff as well as support for other students and families and should acknowledge the staff member's role in the life of the child. It is recommended that all staff be involved in the plan's conception to ensure it reflects their preferences and needs. As part of this grief plan, staff should develop rituals to say goodbye when a student dies (e.g., developing a memory book) and methods as to how they want to remember the

student (planting a tree; having an end of the year memorial service for deceased children; inviting families to such a memorial service). The grief plan should include resources for members of staff who had contact with the student who has died and such resources should be a part of the school's professional library. As with other procedures, the grief plan should be reviewed annually, possibly during in-service training.

(iii) Develop Staff Support Initiatives

Examples of staff support initiatives could include bereavement debriefing and an emotional safety policy. Bereavement debriefing would consist of the provision of supportive sessions for staff in the wake of a death to offer them the opportunity to respond to the student's death and to contextualise it in the context of their relationship with the student. During each session, the factual circumstances of the student's death could be reviewed and staff members who knew the student are offered an opportunity to describe their emotional response to the situation, their coping strategies and what they learnt from working with the deceased student. Palliative care staff who participate

actively in similar debriefing sessions report an increased ability to manage grief and maintain their professional integrity⁴⁸.

The creation of an emotional safety policy is to ensure that staff members feel emotionally supported to deal with the unique demands of their work⁴⁶. The support needs of all staff should be identified and incorporated into this policy. Staff should be able to articulate the type of assistance they need during the initial stages of grief as well as during the extended grief process. Such a policy can specify school strategies to support staff (in-service workshops etc.) and the responsibilities of individual members of staff (e.g. To use rituals to acknowledge one's own losses and to attend to "grief work;" to maintain careful boundaries; to engage in restorative activities; to maintain a healthy work-life balance; to acknowledge painful experiences).

(iv) Guidelines on Supporting Surviving Students:

The death of a student must be addressed in the special education classroom, as there are significant consequences for

individuals with an intellectual disability if they do not understand dying and death³⁸. Schools must support their staff in exploring death with students as teachers' comfort with the topic of death has a direct impact upon their ability to provide a positive environment in which children can explore the concepts of death and dying⁴⁹⁻⁵².

The school should help teachers to understand each student's developing conceptions of death, as this will enable the teacher to respond to children's level of cognitive development as well as their unique individual experiences with death⁵³⁻⁵⁶. Moreover, the school should ensure that teachers have familiarity with children's literature on death^{57, 58} and provide resources available on explaining death to children with intellectual disabilities^{34, 37, 59, 60}. Table 2 provides key suggestions for special schools to support their students after the death of a peer^{32, 34, 59, 61}.

Table 2: Support for Students

Use simple language to explain death	<ul style="list-style-type: none"> • Use the language of the child to provide information that the child desires. • A simple, factual description of death is recommended for children with learning disabilities. • Children with an intellectual disability are concrete thinkers, often experiencing difficulty with abstract concepts. Therefore, communication about death and dying should utilise various mediums and include multi-sensory components to ensure comprehension and understanding. • Be careful about the language used. Avoid euphemisms such as “gone to a better place”, or “gone to sleep” as these may be taken literally, and the child may become scared of going to sleep at night. • Something simple such as "<i>sometimes people's bodies become worn out and stop working</i>" may be appropriate. If they want to know what this means, or how it will affect their lives, something such as "<i>Although we miss them, when someone dies their body is dead and we cannot make their body be alive again. We will not see them again,</i>" may be appropriate.
Utilise techniques of guided and supported grieving	<p>This may include expression of emotions, verbal rehearsal, and explanation of loss events. This is particularly important for children with reduced verbal expressive skills and limited intellectual abilities. Consider offering complementary activities that may facilitate non-verbal expressions of grief (e.g. art, dance, music, drama and yoga).</p>
Encourage activities that facilitate grief processing	<p>Such activities may include drawing pictures of activities the child misses doing with the deceased loved one and simultaneously identifying others who may be able to provide these or similar experiences. The child may assist in gathering mementos that are connected in some positive way to the loved one. In reviewing and organising mementos, the child may create a tangible memorial of the deceased (e.g. a collage, photo album).</p>
Assist in searching behaviour	<p>This kind of help is required if the child is experiencing hoarding behaviour or is found wandering may be trying to find their “lost” friend. Support this individual by revisiting old haunts and can assist in appropriate searching behaviour to support emotional recovery.</p>
Maintain routine	<ul style="list-style-type: none"> • Keep the same schedule. • Maintain clear expectations - Keep rules and boundaries consistent. Children gain security when they know what is expected from them • Be consistent with discipline, firm but fair. It is easy for this to become relaxed, in order to be kind to children, but children feel safe if the same rules apply in the family after the death.

Staff Recommendations

(i) Anticipatory Grief Guidance: Efficacious facilitation of anticipatory grief is encouraged to reduce the risk of burn-out or compassion fatigue while supporting students who are deteriorating ^{19, 62, 63}.

Such strategies are outlined in Figure 3. The objective of employing these strategies is not to alleviate anticipatory grief but to facilitate and guide the grieving process for adequate functioning and support at the end of life and post-bereavement ^{62, 63}.

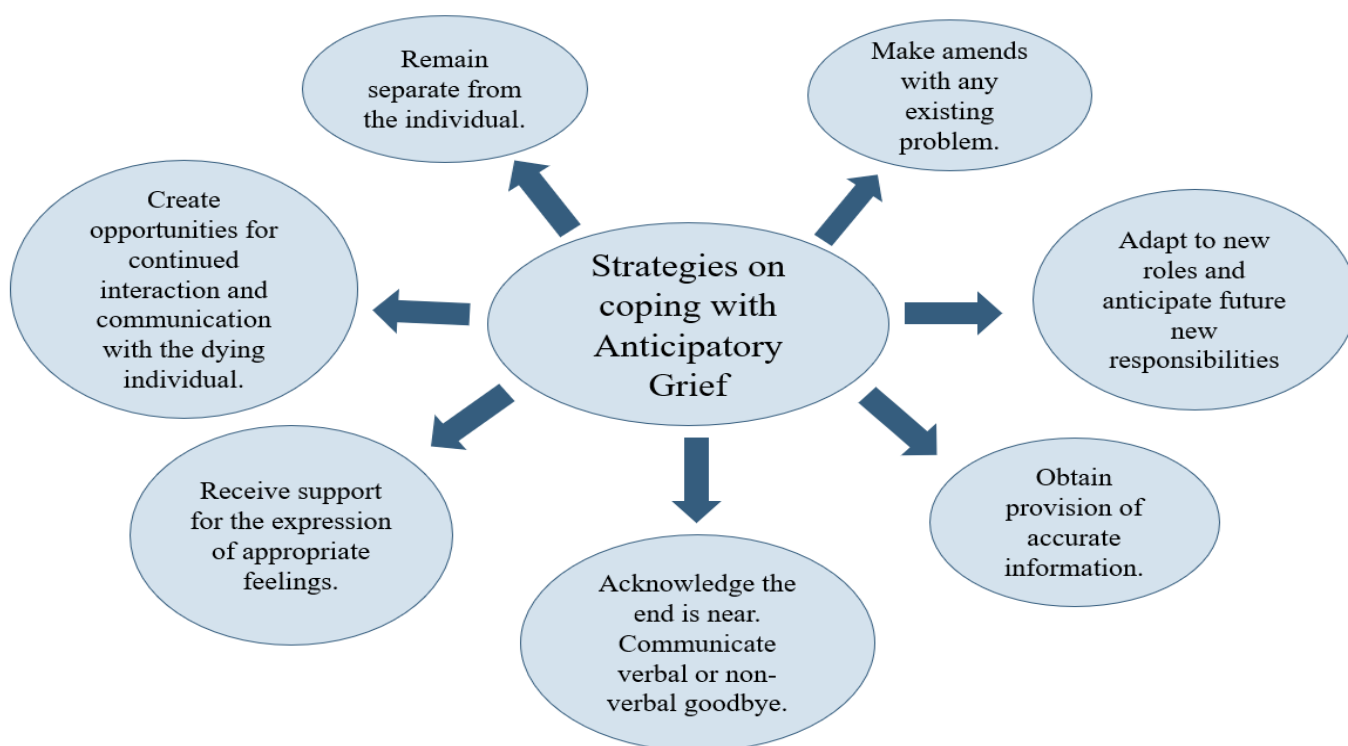


Figure 3: Strategies on coping with anticipatory grief ^{62, 63}

(ii) Grief Guidance: The five realms of nurturing oneself (see Table 3) are conducive to coping with grief ⁶⁴⁻⁶⁷.

Table 3: Five realms of self-care ⁶⁴⁻⁶⁷

Physical Self-Care	Getting enough rest, eating healthily and exercising regularly.
Emotional Self-Care	Permitting oneself to express emotions and to grieve when needed, taking the opportunity to reflect or meditate regularly and making time for recreation and amusement.
Cognitive Self-Care	Monitoring one’s internal dialogue and identifying perfectionist tendencies, avoidance strategies and harsh self-judgements. Developing specific ways of letting go of the day’s concerns by practicing particular “release rituals.”
Relational Self-Care	Establishing and maintaining healthy professional boundaries, developing supportive personal relationships and learning to manage interprofessional conflict.
Spiritual Self-Care	Focusing on the “bigger picture” and finding a way of making meaning of the world and one’s place in it. The use of humour is also an important aspect of relieving tension and mitigating grief

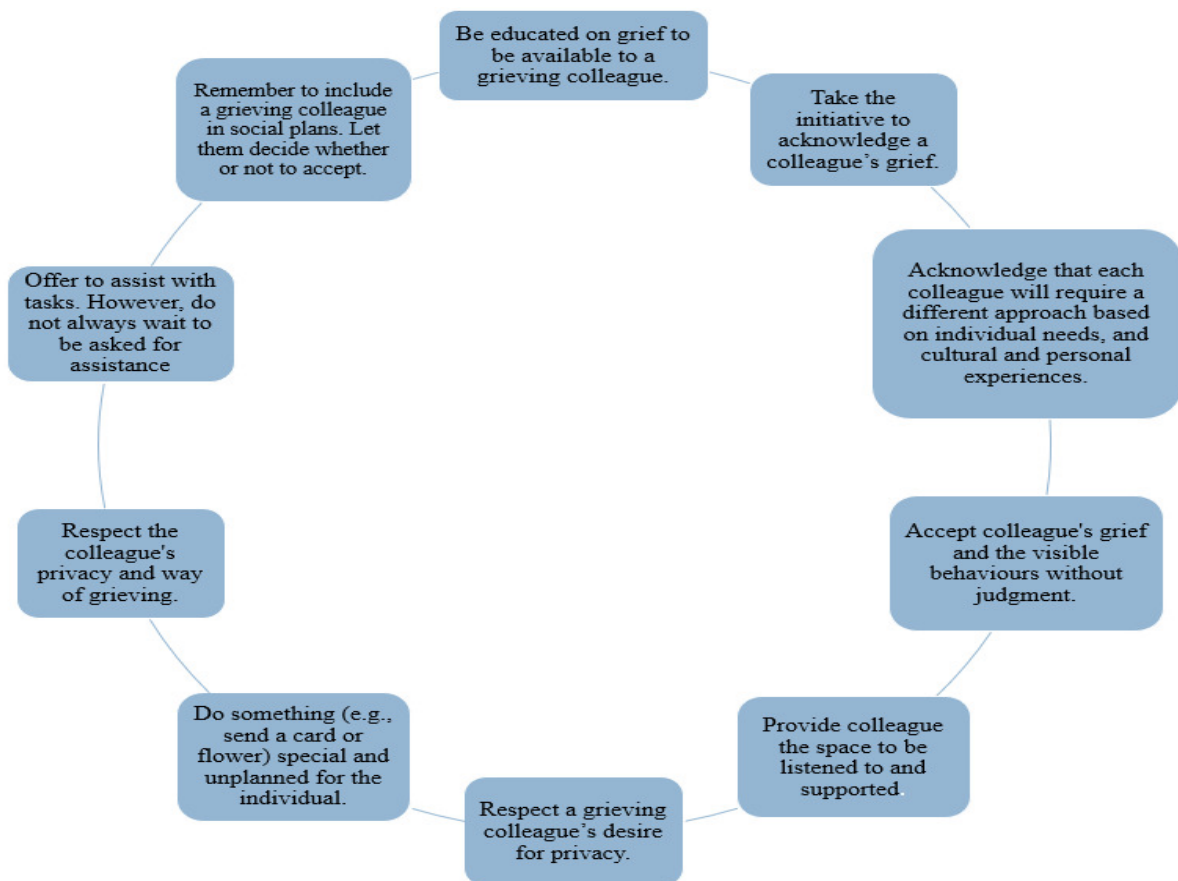


Figure 4: Supporting grieving colleagues

(iii) Cultivation of Supportive Interprofessional Relationships: In order to continue to support surviving students without becoming overburdened by loss, staff may require support from fellow colleagues⁴⁴. Colleagues can provide assistance for the staff who worked closely with the deceased student. Recommendations for supporting grieving colleague are outlined in Figure 4⁶⁸.

FUTURE RESEARCH INQUIRY

The available research within the field of grief in special education is dated. Current research regarding the training received by current special educators on grief (lectures, preservice, in-service) and the grief practices of special schools are necessary to inform further support for special education practices. The authors of this article plan to conduct small scale research regarding staff training and school grief practices in conjunction with the piloting of a grief workshop in special schools. Research exploring the grief support in special schools in Ireland would be an incredibly informative addition to the field and will inform best practice regarding this sensitive area.

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