

**Brief Crisis Intervention after a Disaster:  
Client and Counsellor Experiences and Perceptions of Change  
following the February 22nd Christchurch Earthquakes**

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of Master of Science in Psychology

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## **ABSTRACT**

This thesis set out to explore the experiences of clients and counsellors in immediate crisis intervention shortly after a major earthquake. It explored the experiences and perceptions of change during counselling for both clients and counsellor, all of which were exposed to the disaster. This study supported the idea of counsellors needing to adapt to the context of post-disaster counselling and addressing client's immediate needs. Having both been through the same disaster meant counsellors were often going through similar experiences and emotions as their clients during this time. This led counsellors to develop a greater sense of connection and understanding of their client, as well as showing more emotional responsiveness and self-disclosure. This was experienced as different to their normal therapy engagement. The implications of these counsellor responses were seen to be helpful, but at times had the potential to be hindering for counselling. Clients valued their counsellor's techniques and personal qualities but often failed to identify what contribution they, themselves, made to change processes. The differing nature of counselling in post-disaster areas, as gauged by this study may help inform expectations and experiences regarding provision of post-disaster acute interventions.

## CHAPTER ONE

### INTRODUCTION

#### **Disasters**

Disasters are most commonly conceptualized as natural or man-made events that cause sweeping damage, hardship or loss of life across one or more strata of society (Bonanno, Brewin, Kaniasty, La Greca, 2010). For any human being at any one time, the risk of experiencing a disaster during their life is relatively low, as disasters are relatively rare, but, when they happen they affect many people, sometimes very badly, sometimes for a long time. Disasters can affect individuals, their communities and their nations. For this reason, disasters are important to understand in all their complexity and all developed societies try to prepare for disasters in some way, including by having trained personnel on standby and by public education.

Nevertheless, this is difficult due to the fact that, firstly, disasters are unpredictable, and secondly, they are hard to simulate, so authentic practice is difficult to arrange. This means that when a disaster strikes, individuals, groups, and agencies have to improvise, and have to learn while doing. It is important that these improvisations and the learning's that go with them are not forgotten after the disaster, but are preserved, analysed for their effectiveness, and shared across communities and nations. This is important not because, while disasters may be rare, predictions are that with population growth and global warming (and increases in civil strife associated with these developments) disasters are predicted to increase in frequency and perhaps severity in the future.

#### **Impact of Disasters on Mental Health and Well-being**

##### *The Christchurch Earthquake*

In the early hours of the morning of 4th September, 2010, a 7.1 magnitude earthquake hit the Canterbury region, New Zealand (Quigley, Van Dissen, Litchfield, Villamor, Duffy, Barrell, Furlong, Stahl, Bilderback & Noble, 2010). The epicentre of the earthquake was 40 kilometres west of Christchurch's city centre and was 10 kilometres deep. The city was left with extensive property damage and overall disruption however there were few injuries and no deaths (Quigley et al., 2010). Almost 6 months later, at 12.51 pm on Tuesday, February 22, 2011, a 6.3 magnitude aftershock hit the city. The epicentre was only 10 kilometres south-east of the Christchurch city centre and 5 kilometres deep. The timing and location of this major aftershock resulted in greater devastation to the region than was caused by the initial earthquake. More than 6000 people were injured, and unlike the September quake when deaths were avoided, 185 died.

In the immediate aftermath of the February event, Canterbury District Health Board psychologists, private practitioners, and academics were involved in providing direct support to rescue workers, family members, and survivors (Chambers & Henderson, 2011). Many private practitioners were out of work as their workplaces were damaged or inaccessible, and so for a time a number volunteered to assist with counselling at the Canterbury Charity Hospital. This is a fully volunteer hospital which, prior to the February quake, provided day-surgery treatment for those not qualifying for public or private health services. Following the February quakes, the Charity Hospital improvised a solution to the problem of having large numbers of people needing counselling in a city where services were destroyed, damaged, and/or not able to cope with need. Management realised the need for counselling services, recruited volunteer counsellors, and found premises for the work. The CCH was estimated to have seen approximately 1200 clients throughout the 2011 year. Thus the purpose of this thesis is to capture what was learned from both clients and therapists' experiences that can be potentially useful for other communities facing disaster.

### ***Responses to Trauma: Bonnano's Four Trajectories of Trauma***

Bonanno (2004) carried out empirical research into the area of individual variation in response to traumatic events and studies revealed a number of unique and variable patterns or outcome trajectories. The authors indicated a pattern of four trajectories of disruption in normal functioning across time following a traumatic event: resilience, recovery, delayed reactions and chronic dysfunction. Resilience refers to the ability of individuals in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event to maintain relatively stable, healthy levels of psychological and physical functioning as well as “the capacity for generative experiences and positive emotions. Recovery refers to those of which normal functioning temporarily gives way to threshold or sub-threshold psychopathology (e.g., symptoms of depression or Posttraumatic Stress Disorder (PTSD)), usually for a period of at least several months, and then gradually returns to pre-event levels. Delayed trauma may be evident when an individual’s adjustment appears normal but then distress and symptoms increase months later. Lastly, chronic dysfunction includes those who experience prolonged suffering and inability to function, and this usually lasting several years or longer.

This research lends to the idea that the focus of dysfunction and psychopathology in the aftermath of a disaster should be to identify that people responded to trauma in different ways and therefore require different kinds and levels of service. The majority, with few or no symptoms, need help that maintains their resilience and recovery and supports coping when facing particular, perhaps transient, difficulties. The second group may experience delayed reactions, showing few symptoms initially but who get worse with time, need services that provide early identification and intervention, with the intervention available as long as symptoms persist, plus follow-up maintenance and boosters. The third group are those with severe symptoms (e.g. acute stress disorder (ASD)) from the outset, and who are at risk of

PTSD after 6 months or more and need early identification and comprehensive mental health services in the longer term. Furthermore, given the majority of the population fall into the first and second groups, the widest demand for mental health services will be from those groups, not from the severely affected group. Yet it appears that the severely affected group that gain research and clinical attention. Mental health services may be relatively less well prepared to meet the needs of the other.

### ***Factors Associated with Resiliency and Recovery***

Much historical research on the psychological and physiological impact following traumatic events often suggests that such events almost always produce lasting emotional damage (Neria, Nandi, & Galea, 2008). Most recently, however, research appears to consistently show that across different types of traumatic events, including bereavement, serious illness, and terrorist attack, people generally do display resilience and most people cope with such events extremely well (Bonanno & Mancini, 2010).

It is well known that natural disasters, and earthquakes in particular, can have detrimental effects on psychological functioning (Cardenna & Spiegel, 2005; Bonanno et al, 2010); however, one's ability to adjust can be associated with a number of risk and resiliency factors. It has been widely assumed that the enduring absence of psychopathology after exposure to a traumatic event occurred only in people with exceptional emotional strength (McFarlane & Yehuda, 1996). However, current research indicates that that resilience is common and not a sign of exceptional strength or psychopathology but rather a fundamental feature of normal coping skills (Bonanno, 2004).

Research on resilience in children suggested that there are multiple protective factors that might buffer against adversity, including person-centred factors such as temperament (Agaibi & Wilson, 2005) and community resources (Bonanno, 2007; Norris et al, 2002).

Socio-contextual factors such as having supportive relations (Cao, McFarlane & Klimidis, 2003; McFarlane & Yehuda, 1996) has also been found to be a protective factor, although contrary to expectations, social isolation was not significantly related to psychological difficulties in one study which investigated 101 people seeking treatment following exposure to a significant earthquake (Havell, 2012). Further, resilience does not result from any one dominant factor, rather, there seem to be multiple independent risk and protective factors, each contributing to or subtracting from the overall likelihood of resilient outcome (Bonanno & Mancini, 2010).

Demographic variation appears to be a large predictor in resiliency. Resilience to trauma has been associated with male gender, older age, and greater education (Bonanno et al, 2007; Udwin et al, 2003). Udwin et al. (2003) examined the risk factors for the development of PTSD in a group of 217 young adults who survived a shipping disaster in adolescence. The survivors were followed up 5 to 8 years after the disaster and the authors found that development of PTSD was significantly associated with being female, pre-disaster factors of learning and psychological difficulties. Although there has been relatively little research on ethnicity as a predictor of resilience, recent evidence indicated that ethnic Chinese were more likely to be resilient after the September 11th attack (Bonanno et al, 2007).

Resilience to trauma has been associated with the relative absence of current and previous life stress (Brewin, Andrews, Valentine, 2000). A recent review of early intervention in trauma also indicated that individuals with prior critical events were at increased risk to develop intense reactions to subsequent traumatic incidents (Litz, Gray, Bryant & Adler, 2002). In the study conducted by Udwin et al (2003) of survivors of a shipping disaster, research found that adjustment in the early post-disaster period, and life events and social supports were found to be risk factors for the development of PTSD 5 to 8 years after the disaster.

An important qualifier of these findings, however, is the outcome of previous life stressors. Prospective research suggests that only previous stressors that result in PTSD tend to predict PTSD at subsequent exposure (Breslau, 2002). Furthermore, it appears likely that resilience to past stressors can predict subsequent resilience. For example, the same study conducted by Litz et al, (2002) found pre-disaster psychiatric disorder predicted post-disaster psychopathology with a sensitivity of 72% and a specificity of 90.

Having an earlier psychiatric history may also be a risk factor for the development of psychological dysfunction. Smith, North, McCool and Shea (1990) found that more than two-thirds of the cases of acute post-disaster psychiatric disorders following the bombing of Oklahoma City were predicted by identifying the subjects who had pre-disaster psychiatric histories. This has led researchers to question whether individuals with pre-existing problems of mental health may find their problems exacerbated (Brewin, et al, 2000; Litz et al, 2002).

However, research conducted by Rucklidge & Blampied (2011) conducted a natural experiment into the protective effects on well-being of taking EM Powerplus (EMP+), a micronutrient supplement, in a group of 33 adults diagnosed with ADHD who had been assessed prior to the earthquake. Following the Christchurch Earthquakes 16 were currently taking the supplement as part of on-going research at the time of the quake, while 17 were not (they had completed their trial of EMP+ or were waiting to begin consumption). The Depression Anxiety and Stress Scale (DASS-42) was administered at varying times before the earthquake on recruitment into the micronutrient study was re-administered by telephone 7-10 and again 14-18 days post-earthquake to volunteer, earthquake-exposed participants. A modified DASS-42 score showed that the 16 participants on the nutritional supplement were more resilient to the effects of the earthquake than the 17 individuals not taking the supplement. Thus improving nutrition in adults with pre-existing vulnerabilities, such as ADHD, facing stressful life events, may enhance personal resilience in stressful times.

In addition, specific disaster research has indicated that risk is associated with factors related to the disaster itself such as closer proximity to the disaster zone (Norris, Bryne, Diaz & Kennedy, 2001; Eildeson, 2007), higher degree of exposure (Van Griensven et. al., 2006); displacement (Van Griensven et. al., 2006); greater levels of property and personal loss (Norris, Bryne, Diaz & Kennedy, 2001; Brewin et al, 2000); and the extent of injury (Van Griensven et. al., 2006).

### ***Psychological distress following natural disasters***

It is well known that natural disasters, and earthquakes in particular, can have detrimental effects on psychological functioning (Cardeña & Spiegel, 2005; Bonanno et al, 2010). When individuals are exposed to potentially life threatening situations, a common response is to react with intense fear and helplessness (Smith & Rauch, 2010), and when individuals are confronted with on-going threats of this magnitude deeply embedded psychophysiological and neurobiological reactions occur (Smith & Rauch, 2010). Immediate trauma reactions can include symptoms as shock, denial, anger, rage, sadness, confusion, terror, shame, humiliation, grief, sorrow (Cardeña & Spiegel, 2005; Bonanno et al, 2010; . Other responses include restlessness, moodiness, sleep disturbance, eating disturbance, reactive depression, nightmares, profuse sweating episodes, heart palpitations, vomiting, hyper-vigilance, paranoia, phobic reaction and problems with concentration or anxiety (APA, 1994; Horowitz, 1976; Young, 1994). People may also begin to experience flashbacks and mental images of the traumatic event (Harvey et al, 2007). These responses, at least in the short-term, are thought to be normal and adaptive responses for crisis survivors (Bonanno et al, 2010).

***Acute Stress Disorder.*** Although it is common for most people within a population exposed to disaster to experience immediate trauma responses, acute stress disorder (ASD)

was introduced into the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000) to address the lack of a diagnosis for short term pathological reactions to trauma (Bryant, Harvey , Guthrie & Moulds, 2000). ASD places a particular emphasis on the role of dissociation (Koopman, Classen, Cardenna & Spiegel, 2005; Bryant et. al, 2000) which is thought to manifest in a number of ways following trauma and can include emotional numbing, a dulling of the senses at the time of and following the traumatic experience, and an unawareness of one's environment (Harvey & Bryant, 1998; Koopman et al., 2005).

Mills (2007) explored trauma and stress responses among Hurricane Katrina evacuees and found 62% of the sample met ASD threshold criterion in days 12 to 19 after the hurricane. Sattler (2006) assessed a community sample and a university sample after three major earthquakes in El Salvador and both groups were shown to have symptoms of ASD. Symptoms included sleeping difficulties, becoming easily upset and/or angry, feelings of anxiety, avoiding talking about things that reminded participants of the earthquake, feeling that time was standing still, and feelings of disorientation. Cardeña and Spiegel (1993) looked specifically at dissociative symptoms in a study of the 1989 San Francisco earthquake and found symptoms of dissociation were much more prevalent in the week following the earthquake than at a four month follow up, characteristic of an ASD diagnosis.

Although ASD has been regarded as a high risk factor for the development of long-term pathologies, such as post-traumatic stress disorder (PTSD) (Bryant, 2011; Cardeña & Carlson, 2010; Neria et al., 2008), research has indicated that ASD may not be an effective predictor of PTSD. For example, although approximately 75% of those who initially have symptoms of ASD go on to develop PTSD, it is estimated that half of those individuals with PTSD will not have experienced initial ASD symptoms (Bryant, 2006; Mills, Edmondson, & Park, 2007).

***Posttraumatic Stress Disorder.*** Despite the highly aversive nature of most traumatic events, a relatively small subset of exposed individuals typically exhibit chronic psychopathology (Bonnano et al, 2004; Kessler, Sonnega, Bromet, Hughes, Nelson, 1995). As has been indicated, long-term dysfunction following trauma is likely to depend on a number of factors and this is somewhat reflected in the variability of PTSD rates within disaster research (Bonanno et al, 2007). Galea et al. (2007) found high rates of PTSD after Hurricane Katrina whereby residents of New Orleans were estimated to have a 30% prevalence of PTSD 30 days after the hurricane. In a United Kingdom (UK) sample exposed to the floods of 2007, PTSD was estimated to be prevalent at a rate of around 22% and a study of the Wenchuan earthquake in China, conducted 2.5 months post-quake, found an even higher PTSD prevalence, reaching almost 50% (Kun et al., 2009). Although research varies in regards to the likelihood of individuals who do go on to develop long-term disaster-related problems (Norris, Friedman, & Watson, 2002), most recent data suggests that PTSD is typically observed in 5% to 10% of exposed individuals (Kessler et al., 1995).

Psychological dysfunction can be masked within other problems such as excessive alcohol, tobacco and/or drug use. Interpersonal relations can become strained, work-related absenteeism may increase and, in extreme situations, divorce can be an unfortunate by-product. Survivor guilt is also quite common and can lead to serious depressive illness, suicide, or anxiety (APA, 1994; Alexander, 1991; Khouzam & Kissmeyer, 2006).

Research has also found that negative post-trauma reactions are found to persist under conditions of on-going threat or danger (De Jong, Mulhern, Ford, Van der Kam, & Kleber, 2000; Eidelson, 2003). For example, Eidelson (2003) identified that exposure to on-going adverse events such as continuing terrorist attacks generally led to the development of increasing symptomology over time. Evidence of this appears mixed, however. Renouff (2012) conducted research following the February earthquakes which indicated exposure to

on-going earthquake aftershocks leads to a decline in symptoms over time. Residents of two Christchurch suburbs differentially affected by the earthquakes (N = 128) were assessed on measures of acute stress disorder, generalised anxiety, and depression, at two time points approximately 4-5 months apart. Differences in perceived controllability and blame between man-made and natural adverse events were also assessed to further explore whether these factors may contribute to differences in symptom trajectories. At time 1, clinically significant levels of acute stress were identified in both suburbs, whereas clinical elevations in depression and anxiety were only evident in the most affected suburb. By time 2, both suburbs had fallen below the clinical range on all three symptom types.

Therefore, evidence from disaster research indicates that although the majority of individuals exposed to disasters experience few to mild levels of trauma symptoms, some of which may cause a degree of dysfunction; a proportion may go on to develop substantial, long-term psychological difficulties. This indicates the significance of understanding the variance of trauma reactions within a population, particularly for the provision of psychological support and intervention following a large-scale natural disaster.

### **Models of Counselling in a Disaster Situation**

Despite evidence that people generally show resilience and the ability to go on to live a normal life (Ballenger, Davidson, Lecrubier, Nutt, Marshall & Nemeroff, 2004) it is paramount that disturbances may be experienced to varying degrees, and that effective interventions are in place to mitigate these risks. Crisis interventions following traumatic events have been utilized for many years (Boudreaux & McCabe, 2000; Kaplan et al., 2001; Mitchell, 2004); and although there appears to be no single model of crisis intervention (Jacobson, Strickler, & Mosley, 1968 Castellano, 2003; Flannery & Everly, 2000; Mitchell, 2003) there does appear to be common agreement on the general principles to be employed

by practitioners to alleviate the acute distress of victims, to restore independent functioning and to prevent or mitigate the aftermath of psychological trauma and PTSD (Butcher, 1980; Everly & Mitchell, 1999; Flannery, 1998; Raphael, 1986; Robinson & Mitchell, 1995).

### ***Crisis Intervention***

Crisis intervention is defined as the provision of emergency psychological care to victims to assist them in returning to an adaptive level of functioning and to prevent or mitigate the potential negative impact of psychological trauma (Everly & Mitchell, 1999). Crisis intervention procedures have evolved from research on grieving conducted by Erich Lindemann (1944) following a major nightclub conflagration; from Kardiner and Spiegel (1947) which drew from military experiences and purported three basic principles in crisis work which include immediacy of interventions, proximity to the occurrence of the event, and the expectancy that the victim will return to adequate functioning. Importantly, research also stemmed from community placements, emphasising the prevention of primary and secondary effects (Caplan, 1964).

***Critical Incident Stress Debriefing (CISD)***. Debriefing is a specific technique designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing allows those involved with the incident to process the event and reflect on its impact but the type of intervention used can depend on the situation, number of people involved and their proximity to the event. The ideal three step approach enables health workers to address the trauma at various stages of progression including defusing, debriefing and individual follow-up.

Defusing is done the day of the incident before the person(s) has a chance to sleep. The defusing is designed to assure the person/people involved that their feelings are normal, tells them what symptoms to watch for over the short term and to offer them a lifeline in the

form of a telephone number where they can reach someone who they can talk to (i.e. allows for the ventilation of emotions and thoughts associated with the crisis event). Defusing is limited only to individuals directly involved in the incident and is often done informally, sometimes at the scene. It is designed to assist individuals in coping in the short term and address immediate needs.

Debriefing is usually the second level of intervention for those directly affected by the incident and often the first for those not directly involved. A debriefing is normally done within 72 hours of the incident (Davis, 1992; Mitchell, 1996) and as the length of time between exposure to the event and CISD increases, the less effective CISD is thought to become. Therefore, a close temporal (time) relationship between the critical incident and defusing and initial debriefing is believed to be imperative for these techniques to be most beneficial and effective (Mitchell, 1999; McMillen, Smith & Fisher, 1997 ). Debriefing gives the individual or group the opportunity to talk about their experience and how it has affected them, brainstorm coping mechanisms, identify individuals at risk, and inform the individual or group about services available to them in their community (Corrective Service of Canada. Retrieved July 16, 2009).

The follow up is the final important step as it ensures that participants are safe and coping well or that they have been referred for professional counselling. It is indicated that this is generally done within the week following the debriefing by team members as a check-in ( Flannery & Everly, 2000).

***Critical Stress Incident Management (CSIM).*** CSIM is a relatively new concept that has emerged in the crisis intervention literature within the last decade (CISM; Everly & Mitchell, 1999; Flannery, 1999). CSIM is a comprehensive crisis intervention system consisting of multiple crisis intervention components which span across the entire temporal

range of a crisis. CSIM interventions range from the pre-crisis phase through the acute crisis phase, and into the post-crisis phase. In addition, they incorporate CISD within their approach. CSIM consists of interventions which may be applied to individuals, small functional groups, large groups, families, organizations, and even entire communities. As currently evolved, CISM (Everly & Mitchell, 1999) includes numerous core elements: 1) pre-crisis preparation; 2) large scale demobilization procedures for public safety personnel as well as large group crisis management briefings for civilian victims of terrorism, mass disaster, community crises, school system tragedies and the like; 3) individual acute crisis intervention; 4) “defusing”, which consist of brief small group discussions, to assist in acute symptom reduction; 5) CISD – which involves longer small group discussions (CISD; Mitchell & Everly, 1996); 6) family crisis intervention procedures; 7) organizational development interventions; and, 8) referrals for additional psychological assessment and treatment where required.

***Hobfoll’s Principles of Immediate Crisis Intervention.*** It was identified that no evidence-based consensus had been reached supporting a clear set of recommendations for intervention during the immediate and the mid-term phase after mass trauma (Hobfoll et al, 2007). In response to the improbability of evidence in the near or mid-term future from clinical trials that would cover the diversity of disaster and mass violence circumstances Hobfoll (2007) assembled a worldwide panel of experts on the study and treatment of those exposed to disaster and mass violence to generalise from related fields of research, and to gain consensus on intervention principles. Five empirically supported intervention principles that should be used to guide and inform intervention and prevention efforts at the early to mid-term stages. These five elements are promoting: a sense of safety, calming, a sense of self- and community efficacy, connectedness, and hope.

Together, CISD, CSIM and Hobfoll's five principles, reflect current models and principles of disaster intervention. These guidelines appear to be developed from different pragmatic and theoretical perspectives, but they cannot be regarded as evidence-based practices at the present time. Nevertheless, they are widely influential among those preparing for disasters, and influenced the Charity Hospital initiative.

***Findings Associated with Brief Crisis Intervention.*** Post-disaster crisis interventions have been viewed by many as necessary to validate attempts to enhance psychological well-being among persons affected by large-scale traumatic events (Flannery & Everly, 2004; Mitchell, 2004) and there has been some support for the claim that brief crisis interventions can be effective. Chemtob, Tomas, Law, Cremniter, 1997) evaluated the effectiveness of brief psychological intervention (within 6 months of the disaster) following Hurricane Iniki in Hawaii in reducing disaster-related psychological distress as measured by the Impact of Event Scale (IES). A group intervention was implemented whereby two groups of individuals (N=43) who had been exposed to the hurricane were assessed before and after participating in a multi-hour debriefing group. The intervention targeted ventilation of feelings, normalization of responses, and education about normal psychological reactions to the disaster in a context of group support, and results indicated that Impact of Event Scale scores were reduced in both groups after the treatment.

Bascarino, Adams and Figley (2007) found evidence to suggest that post-disaster crisis interventions in the workplace significantly reduced mental health disorders and symptoms up to two years after the initial interventions. Following the 9/11 World Trade Centre disaster (WTCD) 1,681 adults were selected from a random sample of New York adults to take part in a prospective cohort study whereby they were interviewed by telephone at 1 year and 2 years after the event. Results indicate that worksite crisis interventions offered by employers following the WTCD had had a beneficial impact across a spectrum of

outcomes, including reduced risks for binge drinking, alcohol dependence, PTSD symptoms, major depression, somatization, anxiety, and global impairment, compared with individuals who did not receive these interventions. In addition, it appeared that 2–3 brief sessions achieved the maximum benefit for most outcomes examined.

David (2001) carried out a prospective field trial which found evidence that intervention was most effective when CISD and CSIM are delivered as an integrated format versus on their own. CISD was used as a standalone group intervention and integrated CSIM was also delivered to two groups of employees exposed to an armed robbery. Morbidity was measured using two measures of post-traumatic stress and a general health measure. Morbidity in both groups was equivalent at day 3 and one month post-raid. The CSIM group had significantly less post-trauma morbidity at follow-up (3-12 months post raid) compared to CISD alone.

The effectiveness and safety of these interventions have been debated (Flannery & Everly, 2000). A number of studies have shown that CISM has little effect, or that it actually worsens the trauma symptoms (Kagee, 2002). Several meta-analyses in the medical literature either find no preventative benefit of CISM (Rose, Bisson, Wessley, 2002; Harris, Stacks, 1998) or negative impact for those who were debriefed (Van Emmerik, Kamphius, Hulsbosch, Emmelkamp, 2002; Carlier, Lamberts, van Ulchelen, Gersons, 1998).

These findings indicate the need for considerable caution in recommending such approaches, and the need for more research on the agreement and outcome to post-disaster counselling services. Further, while some studies (e.g., Bisson, Jenkins, Alexander, & Bannister, 1997; Kenardy, Webster, Levin, Carr, Hazzell, & Cater, 1996; McFarlane, 1988) have found either partial or no support for debriefing interventions, research has indicated that many of these studies have had methodological research issues. Recent meta-analytic

reviews have demonstrated (Everly, Boyle, & Lating, 1999; Everly and Boyle, 1999; Everly and Piacentini, 1999) when the intervention model is clear, and emergency mental health personnel are correctly trained, and the assessment procedure for effectiveness is adequate, then even a limited array of crisis intervention procedures are found to be effective in helping survivors (Everly & Piacentini, 1999; Brom, Kleber, & Hofman, 1993). Furthermore, there appears to be agreements that ceasing debriefing would be hasty and that it is important for CSIM to be the subject of randomized controlled studies (Horne-Moyer & Jones, 2004; Bascarino et al., 2004).

### **Factors which Impact on Therapy Outcome**

Following a fatal disaster, mental health workers such as social workers, therapist and counsellors are increasingly called to assist with relief work (Sommer, 2008; Uhernik, 2008). Furthermore, various factors are known generally to impact on the outcome of therapy, and in the context of disaster intervention, research is beginning to uncover the potential risks that counsellors who treat victims of trauma may be exposed to (Trippany, White & Wilcoxon, 2004; Uhernik, 2008).

#### ***Vicarious trauma***

Short-term stress reactions have been found in people assisting crisis survivors. Vicarious traumatization (VT) is one way that counselors may be negatively impacted by their work and can be understood to be when trauma workers experience subclinical versions of the deleterious effects experienced by the trauma survivors themselves (Pearlman & MacIain, 1995). Therapists may experience physical symptoms such as nausea and exhaustion (Illeffe and Steed, 2000); difficulties sleeping; an increased susceptibility to illness (Jenkins, Mitchell, Baird, Whitfield & Meyer, 2011); behavioural symptoms, such as increased irritability (Sommer, 2008); and increased substance abuse (Feldner et al; 2007) and

psychological symptoms, such as experiencing intrusive thoughts (Talbot, 1992), burnout (Pearlmann & MacIain, 1995; Trippany et al, 2004) and disrupted cognition (Illife & Steed, 2000). For example, Iliffe and Steed (2000) found that counsellors treating survivors of domestic violence showed disrupted world views and sense of self such as being more fearful and unsafe in the world and less trusting of the other sex as a result.

For individuals involved in trauma work, being in close proximity to the disaster has been implicated as a risk factor for secondary reactions to trauma. Eidelson, Alessio and Eidelson (2003) conducted a study on mental health workers who provided relief work following the September 11 attacks on the Twin Towers in New York. Surveys were mailed out on a random basis to practising psychologists in four Zones of increasing radius's from ground zero (zone 1) to 161km away (zone 4). Results indicated that those who worked closest to ground zero were more negatively affected than those who worked farther away. In particular, those closest to ground zero reported more common negative responses to their relief work which included feelings of inadequacy or hopelessness, feelings of burnout and exhaustion and at times reported being over burdened with work and underappreciated. On the other hand, those who were closest to ground zero also reported more positive feelings towards their work.

### ***When therapists experience the same crisis as their clients***

There appears to be a great deal of research into the domains of Vicarious Trauma (VT) with health workers who are working with trauma victims but less research about the impact of trauma work for therapists who have experienced the same disaster as their clients. Of the few studies conducted, Illeffe and Steed (2000) found evidence that clinicians who experienced the same event as their clients tended to feel anxiety at being brought face to face with the horror of the patient's experience. In addition, a survey of 501 clinicians found that

32% reported Childhood Sexual Abuse histories and sexually abused therapists were more likely to report difficulties in keeping boundaries than non-abused therapists (Little & Sherry, 1996)

Karakashian (1994) explored the processes of Armenian counselors who witnessed and treated victims of a large earthquake and found trauma reactions were evident in their work. These included denial of emotions, loss of interest in mundane activities, and an inability to distance themselves from trauma work and home life, and guilt for not having helped enough. Therapists also revealed symptoms of depression and PTSD to the level of DSM-III-R criteria. This same study also found trauma symptoms were less prominent in the American counsellors who volunteered following the Armenian earthquakes. In addition, those who were not witnesses' or children of survivors reported feeling like outsiders and tended to feel pity and contempt for their patients.

Danieli (1998) studied a group of psychoanalytically trained psychotherapists, some of who were either survivors of the holocaust themselves or children of survivors. All participants stated that their reactions to treatment were unique to this population. Furthermore, the author found differences among reactions of therapists who were not witnesses of the Holocaust or children of survivors, and those who were. Those who were, expressed a sense of bond, a need or mission to help their people, and a belief that they will be helped in the process whereas those who were not witnesses or children of survivors reported feeling like outsiders, and tended to feel pity and contempt for their patients. Danielli (1998) suggested that such finding reflect therapist's reactions as countertransference reactions to the Holocaust rather than reactions to patients themselves.

Thus, trauma counsellors can be affected by both what they themselves have experienced, and also what the client may bring to therapy. These features have been

commonly associated with aspects of countertransference (CT), a term coined by Freud (1910/1957) to refer to the therapist's emotional entanglement with a client and it was characterized by Freud (1910/1957) as a patient's influence on the unconscious of the therapist. Furthermore, in situations where the client and counsellor have experienced the same trauma it is important to understand the therapy processes, and their effect on the client, counsellor and service being provided (Feldner et al; 2007; Sommer, 2008; Trippany, 2004).

### ***Therapeutic Processes in Counselling***

The studies reviewed above, then, indicate the overall consensus that therapy may be effective in helping individuals overcome psychological disturbances post-disaster. However, over the past few decades, diverse opinions have been expressed about what therapy is the most effective and what the factors are which contribute to whether or not a client makes improvements. Research has attempted to discern what therapeutic factors are important for therapy outcome. The factors can include extratherapeutic factors, such as things outside of therapy including remission and social support; expectancy factors such as placebo; clients belief in any particular technique; client factors such as their motivation, willingness and diagnostic status; treatment factors which include features of a technique or that technique specific to the prescribed therapy (e.g. hypnosis, systematic desensitization); factors related to the therapy relationship such as process factors including the confidentiality of the relationship; and therapist factors such as empathy, warmth, and good listening skills (Norcross, 2011).

***Norcross' model of outcome variance.*** The contribution of therapy factors has been vigorously debated on theoretical and empirical grounds for decades. Based on years of reviewing research studies, Norcross (2011) proposed two models to account for psychotherapy outcome. Model 1 was focused on psychotherapy outcome research and

looked at the percentage of improvement in psychotherapy patients as a function of therapeutic factors (Lambert and Barley, 2002). Model 2 looked at the percentage of total psychotherapy outcome variance attributable to therapeutic factors (Norcross, 2011). Evidence from this research proposed that the greatest therapeutic factor contributing to change was the patient's contribution at 30%. The therapy relationship accounted for 12%, treatment method for 8% and therapist factors accounted for 7% of the outcome variance. On the other hand, unexplained variance accounted for 40% of the total. This is important as it indicates the complexity of therapeutic change and that research has not yet determined all the factors that contribute to successful outcomes in therapy.

*Treatment Factors.* The implications of these findings are substantial, particularly because it challenges the notion that specific therapy techniques are a major contributor to client progress. The model proposed by Norcross (2011) suggests that the technique which a therapist or counselor chooses to adopt may only have a minor contribution to the outcome of therapy. This has been supported by a range of literature whereby therapist's effects have generally over shadowed the variance attributed to treatment differences (Luborsky, 1986). In particular, meta-analytic reviews have indicated there is no superiority of any particular technique with disorders (Wampold, Mondin, Moody, Stich, Benson, Ahn, 1997), and almost no differences have been found between major schools of psychotherapy (Shadish, Navarro, Matt & Phillips, 2000).

*Client Factors.* Empirical evidence has indicated that the patient's contribution to psychotherapy outcome is vastly greater than that of the treatment type or the therapy relationship (Norcross, 2011; Lambert & Barley, 2002). One reason why technique may play a minor role in outcome success may be due to the problems that arise when people try to advocate a specific treatment with a specific disorder. Although some treatments are found to

be superior for some specific diagnoses, doing so may lead therapists or counselors to overlook the contribution of other factors that clearly influence a client's progress.

Most clinicians understand that different types of patients respond to different types of treatments and different types of relationships. In particular, pre-existing client factors which have been found to influence treatment outcome include willpower to change, motivation and diagnosis (Bergin & Lambert, 1978). Thus, although certain psychotherapies make better marriages for certain disorders and the therapist can be seen as the central agent of change, the client appears to be intertwined with the outcome.

*Counsellor Factors.* Orlinsky and Howard (1977) once stated that 'the therapist is a person – as much as he makes himself an instrument of the client's treatment' (page 567). Project MATCH research group (1998) studied the influence of therapist effects in the treatment of panic disorder and alcohol abuse. Attempts were made to standardise treatment, therapists and patients. Treatment was manualized and structured, and therapists were identically trained and patients selected according to criteria. Results showed clients differed in magnitude of change. Additionally, outcome variance attributed to the therapist was 0-18% for panic treatment and 0-12% for alcohol treatment. Furthermore, this sheds light on the need to understand why certain therapists are better than others at promoting positive client outcome and what factors may be contributing to this.

Therapist factors can refer to specific characteristics of the therapist. Qualitative research of clients who have experienced positive outcomes often describe their therapist as being 'sensitive', 'gentle' and 'honest' (Lazaruss, 1971) and warm, attentive, interested, understanding and respectful (Lessler, 1969). Therapist experience has also been closely linked with client outcome (Orlinsky and Howard, 1977). For example, Orlinsky and Howard

(1980) analysed outcome ratings of 143 female cases treated by 23 therapists and found that therapists with experience beyond 6 years was associated with a more positive outcome.

The style of interaction by the counselor has also been shown to play a role in positive outcome. For example, Ricks (1974) assessed the outcome of two groups of equally disturbed adolescence boys who received therapy. Differences were most evident for therapists when it came to their most severe cases. The therapist who had the most success with their patients appeared to spend more time with the difficult cases, made use of resources' outside of the therapy, was firm and direct with parents, encouraged autonomy, implemented problem solving skills and had a strong therapeutic relationship with the clients. The less successful therapist seemed frightened by the pathology and withdrew from them.

*Therapeutic-relationship factors.* In light of the model proposed by Norcross (2011) and Lambert (2003) there has been considerable debate and polarization within the counselling psychology field, particularly towards the relative importance of treatments “curing” disorders or relationships “healing” people (Howe, 1993). Evidence-based practise (EBP) refers to treatment methods adopted due to their stringent testing and the APA Division 12 Taskforce is one psychology funded group that drives this research (Norcross, 2011). Standards of practice advocated by the Division 12 Taskforces are believed to have not placed enough emphasis on the importance of relationship factors while over emphasizing therapy technique. More specifically, currently, the therapeutic relationship is not included in testing therefore the value of the client-therapist relationship in outcome success cannot be shown (Howe, 2004).

The effectiveness of treatment on patient outcome can be assessed in a number of ways. Quantitative methods enable us to apply systematic empirical investigation of social phenomena via statistical, mathematical or computational techniques. This is requires asking a

specific, narrow question and collecting a sample of numerical data from participants to answer the question. It has, however, been suggested that past research on change has focused too much on quantitative methods' for assessing process analysis (Helmeke & Sprenkle, 2000) and rather, when attempting to see how counselling and therapy has contributed to clients improvements, qualitative methods may be equally as important. Qualitative methods, such as interviews, enable us to understand the change process as perceived directly from the clients. This is the rationale behind using qualitative methods for this current research.

### **Client and Counsellor Perceptions of Change**

Much empirical research attempts to account for client outcome, it may be just as important to understand change from the perspective of the client. Clients appear to have a degree of insight into their change. However, inconsistent with the models of therapy outcome variance presented above, clients and counsellors are more likely to attribute change to therapy processes rather than client factors.

Jinks (1999) demonstrated how clients indicated feeling more in control of their lives, which they attributed to a number of factors including increased self-awareness, confidence, insight, ability to make decisions and act to influence events, and assertiveness; however these changes were attributed to their counsellor. Many clients attribute positive outcome to specific qualities of their therapist such as their ability to listen and perceived empathy (Jinks, 1999), factors also strongly related to positive outcome (Kurtz & Gurmon, 1977) and to insight and assertiveness (Jinks, 1999).

Clients from one study indicated that the personal qualities of their therapist were more important than technical factors of treatment (Lazarus, 1978). In addition, client's perceptions of therapy appear consistent even when they are receiving different treatments. For example, Gershefski, Arnkoff, Glass and Elkin (1996) assessed the perceptions of

treatment of clients with Major Depressive Disorder and who were receiving different types of therapy treatments. The authors found no significant group differences, and helpfulness of the therapist was reported most frequently (Gershefski et al, 1996).

It has been proposed that congruence between client and therapist attributions about therapy are related to treatment success (Brickman et al., 1982), however clients and counsellor perceptions are often incongruent. For example, a lack of overlap was found between couples' and counsellors' identifications of pivotal moments in therapy that were perceived to be important in the couple's improvement (Helmeke & Sprenkle, 2000) and clients have been found to value immediate changes whereas counsellors are more likely to value client insight and long-term processes

Therapist's self-disclosures have been found to impact clients' perceptions of therapists. Knox and Hill (2003) looked at the disclosures of doctors working with clients with difficulties conceiving and who were also struggling with conceiving. The authors found that clients often perceived their therapists to be more real and human and this helped clients to feel normal and reassured. It also improved the therapy relationship whereby it enhanced client's openness and honesty, equalised the therapeutic relationship, and empowered the patient to make changes (Mahalik, Van Omer & Simi, 2000).

Barrett and Berman (2001) conducted one of the few treatment outcome studies looking at therapist self-disclosure. Not only did they find that clients rated their therapists higher after their disclosure, but they found disclosure decreased symptoms. Furthermore, Hill, Mahalik, and Thompson (2000) found that the types of disclosures experienced as being most effective by both therapist and patient were similar. These were characterized by emotional involvement and affirmation of the patient's experience by the therapist. However, client and therapists perceptions of self-disclosure appear to be different whereby research

carried out by Hill et al. (1988) found therapists evaluated self-disclosing interventions as being only marginally efficacious whereas, patients tend to perceive it as highly beneficial.

There can be situations where therapist disclosure may hinder therapy. Myers and Hayes (2006) found that when the therapeutic relationship was sound, therapists received higher ratings if they made disclosures (compared to no disclosures), but if the alliance was weak, the therapists disclosures were perceived negatively. Barrett and Berman (2001) also found that too much disclosure can have the opposite effect on the therapy relationship whereby a client can feel overwhelmed, burdened, or distracted by their therapist's own needs.

### **The Present Study**

The present study had a different focus to most previous research. As mentioned above, there are a number of factors that must be taken into account when exploring the experiences of individuals who have had a traumatic experience. This study aims to examine the experiences of clients receiving treatment and counsellors providing treatment following the devastating earthquake. In utilizing Interpretative Phenomenological Analysis (IPA) this study will attempt to analyse and interpret the rich accounts of these individuals' experiences.

### ***Interpretative Phenomenological Analysis (IPA)***

IPA is a qualitative method, used here to explore in detail the participant's view of the change processes they experienced. It is concerned with an individual's personal perception or account of an event. IPA differs from discourse analysis (DA) in that DA is not concerned with mapping verbal reports onto underlying cognitions or themes (Hays & Wood, 2011). In the case of this study, IPA was deemed more suitable because it recognises that a researcher cannot get close to a person's world directly, but that the ability to do this depends on the

researchers own concepts and these are needed in order to make sense of that person's world through the processes involved with interpretation.

Smith and Osborn (2003) specifically state that IPA is not a prescriptive methodology but rather a set of flexible guidelines to be adapted by the individual researcher to their specific research aims. IPA requires the researcher to engage in an intensive immersion in each transcript therefore each transcript was read several times. It is hoped that multiple readings will allow for fresh insight with each reading. Smith and Osborn (2003) indicate how IPA is a dynamic process whereby it involves both the individual's personal perception and an active interpretative role for the researcher. Therefore, analysis is influenced by the researchers own experiences, interpretations and biases. Given the researcher had also experienced the earthquakes; great effort was made to avoid personal knowledge biasing analysis or interpretation. Smith and Osborn (2003) recommend five or six as a reasonable sample size. Seven individuals agreed to participate in the study, four were counsellors and three were clients. Participants all stated that they found the service helpful. The ages and gender of the participants are provided in Table 1 of the Results section. The names given are pseudonyms created to preserve the anonymity of participants.

The primary aim will be to explore the accounts of clients and counsellors with an emphasis on perceptions of change within the therapeutic process. For the clients, the focus will be on features of the counselling experience that they perceive as being helpful or hindering, and what they recognize as having contributed to their outcome. For the counselors, the focus will be on what they perceive as having contributed to the outcome of their clients, secondary trauma effects and personal learning's. In doing so, it also aims to capture an understanding of relief work that is relatively under-researched, whereby counselors too were exposed to the event and continued to provide relief work through on-going aftershocks and their effects. These can be attributable to features of the actual event,

the individual and the counsellor. Emerging evidence indicates that psychological dysfunction is prevalent following trauma and although symptoms may cease, a number of factors contribute to whether or not an individual makes improvements after seeking help.

Furthermore, given the devastation caused by disasters, it is critical that people have a clear set of recommendations for intervention during the immediate and the mid-term post mass trauma phases and that intervention policy is based on the most updated research findings.

### **Research Questions**

A number of questions we aimed to examine include:

1. What was the counsellors' experience of doing counselling in the aftermath of an earthquake that they, too, had experienced?
2. What did clients and counsellors find helpful and unhelpful about counselling in the aftermath of a fatal earthquake they had both experienced?
3. Are there any overlaps and similarities between clients and counsellors' perceptions of counselling following the aftermath of a fatal earthquake that they had both experienced?

## **METHOD**

### **Participants**

Eight individuals who experienced the earthquakes and who either 1) provided counselling or 2) presented as a client were recruited. Participants were clients attending, and counsellors working for, a charity hospital (CCH) counselling service. The CCH was a fully volunteer hospital which, following the February quakes, improvised a solution to the problem of having large numbers of people needing counselling. Management recruited volunteer counsellors, and found premises for the work.

Clients who presented in the first six weeks after the February, 2011 earthquake for counselling, and counsellors who volunteered to work during this time were selected at random and sent invitations to participate, with information and a consent sheet ( See Appendices A and B). Fifty client and twenty-five counsellor invitations were sent in the first round of recruitment. This process was carried out by the staff of CCH to preserve anonymity. Unfortunately, an error was made and the invitations were sent to the wrong mailing group (donators to the trust), before being rectified in a second posting. Of the invitations sent, twelve were returned due to change of address. We anticipated this due to people leaving the city and/or having to move out of their damaged or unsafe homes. There were two further rounds of sending invitations until all eligible clients and counsellors had been contacted.

In total 10 clients responded; six indicating that therapy was very helpful and that they would like to participate in the study and four indicating that therapy was not helpful and that they would not like to participate. When the consenting clients were contacted to schedule the interview, two participants no longer wanted to be involved. Of the counsellors, six responded and all six indicated that the counselling they provided was helpful for their client. Two counsellors eligible to participate were unable to be contacted. Pseudonyms, demographics of clients and counsellors, including client occupations and counsellor training and background can be seen in Table 1. Counsellors came from numerous therapy backgrounds and had skills in many areas including Eye Movement Desensitization and Reprocessing (EMDR), hypnotherapy, psychotherapy, reiki and person-centred counselling. Information regarding some demographic information, such as age were not available.

Table 1: Pseudonyms and Demographic Information of Clients and Counsellors

<b>Pseudonym</b>	<b>Gender</b>	<b>Occupation/Therapy training</b>
<i>Client</i>		
Mary	Female	Retired
Penelope	Female	Social Worker
Stephanie	Female	Personal Trainer
<i>Counsellor</i>		
Chris	Male	Registered Clinical Psychologist (EMDR, Psychotherapy)
William	Male	Qualified Counsellor (Person-centered)
Rochelle	Female	Registered Clinical Psychologist (Psychotherapy)
Gerry	Male	Qualified Counsellor (Hypnotherapy, Reiki)

The invitation letter provided a brief description of the study (Appendix A for clients and Appendix C for counsellors). A consent sheet was enclosed which asked participants whether or not they consented to be contacted and if they consented, they were further asked about the extent to which they felt their experience at the CCH was helpful. (See Appendix B for clients and Appendix C for counsellors).

The latter question was included with the initial intent to form four separate groups 1) Clients who reported their counselling experience to have been helpful; 2) Clients who reported their experience to have not been helpful; 3) Counsellors who reported the service to have been helpful for their clients; 4) Counsellors who report that it was not helpful for their clients. Invitations were sent in the hope of finding a mix of people, however no individuals

who responded indicated that they were in the “helpful” group. Intuitively this makes sense as it is more common for people to ‘opt in’ if they felt the service was helpful.

### **Interview Schedule**

Development of the interview schedule for this study followed Smith and Osborn’s (2003) recommended four steps for designing an interview schedule:

Step 1: Begin by considering the broad issues of the study. For this study we were concerned with the experiences and perceptions of both clients and counsellors.

Step 2: Structure the topics in the most logical or sensitive order. In this case, the most logical order was to begin with participants’ own initial responses and experiences, followed by their experiences and perceptions of therapy, and lastly the perceived outcome of therapy.

Step 3: Creation of questions. Questions were based on guidelines outlined in Smith and Osborn (2003). Questions should be open-ended to encourage participants to give full answers; questions should be neutral to avoid influencing participants’ responses; there should be no jargon or technical terms so that questions are clear and well understood; questions should encourage participants to speak openly and freely with minimal prompts. An initial question was designed to build rapport and to make participants feel more comfortable. The research questions were designed to encourage participants to engage in a rich account of their experiences and perceptions of counselling after the Christchurch Earthquakes.

Step 4: Development of prompts to allow elaboration of responses or more explicit details if required. This step may depend on the specific study or individual participant, and may be used to encourage further discussion about any area of interest to the researcher. For this study, general prompts were used at the interviewer’s discretion to enquire about areas of interest or importance. These were used or adapted. Topics captured by the client proforma

focus on features of the counselling experience, what they perceive as being helpful or unhelpful for counselling, what they recognize as having contributed to their outcome, and how they see themselves following their counselling experience. See Appendix G. Topics captured by the counsellor proforma include what they perceive as having contributed to the outcome of their clients, secondary trauma effects and personal learning's. See Appendix H.

## **Procedure**

This study was approved by the University of Canterbury Ethics Committee (Appendix D). Consenting participants were invited to take part in a face-to-face interview at a mutually convenient time. They were informed that they could bring a support person with them to the interview, but none of them did. When participants arrived, they were asked to read and complete the information and consent form (Appendix E and F) and provided with a petrol voucher as reimbursement for travel costs. They were informed that the interview would be recorded and given an opportunity to ask any questions. Utilising the semi-structured interview schedule, interviews took roughly 45 minutes. Once the interview was completed, participants were thanked for participating and debriefed about their experience of the study. There was no further involvement of participants following the interview. Participants did not get the opportunity to read and correct their interview transcript.

## **Analysis**

The audio recordings were then transcribed and analysed. Data was analysed using IPA. Each transcript was read several times and initial reactions and thoughts were noted in the left hand margin of the transcript. Based on these initial comments emergent themes or phrases were noted in the right hand margin of the transcript. The same detailed analysis was carried out for each individual's transcript to produce a set of possible subthemes for counsellors and clients. A table was then made of super-ordinate themes that were relevant

for at least half of the participants in each group. Original accounts were consistently referred to, to ensure that the researcher's interpretation reflected the participant's original account.

Each set of themes was labelled to represent superordinate themes and subthemes. To comply with the iterative nature of IPA, the narratives were re-read several more times to ensure the themes were supported by the participants' accounts. In order to assess the reliability of the analysis, all seven transcripts were analysed by a second researcher completing a Master's degree in Psychology. Due to the non-prescriptive nature of IPA analysis, it is likely that the analysis will vary between individuals depending on the interpretation. However, these narratives produced similar results to the primary researcher.

## **RESULTS**

### **Emerging Themes of Counsellors**

IPA revealed four superordinate themes from the counsellors' accounts. This includes 'Counsellor Perceptions of Shared Experience' with sub-themes of 'Explicit shared experiences with clients'; 'Distancing experiences from clients'; and 'Distancing from outsiders'. The second refers to 'Adaptation and Adjustment', with sub-themes 'Adapt to context' and 'Adaption to clients needs'. The third, 'Emotional Responsivity of Counsellor' includes 'Emotional responsiveness to client' and 'Emotional responses to environment'; and the fourth refers to 'Counsellor Identity and Learnings' with the sub-themes 'Increased awareness of own skills' and 'Ability to be helpful'. These themes (Table 2) are related to both individual experiences of the earthquake and relational aspects of counselling post-quake.

Table 2

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Master Table of Themes: Counsellors

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1. Counsellor Perceptions of Shared Experience
    - Explicit shared experiences with clients
    - Distancing experiences from clients
    - Distancing from outsiders
  2. Adaptation and Adjustment
    - Adapt to context
    - Adapt to client needs
  3. Emotional Responsivity of Counsellor
    - Emotional responsivity to client
    - Counsellor responses to the environment
  4. Counsellor Identity and Learnings
    - Ability to be helpful
    - Increased awareness of own skills
    - Time and resource constraints
- 

**Counsellor perceptions of shared experience**

**Explicit shared experiences with clients.** A theme that emerged from the counsellors' accounts was that of having shared this experience with their clients. They acknowledged having been through the same traumatic experience as their clients:

*Not only were the clients in traumatic (sic), had gone through traumatic event, the counsellors had gone through a traumatic event, so we were a community experiencing this (William)*

Shared experiences also included counsellors perceiving their reactions to be the same as others in Christchurch, including their clients. As Rochelle indicated:

*Thoughts and feelings probably similar to anyone in Christchurch...they [clients] were going through similar emotions to the emotions we were experiencing as well*

Sharing these feelings with clients often led to counsellor's feeling a connection with clients. Counsellors were often dealing with the same issues and, as Rochelle notes, this provided a sense of understanding towards her client:

*There's an immediate understanding of "oh, I know what it was like [and] that understanding that I am going through the same things they are*

Counsellors often viewed having been through the earthquake as a positive thing for therapy. As William notes, although he did not want the earthquake to have happened, he viewed having experienced what his clients had experienced as having had a positive impact on his work as a clinician:

*Um, I think that's outside of the fact that I never wanted the EQ to have occurred, outside that fact, as a clinician, that I had also had the experience, that's a very positive thing (William)*

Furthermore, counsellors acknowledged that although having experienced the same experiences as their clients may be beneficial; many indicated that it was not common for

them to have experienced what their clients had and that it was not normally necessary for effective therapy:

*A sense of shared experience makes somewhat of a difference but you don't have to have broken a leg to be a good surgeon (William)*

**Distancing shared experiences with clients.** Some counsellors indicated that their experiences were not as bad as their clients:

*You always heard from people who were in a bad situation, but you know, this person's got it a lot worse than me. (Chris)*

However, some counsellors who perceived themselves as being less affected by the earthquakes, at times, showed similar emotional responses to their clients. For example, although Chris indicated that, physically, his situation was not as bad as many of his clients; he later described some of his emotional responses to the EQ as being "...less relaxed, more tense and tighter, physically..." and the techniques he found helpful to manage his own responses were often shared with his clients:

*It [music] really helped me a lot and I was able to give it to my clients (Chris)*

Another counsellor appeared to distance himself from his clients when describing clients as "people" and "they". However, when he corrected himself from saying "we" to "people" it seemed to indicate that he initially included himself (we) when speaking about the struggles that came from the EQ, but then referred to his clients' as being different:

*We (pause)... people, had coped with the September EQ and then they had the February EQ, perhaps they were finding it a bit difficult (Gerry)*

**Distancing from outsiders.** Another subordinate theme under ‘counsellors’ shared experiences’ was that of counsellors distinguishing those who had experienced the earthquakes from those who had not. Without prompting, most counsellors appeared to separate themselves both personally and professionally from those who had not experienced the earthquakes. Counsellors spoke about people from outside of Christchurch being different from themselves and their clients, and expressed the idea that those who had not experienced what they had would not understand what they were going through. It was one counsellor’s experience that it was rare for any person from outside Christchurch to understand what they were going through:

*... if you ever talked to somebody from Christchurch they always get it...whereas, somebody from outside...they just don’t get it. They didn’t understand what you were talking about, or they didn’t understand, how, what you were experiencing (Rochelle)*

This appeared to filter down to the counsellor’s perceptions of people who had come from other cities to provide help in the form of counselling and their perceptions of what is helpful for the client. One counsellor indicated that having experienced the earthquake “probably made it easier” (Rochelle) and that clients may prefer to be counselled by somebody who had experienced the earthquakes:

*I suspect that people being counselled were probably quite happy to have somebody in their community listening to them, rather than an outsider (William)*

Counsellors indicated that clinicians coming from outside Christchurch may be different because they have not been through the same experiences and responses as their clients:

*If somebody had come in from the outside...they may not have those experiences and responses (Rochelle)*

It was perceived that counsellors who had experienced the earthquake may be able to offer something different to therapy than those who had not experienced it. One counsellor expressed concern about the effectiveness of having other counsellors come and help ....

*I think that a check on the local resources is important because being able to join with the community and being able to say that 'I was in ...' or "this happened..." so there's a degree of sharing...I suspect we didn't really need many outsiders...I'm not sure how wise that it...it's lead me to wonder of people descending upon the disaster centre, um, with good will and good intent, but in fact, who hadn't experienced , um, what we went through (William)*

This indicates that sharing these experiences may have led the boundaries between client and counsellor to become less distinct whereby counsellors felt more connected and more equal with their clients. On the other hand, sharing these experiences with clients may have influenced some counsellors to attempt to distinguish the boundaries. Counsellors also

attempted to distinguish between those who did and those who did not experience the earthquakes. This may have been a way of reinforcing their connection with their clients, but may have also been a result of counsellors drawing from their own experiences to do what they thought best for their clients given the limited experience or knowledge they have about this type of trauma counselling.

### **Adaptation and Adjustment**

**Adapt to context.** Counsellors came from numerous therapy backgrounds and had skills in many areas including Eye Movement Desensitization and Reprocessing (EMDR), hypnotherapy, psychotherapy, reiki and person-centred counselling. However, counsellors indicated that they had to adapt their therapy due to the context being different from normal therapy:

*Um, so the context is very different. I'm trained at person-centred counselling which is more medium to long term type process. So I guess the initial stages really focused on what was the most disturbing part of their life and trying to work through that to a degree (Chris)*

Counsellors also found that the earthquake brought about a more broad range of client types, atypical of normal, long-term clients, and this typically had an impact on their therapy practice. In particular, many counsellors found they needed to address pre-earthquake factors in clients such as their childhood history and mental health history.

*They were not the everyday Joe Blogs or Sue Blogs. Um, off the street....the thing that surprised me was the demographic of the people that I saw because they were right*

*across the, um, they were people that were in good jobs, IT jobs, competent perhaps supervising or managing a shop, um, a whole variety. They weren't, um, like if you like some long term psychiatric patients that didn't have employment much. So it was a real broad demographic (William)*

Counsellors felt they were able to relate to their clients stories given they had shared the same or similar experiences:

*As opposed to under normal circumstances when you're seeing someone for psychotherapy and they are, um, they are (pause) experiencing that you're not going through, that's a very different thing from them describing something that you are also trying to deal with yourself (Rochelle)*

**Adapt to client needs.** Counsellors acknowledged the need to ensure the immediate and on-going safety of their clients. This included addressing their immediate safety, as well as providing clients with information to ensure that their basic needs were met such as where to get essentials like food and water. As one counsellor indicated:

*I was checking whether they were at any physical harm at home, you know, whether they had the services that they needed to survive the earthquake, whether they had power, or food, you know those basic things (Chris)*

In light of addressing the basic needs of clients, counsellors also recognised the importance of providing psychological support. For Rochelle, although she lacked the skills

to provide physical help she was able to utilise her skills as a psychotherapist to provide emotional help for clients:

*I don't have the skills to help fix peoples roofs or, you know, do some practical things around the city that would be really helpful; those types of skills. This is my skill; my skill is being able to do psychotherapy (Rochelle)*

In most cases, counsellors focused on providing what they called 'psychological first aid', and this was the case for most of their clients:

*What I call psychological first aid, that's what I basically (pause) what I was initially working with...the majority (Chris)*

Typically as counsellors perceived it, therapy was a place for clients to tell their stories and be listened to:

*I saw people once or twice, maybe three times, and typically it was listening to their stories and listening to why they, um, why they came to the Charity Hospital (Rochelle)*

Counsellors also recognised that although they had experienced the earthquakes and had stories of their own, it was important for their clients to tell their stories. For one counsellor, building rapport was particularly important for a client to open up and tell their story:

*It's about their story, not my story. And as a good counsellor it's establishing the rapport so that they can open up...it's been a life changing thing for many people (Gerry)*

There were times when all clients wanted to do was unburden themselves of their emotional distress, and this led to situations when applying structure to therapy seemed unproductive because of the client's needs:

*So 5 things that I sort of checked off initially, and then, umm (pause) some people, it was just letting them pour out. You know they were just in a place to just pour. They were all quite different but there were a number in that category where you didn't, well it was a waste of time or inappropriate to interrupt. You know. You just, they had the floor and that was a session (Chris)*

Another important focus for counsellors was to normalise client's responses. Counsellors used many techniques of normalising, included educating clients about the origin of their responses and how they are natural human responses and "showing them that they were not alone and what they were experiencing...a lot of people were experiencing this" (Gerry). Therefore normalisation became a central feature of many counsellors' therapy:

*Normalizing a lot of what they were feeling and, um, we saw a lot of people whose you know spouse or children were in the CTV building so I can remember one of the mothers, who was obviously incredibly distraught, who thought it wasn't normal to feel that way. So, a lot of normalization sort of stuff and feelings (Rochelle)*

Counsellors also found it important to provide clients with practical tools to manage their responses. This included teaching clients how to breathe and ways for them to regain a sense of control:

*Learning that we can't control earthquakes but we can control what we do. And just making sure that they know what to do and that gives them a sense of control. That was probably a big aspect of the work (Rochelle)*

Counsellors appeared to disclose more personal information because they had been through the same experience as their clients. Counsellors appeared to adjust to the needs of her clients even if it was something that they would normally not do in therapy. In Rochelle's experience, it only seemed appropriate to disclose more about their own experiences given they had both been through the earthquake:

*I think that you probably talk, or reveal more about yourself like your own personal world, more likely than I have in other situations. Because it felt (pause) perfectly fine. Like, when somebody under normal circumstances asks you where you live you would find that a bit of an unusual question and you obviously wouldn't tell them where you live or, you know, it would just be peculiar. But if, under those circumstances the number of times that people would say where do you live, and I would say XXX, and there's an immediate understanding of "oh, I know what it was like in XXX (Rochelle)*

Therefore, the nature and context of the therapy service often led counsellors to make adjustments to the type of therapy that they provided. This appeared to occur quite rapidly,

given the sessions were indicated to be, typically, to 1-3 sessions (Rochelle). Unlike other therapy situations, counsellors had to help clients cope with the physical impact of the earthquakes, as well as the psychological impact. The unique circumstances of providing counselling in a disaster situation led counsellors to adopt a primary focus on ensuring the safety and the basic needs of their clients were met. Once these needs were met, counsellors found therapy to be centred on their clients' stories and normalisation of responses. Regardless of the counsellor's background or the limits to a counsellor capacity to apply a desired treatment, these factors (basic needs, ventilation, and normalisation) were common to therapy and were perceived to be equally helpful by counsellors.

### **Emotional Responsivity of Counsellor**

**Emotional responsivity to client.** The emotional impact of hearing the client's experiences elicited emotions in counsellors' that they acknowledged as surprising, difficult to control and unlike their usual responses in therapy. In Rochelle's experience, there were a number of times she was on the verge of tears as a result of her clients' stories and noted that this response was out of character for her:

*One thing I remember feeling quite often ...I was often on the verge of tears from their stories and that's somewhat unusual response for me...you know, normally, other times I'm quite good at being able to...that just doesn't happen (Rochelle)*

Furthermore, Rochelle did not believe this was impairing her ability to be empathetic during therapy.

*I don't remember feeling that it was impairing my ability to be empathetic and listen and be helpful...because it felt (pause) fine*

In contrast, Chris spoke about how his personal response may have impeded therapy. His desire to speak about his own experiences was difficult to control and would often just come out:

*Sometimes instead of following the client I just had something that I just really, really wanted to get out. And I'm sure when all that came together it didn't assist the process. So instead of being there and available for the client something would ping up in my mind and I would feel like I had to get it off my chest (Chris)*

**Counsellor's responses to the environment:** Counsellors also experienced being more emotionally responsive to their environment, particularly during therapy. Gerry indicated that he was somewhat hyper-aware of stimuli that may provoke anxiety in his clients. He spoke about construction being carried out in the car-park and indicated that he would warn clients of possible noises and vibrations. Furthermore, Gerry's vigilance to sounds appeared to be transferred into our interview when the hot water cylinder made a noise. Although I did not appear fearful of the noise, he immediately paused during his story and attempted to reassure me that it was not an earthquake:

*It's alright, that's the hot water going off*

Counsellors indicated that their own anxieties were often with them, and heightened during therapy:

*That was certainly there [anxiety] and it was heightened for some time, just as I was talking to my clients (Chris)*

William was made aware of his own hyper-vigilance during therapy when an aftershock hit. Furthermore, he thought he was probably as frightened as his clients:

*One or two occasions we were sitting in the room and a major shock came through the building and I think I was probably as frightened as my clients*

The way in which a counsellor reacts to their client is intrinsically tied to the idea of something being brought up in response to their client's experience, or something that is being brought up in response to their own experiences. Furthermore, decisions about self-disclosure are made in the context of these dynamics. In addition, counsellors were able to identify their disclosures and their potential risks. This is important as it may make management of their responses easier in the future. In addition, counsellors generally provided a perception or reason for their emotional responses to clients, particularly whether it was helpful or unhelpful. Most counsellors did not believe that sharing their experience with their clients was unhelpful, with one counsellor indicating that although she was on the verge of tears when listening to some of her clients' stories this did not hinder her ability to be empathetic. On the other hand, some counsellors indicated self-disclosures or personal reactions to clients may be problematic for therapy.

### **Counsellor contribution and limitations**

**Ability to be helpful.** Counsellors appeared to take many learning's out of their experiences as a counsellor in the immediate aftermath of the earthquake, particularly how helpful they could be in a short time frame:

*I was, in a way, pleasantly surprised how we could be so helpful in a very short period of time. I think that was pretty cool (Rochelle)*

**Increased awareness of own skills.** Counsellors also expressed an increase in awareness of their skills and ability to give back to the community. In Rochelle's experience, although she was unable to help with practical things, she was able to contribute through her work in research and psychotherapy:

*I don't have the skills to help fix peoples roofs or, you know, do some practical things around the city that would be really helpful; those types of skills. This is my skill, my skill is being able to do psychotherapy and also to do research so I did both of those things as my contribution to the community. So that's why, I don't see myself as different to anybody else, everybody made a contributions in their own way and that was my contribution.*

Furthermore, it was Gerry's personal struggles and experiences of the quakes that provided them with the motivation and strength to help other people:

*knowing that I have more skills to offer means that, um, I have been able to survive a building which came down around me killing 115 people... means that someone around me must wants me to do more. And that is something to latch onto. If you*

*believe that then no you can't walk on water, because that's already been done, but you can think, um, yes, I am strong enough to survive that, given my techniques I can share those with other people.*

**Time and Resource constraints.** Counsellors did not find many things to have been unhelpful from their counselling experiences. Many indicated that there was nothing unhelpful about their therapy practises but did note some unhelpful factors related to the service itself. Things included the noise from the construction being carried out in the car park, lack of office space and it was one counsellors concern that some counsellors working there at the time may not have had enough experience for this type of trauma work.

### **Emerging Themes of Clients'**

IPA revealed four superordinate themes from the clients' accounts (See Table 3). This includes 'Contribution of Therapy Factors' with sub-themes of 'The impact of counsellor factors on therapy; and 'The impact of treatment factors on therapy'. The second refers to 'Earthquake as trigger for current experiences', with sub-themes 'Impact on current relationships' and 'Linking with past experiences'. The third, 'Personal growth' includes 'Identity'. These themes can be seen in Table 3 and are related to both individual experiences of the earthquake and relational aspects of counselling post-quake.

Table 3

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Master Table of Themes: Clients'

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1. Contribution of therapy factors

The impact of counsellor factors on therapy

The impact of treatment factors on therapy

2. Earthquake as trigger for current experiences

Impact on current relationships

Linking with past experiences

3. Personal growth

Identity

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### **Contribution of therapy factors**

An emerging theme was the contribution therapy factors to the therapy processes. Clients attributed therapeutic factors, specifically, counsellor factors, therapy relationship and technique as being helpful during therapy.

**The impact of counsellor factors on therapy.** Clients valued their counsellors being a good listener, warm, open and empathetic. For example, Mary found her counsellor's kind demeanour helpful for therapy:

*I think the fact that XXX was kind. He always had something nice to say to me like when he would say "oh you look very lovely today" I hadn't heard that... (Mary)*

Some clients found it helpful that their counsellors had also been through the earthquakes and therefore had been through similar situations. In Belinda's experience, she was able to feel a connection with her counsellor that she did not think would be possible had her counsellor had not been through what she had. Although Belinda's counsellor had not been in Christchurch for the February earthquake, she still valued the fact that her counsellor had experienced many of the aftershocks, and found this to be important to her:

*She [her counsellor] said that she was in Wellington on Feb 22nd. Something like she had experienced earthquakes after the Feb earthquake but I don't think she was in Christchurch for the February one. So yes, she did, she did [talk about her experiences]. Which I think is really important. If she hadn't been through some of the things that I'd been through then um it wouldn't be quite the same would it. It wouldn't be quite the same connection or, feeling of understanding (Belinda)*

In other circumstances clients questioned whether it was appropriate for their counsellor to share information about their own experiences. Although it was helpful for Mary to hear about her counsellors own experiences, she indicated it may have been breaching some aspect of what she understands to be appropriate in therapy:

*I used to ask him questions, too. About his life... he was saying he's a XXX farmer, and I liked to listen to [him]...I don't know if he should have done it, talk about his life, but it helped me (Mary)*

Here we have a discrepancy between a client's conventional beliefs about appropriate counsellor conduct and what was actually experienced as helpful.

**The impact of treatment factors on therapy.** Specific treatment factors were viewed as being helpful for therapy. Typically, it was important for clients to be able to talk share stories of their experiences and their emotions. For one client, therapy was mainly focused on her talking:

*It was mainly talking. It was mainly talking about you know, how I felt (Belinda)*

Some clients felt being able to do things for themselves out of therapy was helpful. For example, Penelope found it helpful to be given homework because it was something that she enjoyed doing:

*He'd set me homework, um all sorts of things...writing and goal chart type thing and things you wanted to envision. I like homework so it felt good*

Clients were able to work collaboratively with their counsellors by bringing ideas from outside the session to therapy. For example, when Belinda needed to transition her way from living with friends to going back home, she found it helpful to be able to brainstorm ideas and steps to do this and then bring them to therapy where she would receive feedback from her counsellor:

*I went back and talked to XXX and I said, look, what I need to do is transition my way back home....So um, I decided that I'd transition myself back and I would say, 'go back in the morning' and I might go home for a few hours then I'd go back to XX and XX. And after a day or two I would extend that... and I spoke about this with XXX*

*[counsellor] ...So um I was able to talk about those things and I'd come in and she'd say, "Well, how was that? You know spending your first night at home." We'd talk about those sorts of things (Belinda)*

Clients often attributed their changes to their counsellors. For example, Mary indicated that she "wouldn't be here if it wasn't for XXX. I would be one of those people...". Clients found their counsellor's ability to normalise their feelings and responses as being important. For example, Mary indicated her counsellor was central to helping her feel normal "He made me realise I was normal". Normalisation enabled clients to gain reassurance that what they were experiencing was a normal, natural response:

*That stood out for me. She was able to normalise that this was a very horrific situation for a lot of people and [the] things I was feeling and thinking and doing were very normal under these situations (Belinda)*

Normalisation enabled people to feel less anxious about the severity of their responses. For Belinda, she just needed reinforcement from somebody else that her responses were normal even though she had been through the same situation but may not have the same level of anxiety. This may have helped her to understand that people respond differently to trauma:

*She had been through the same situation but I think she was able to normalise you know what I was feeling i.e, everyone had been through this situation... You, kind of, know in your mind that [it is] normal to feel these things but you need someone to sometimes reflect that back (Belinda)*

## **Earthquake as trigger for current experiences**

**Sense of isolation.** Many clients indicated their responses to the earthquake were triggered by their experiences of the earthquake. For some clients, experiencing being alone during the earthquakes created a sense of fear and a subsequent need to be around other people. For Penelope, she had experienced a sense being alone during both the September and February earthquakes which may have maintained her fear of being alone:

*I was calling out to people “what the...” and “kids are you alright...” and nobody answered me and that really freaked me out....and then in this February one, I was at home alone...neither of [my children] had cell phones at that stage and I couldn't get a hold of my husband so for a long time, again, I didn't know where anybody was. And so I think that really freaked me out, I hated being on my own for quite a long time*

For Belinda, having been in a high-rise building in the CBD led her to view her experience as being different from other people. This often left her feeling less understood and somewhat isolated in her experiences:

*Even though I had friends, they experienced it differently they'd experienced it at home whereas I experienced it in the city so they didn't quite understand*

Clients also indicated how their experiences often left them feeling 'crazy' or 'abnormal'. For some clients, their experiences were identified with:

*You know, I was really...I was absolutely crazy.*

Although some questioned whether their reactions were normal, however still had some understanding that others may be experiencing similar things:

*Everyone had been through this situation but I was feeling like overwhelmed at times, was I too anxious? You kind of had to go 'is this normal, is this right, or is there something wrong?' I was feeling like overwhelmed at times, was I too anxious?*  
(Belinda)

**Impact on relationships.** Clients were not only coping with their trauma responses in therapy, but clients also appeared worried about ways in which the earthquake had impacted on other aspects of their lives, particularly their relationships. In Mary's experience, stress in her marriage was attributed to the stresses of the earthquake:

*You know we never fought before...but it's all stemmed from the earthquake, it really has...talk about the marriage first and then it will go into our marriage because that's what was really, really breaking us up (Mary)*

In one client's experience, counselling was a way for her to discuss relationship difficulties she was experiencing with her daughter during the time of the earthquakes:

*[We would] talk about the earthquake first and then it will go to... [the] relationship with my daughter was really breaking up (Penelope)*

**Linking with past experiences.** Clients often perceived the earthquake to have triggered responses related to something from their past experiences. One client described having suppressed her problems from her past and the earthquake led all of her past issues to arise:

*It was like I had issues from my past stuffed away in the back, I called it my wardrobe. I had it stuffed away in my wardrobe and when everything came tumbling out, all these skeletons came tumbling out. So in all the mess of picking up from the house, I had all this shit basically that I had to deal with which is why I ended up here at the Charity Hospital (Penelope)*

Clients indicated a number of pre-disaster factors as underlying their emotional responses to the earthquakes. These included childhood abuse, domestic violence, bereavement, previous diagnoses of depression and having an anxious temperament. In one client's experience, linking her past experiences with her current responses was helpful for her to understand why she was so frightened after the earthquakes:

*I had forgotten all about it until XXX brought it out...which made me feel good because he said that's why you're so frightened (Mary)*

### **Personal growth**

**Acceptance.** Clients appeared to take many learnings from their experiences following the counselling at the CH. For some it was related to better understanding how they react under situations that threaten their safety:

*On the day it affected me from the point of view that I just went into the flight mode. You know, I look back and that's what I was doing. And to this day, if there was a shake now that's exactly what I'd do. You know, I'd be a bit more laid back about it but...that's what I'd do. I've learnt that I run, I flee (Belinda).*

Furthermore, understanding and accepting their behaviour led them to be less critical of themselves:

*I probably wouldn't be so critical of myself and think something's wrong with me and work it out. I know that what I did and the way I behaved was me. So, that's been positive (Belinda)*

For others, the earthquakes were seen as being a way for them to gain the desire and courage to address and accept issues from their past:

*Um and some of the stuff was not just EQ, some of my skeletons started tumbling out as well. So, um, I don't think I would have had the courage or desire to deal with that if the EQ hadn't come. You know, I think the EQ was the trigger, so just dealing with everything (Penelope)*

Thus, clients were able to gain insight and an understanding into their behaviour. This was not only helpful for understanding their reactions to the earthquakes, but some clients also recognised how this transpires in their everyday life. In addition, for client's who had a history of trauma, having to deal with the issues surrounding the earthquakes allowed for

them to gain strength and the desire to also address past experiences that were difficult for them.

## **DISCUSSION**

### **Summary of Findings**

Although most previous research by psychologists on natural disasters has focused on the psychological outcomes, particularly those of the more severe kind such as PTSD, the present study explored the experiences of clients and counsellors who had both been through a catastrophic earthquake, with an emphasis on perceptions of change within the therapeutic process. The impetus for this research arose because the counselling service investigated had been set up directly by a charity as a result of the earthquakes in response to the perception of considerable unmet need for such a service and it was staffed by volunteers. These volunteers, although trained mental health professionals with various backgrounds and orientations, had only the most limited opportunity for training to meet the needs of clients in the post-earthquake situation, and it was considered desirable to see what lessons might be learned from the experience of both clients and counsellors under these circumstances, particularly given that both clients and counsellors were coping with the same post-earthquake difficulties. Results suggest that a brief crisis intervention following the February 22, 2011 quake was perceived to have been beneficial by both volunteer counsellors and their clients. The qualitative findings produced in this study show that this benefit came from addressing clients' immediate needs of safety, normalisation, and ventilation; through clients and counsellors having shared experiences, and from personal development in both skills and confidence.

### **Counselling Processes**

**Immediate Needs, Normalisation and Ventilation.** Addressing the client's immediate needs was perceived to be beneficial in the initial stages of the counselling process following the disaster. With reference to counsellors, the context of therapy was quite different to their standard work. Counsellors indicated that it was important to provide practical advice to ensure their clients were safe physically, and that their basic needs were met. Counsellors did so by providing clients with information about where to get essentials such as food and water, and considered it helpful for clients to be given practical tools to manage their distress, such as knowing what to do when an earthquake occurred and basic techniques on how to maintain proper breathing, as this was often difficult for clients.

In line with counsellors' perceptions, clients also emphasised the importance of their counsellors addressing these immediate needs. Clients found it helpful to have somebody to talk to and tell their story. They valued their counsellor being a good listener and clients found it helpful for their responses to be normalised by their counsellor. This enabled clients to feel understood and that what they were experiencing was normal. Furthermore, while some clients understood that their responses were natural, often they just needed somebody, such as their counsellor, to reinforce this for them.

When people are confronted with on-going threats of this magnitude experienced in Christchurch, it is normal for individuals to experience trauma reactions. Furthermore, it is common for acute stress symptoms to arise quickly but disappear over-time (Altindag et al., 2005; Bryant et al, 2000; Stein & Gerrity, 1990). Thus, it is important client's responses are not pathologised in the immediate stages of a crisis intervention. Rather, the primary focus of crisis intervention is to deliver psychological care to victims to assist them in returning to an adaptive level of functioning and to prevent or mitigate the potential negative impact of psychological trauma (Everly & Mitchell, 1999).

In addition, the importance of addressing immediate needs of safety, ventilation, and normalisation in this study are consistent with those principles found to be most effective for alleviating and mitigating the trauma response in acute crisis intervention (Bonanno, 2010; NICE, 2005; Hobfoll et al., 2007).

**Nature of Acute Counselling.** The nature of the counselling post-quake was to provide brief intervention where sessions were often short, and mostly limited to 1-3 appointments. This meant therapy processes were different for many counsellors who would normally work with clients over a longer period of time. Thus, addressing the client's immediate needs was also viewed as being most appropriate given the limited time and possible resource constraints. In addition, counsellors indicated that therapy was often difficult to structure because of their aim to address the immediate needs of their clients. This is consistent with guidelines for delivering brief interventions to trauma victims that suggest uniformed, homogeneous trauma-focused debriefing should not be routine practice when delivering services (NICE, 2005). In addition, NICE guidelines provide recommendations to watch and wait in the first 3 months while providing support as necessary in this time, but don't do trauma-focused work. This is also consistent with the different trajectories of post-disaster adaptation described by Bonanno, et al (2010) which indicates that most individuals are only mildly affected and display resilience over time.

**Diversity of Clients.** Counsellors indicated dealing with a diverse range of clients. Some clients were said to be regular people with respectable jobs, while some who presented were said to be more complex presentations than their normal clientele, particularly those with prior mental health histories. Counsellors may be referring to those clients who went on to stay in therapy after the earthquakes, however. For example, some counsellors indicated that they were still seeing some clients who had initially presented following the February

quakes and some clients indicated that they were still seeing their counsellors at the time of the study (roughly 18 months).

There is evidence to support the suggestion that those with prior histories of mental illness are more vulnerable to the development of long-term pathology following a disaster (Udwin et al., 2003). For example, Smith, North, McCool and Shea (1990) found that more than two-thirds of the cases of acute post-disaster psychiatric disorders were predicted by identifying the subjects who had pre-disaster psychiatric histories. However, because participants were asked about their experiences following the February 22 Earthquake, it is not possible to know whether the clients perceived as “complex” were those receiving the typical 1-3 sessions, or those who went on to receive more long-term treatment. Thus, although, the latter would be consistent with this research it would be important to distinguish clients who presented with normal, acute trauma symptoms from those more complex, long-term cases.

### **Impact of Shared Experiences on Counselling Processes**

Counsellors and clients had a degree of shared experience and, as is common with this type of counselling, counsellor’s processes may have been influenced by their own personal experiences

**Shared Responses.** During interviews, counsellors and clients alike reported similar personal experiences and responses to the earthquakes. These included increased anxiety, hyper-vigilance, distress and fear and also having to adjust to changes in their everyday lives, such as having to manage added stresses of new living and work situations. Furthermore, some counsellors identified that they were going through many of the same things as their clients, as well as reflectively considering what experiences to share with their clients.

**Increased Connection and Understanding.** Having these shared experiences led counsellors to express having a greater sense of connection with their clients, this included feeling a sense of equality and being on the same 'level' with their clients. Counsellors expressed having a greater understanding of what their clients were going through because they too were experiencing these things. Counsellors often indicated that having these responses to clients was not typical of normal therapy practises and expressed stated that the level of understanding and connection they had with their clients would not have been possible had they not had those experiences.

From the perspective that such sharing of experiences involves crossing boundaries that are normally not crossed in therapy, this finding is somewhat consistent with evidence that sexually abused therapists were more likely to report difficulties in keeping boundaries than non-abused therapists. In addition, Danieli (1988) found differences among reactions of therapists who were and those that were not witnesses of the Holocaust or children of survivors. Those who were witnesses expressed a sense of bond.

It was, however, less common for clients to directly discuss the impact of the shared experience on the client-counsellor relationship. One client did explain that having her counsellor go through similar experiences was important as it, similarly, gave her a greater sense of connection and feeling of being understood. However, it is interesting to note that although Belinda's counsellor had not been in Christchurch for the February earthquake, she still valued the fact that her counsellor had experienced the on-going impact of the earthquake, such as the aftershocks. In addition, although one client found that it was helpful for her to discuss her counsellor's own experiences; she questioned whether her counsellor should have shared this information. In this case, the client may have found it to be important for her process, but it is possible that she was drawing from her knowledge about how counsellors' should conventionally be responding in typical therapy situations.

Although clients did not speak about how their counsellors' experiences may have impacted on their therapy, this may have had an indirect impact on therapy. For example, Knox and Hill (2003) looked at the relationship between doctors working with clients with fertility difficulties who were also struggling with this issue. These authors' found that clients often perceived their therapists to be more real and human and this helped clients to feel normal and reassured. In addition, other research has found that when a client knows that their therapist is dealing with the same difficulties, the therapy relationship can become improved whereby clients are seen to be more open, honest, and empowered to make changes (Mahalik, Van Omer & Simi, 2000). Thus, the shared experience may have had a positive impact on a client's therapy, but this may have been at a more subtle variable in client adaptation, outside narrative formulation.

### **Emotional Responsivity of Counsellor**

**Emotionally responsive to client.** The emotional impact of hearing the client's experiences elicited emotional reactions in counsellors' that they acknowledged as surprising, difficult to control and unlike their usual responses in therapy. Counsellors also felt times when their own reactions were being stirred up by their client's stories and experiences and this impacted on their therapy. Counsellors noted among these reactions were being more tense and less relaxed, and this resulted in counsellors feeling being less available to the client. Counsellors also indicated being more hyper-vigilant to earthquake-related stimuli during therapy. This includes being more aware of sounds that may have the potential to elicit anxiety-provoking responses in their clients. However, for one counsellor he was extremely vigilant of aftershocks and noted that he reacted to a more frightened degree than his clients did in therapy. The way in which a counsellor reacts to their client appears to be intrinsically tied to the idea of something being brought up in response to the client's experience, or

something that is being brought up in response to their (the counsellor's) own experiences, thus, this appears to be evident in the context of counsellors who are working with clients following the aftermath of a disaster that they too have experienced.

**Counsellor Disclosure.** Some counsellors indicated sharing more about their own personal experiences and personal details with clients. This was viewed as being appropriate given the context of having been through similar experiences and may have also been a way to further reinforce this sense of connection with their clients. Counsellors may make the decision to self-disclose for a number of reasons. These include factors related to their past experience, current experiences, and relationship factors, to name a few. Importantly, counsellors from this study were able to identify their disclosures and their potential risks. This is important as it may make management of their responses easier in the future.

For some counsellors, self-disclosures and their emotional reactions were perceived as being problematic for therapy. One counsellor indicated that he had not let his emotions or personal life be brought up in therapy because it was about his clients' stories not his own. In addition, clients do pick up on counsellor's disclosures, thus, reinforcing the need for counsellors to recognise the limits to this and the extent to which sharing personal information can be both helpful or hindering to therapy. Regarding personal disclosures, the counsellors' narratives seemed to express mixed views, though there appeared to be a general leniency about such sharing given that clients and counsellors had both been exposed to the quake.

**Establishing Boundaries.** In contrast, some counsellors attempted to establish boundaries between themselves and their clients by indicating that their experiences were different to others, and they were not as affected as their clients. However, counsellors who attempted to create such boundaries with their clients there were times when they expressed experiencing the same emotional responses to the earthquakes as their clients. It appeared that

counsellor's experiences may have impacted on their ability to maintain boundaries with their client.

Furthermore, counsellors appeared to establish boundaries between those who had not experienced the earthquakes. Counsellors spoke about people from outside of Christchurch being different from themselves and their clients, and indicated that those who had not experienced what they had would not understand what they were going through. It was stated that having shared this experience with their clients may offer something positive to the therapeutic process that may be more helpful and preferred by clients. Furthermore, there was also a question, among some counsellors, of the utility of bringing in professionals from outside the disaster zone. This did not come through in the narratives of clients, however.

In this sense, counsellors may have been attempting to distance themselves from those who did not experience the quake as a way to reinforce their connection with their clients. In addition, counsellors often spoke about their personal experiences of people who did not experience the earthquakes not being able to understand what they were going through.

Although counsellors often spoke about how typically in their professional practice it was not common for them to have been through the things that their clients had, and although not necessary, in this context, counsellors saw going through what their clients had as being a positive feature of their acute therapy experiences. Counsellors can be regarded as somewhat of an instrument within the therapeutic relationship (Howe, 1997). However, following the earthquake counsellors described their capacity to be "emotional instruments" was "put out of calibration" and their reactions to the clients were now influenced by their own experiences of that event. Counsellor's' reactions may have been responses to feeling how the client feels and also in a way which is complimentary to what the client is bringing to therapy. Thus, counsellors may have been drawing from their own experiences to do what they thought best

for their clients given the limited experience or knowledge they may have had about this type of trauma counselling.

### **Attributions of Change**

**Internal Attributions to Trauma Response.** At the time of the earthquake clients perceived the source or cause of their problems to be directly caused by the earthquake. However after counselling they were more likely to attribute the cause of their problem to internal factors. Clients spoke about the earthquakes being a trigger for a pre-existing problem to come to the surface. These issues included childhood abuse, domestic violence, bereavement, or a history of psychiatric illness. This was also supported by two counsellors who both referred to the earthquake as being “the straw that broke the camel’s back” for most people who they met at the CH.

**External attributions of Change.** Clients identified a number of external factors as having been helpful for change. Factors that clients found most helpful were related to therapeutic factors, specifically, counsellor factors, therapy relationship and technique. Counsellor factors viewed as being helpful included being a good listener, warm, open and empathetic. A number of treatment- specific factors were attributed to change including normalisation, ventilation, being given homework and working collaboratively.

Clients viewed their counsellor’s as having brought about the change, with one client indicating that she “would not be here” if it was not for her counsellor. Clients discussed how their past experiences may have contributed to their reactions to the earthquakes and how their counsellors were able to bring their issues to the surface and change has come from recognising and accepting these issues.

**Client Factors Missed.** It appears that both clients and counsellors failed to acknowledge and discuss client factors as having contributed to change, a finding which

challenges empirical evidence that client factors have the greatest contribution to therapy outcome. Empirical evidence supports the idea that 40% of the therapeutic outcome is attributable to client factors; 20% to treatment type and 20% to therapeutic relationship (Norcross, 2011). In this sense the client's personal contribution to therapy, which research clearly indicates plays a role in client outcome, appeared to be somewhat lost in the therapy. Thus, although factors such as how motivated a client is and their ability to be psychologically minded (i.e., show insight) were likely to have played a role in client outcome, these factors were not perceived as being helpful or contributing to change by participants.

However, this existing research on the factors contributing to change may be limited to therapy within a purely psychotherapy context. Consistent with the general guidelines for providing brief crisis intervention, counsellors were less likely to use structured therapeutic techniques and were more likely to be addressing the immediate, or short-term needs of their clients. Therefore, although client factors are important for change, these may have been either missed by clients and counsellors, or they may not have played as much of a role in this immediate crisis phase. In addition, data is based on the perceptions of clients and counsellors so it is not possible to say whether they did have a greater impact on change.

**Clients' and counsellors' perceptions of change.** Evidence from this study indicates that client and counsellor perceptions of therapy and change differ. This would be consistent with much of the literature on client and counsellor perceptions of change. In particular, there is typically incongruency between what clients and counsellors perceive as being helpful (Helmeke & Sprenkle, 2000; Brickman et al., 1982; Jinks, 1999). Literature indicates that while clients are more likely to attribute change to personal qualities of the therapist (Lazaruss, 1971; Gershefski et al., 1996), counsellors may be more likely to focus on long-term processes.

## **Personal Growth and Learnings**

**Helpfulness of Therapy.** Clients and counsellors took various learning's from their experience at the CH. For counsellors, much of what they learned was related to their contribution to therapy. Counsellors learned that they could be effective in such a short amount of time, and many counsellors were surprised about how helpful they could be. When counsellors were asked what may have been unhelpful during their therapy experiences, counsellors often indicated that there was nothing unhelpful about their therapy practices; although one counsellor indicated that she could not truly know given the limited time and follow-up conducted with clients. Counsellors expressed that their experiences at the CH reinforced the effectiveness of particular treatments, such as that of EMDR.

Instead, unhelpful features of therapy were often related to the service itself. These included the noise from the construction being carried out in the car park, lack of office space and inappropriate referrals. This is not surprising given the urgency of the CH to get the service up and running so individuals could be seen as soon as possible, and thus, with inevitable time and resource constraints. These perspectives did not appear to be reflected in client narratives. Rather, it was rare for clients to note anything unhelpful about their therapy. It is possible that clients may not have found anything to be particularly unhelpful, however, this may be more attributable to a sample bias given those who volunteered did so because they felt that counselling was helpful.

**Personal development.** In contrast, clients mostly discussed what they learned as being related to their own personal development. Factors such as an increased confidence, an awareness of their own capabilities, and insight into their behaviours were gained from their counselling experiences. This was not only helpful for understanding their reactions to the earthquakes, but some clients also recognised how this transpired in their everyday life. In addition, for client's who had a history of trauma, having to deal with the issues surrounding

the earthquakes allowed for them to gain strength and the desire to also address past experiences that were difficult for them.

Thus, client and counsellors appeared to have learned different things from their experiences of counselling during this time. This is not surprising given the fact that a counsellor's primary focus is on the client, specifically, how they can best use their skills and knowledge to alleviate a client's distress. On the other hand, a client's focus is on themselves – and their desire to feel better. In this sense, both client and counsellor's learnings are important for them and their counselling processes.

### **Implications and Applications of this Research**

This study examined the experiences of clients receiving treatment and counsellors providing treatment following a devastating earthquake. Furthermore, this research provides greater insight into the therapy processes of individuals and healthcare workers exposed to natural disasters. Firstly, much can be understood about counsellors' experience of doing counselling in the aftermath of an earthquake that they, too, had experienced. In particular, counsellors' own experiences of the earthquakes often impacted on their work. Having been through similar experiences as their clients led counsellors to experience feeling more connected and understanding of their clients. This often led counsellors to disclose more about themselves and their personal experiences. Additionally, it impacted on counsellors' emotional reactivity to clients and also to their environment in that they often experienced their own emotions coming up in therapy, particularly when hearing clients' own stories. This is important for counsellors to recognise as, although it can be helpful in some situations, it is possible for it to hinder therapy processes.

Secondly, this research provides insight into what clients and counsellors may find helpful and unhelpful about counselling in the aftermath of a fatal earthquake they had both

experienced. For individuals who have experienced a traumatic event it is important that counsellors address the clients immediate safety and basic needs. Counselling which includes ventilation, normalisation and regaining a sense of control is important for clients and is perceived as being beneficial for the change. This is consistent with guidelines from the NICE (2005) for PTSD and most recommendations for providing effective, immediate crisis intervention (Caplan, 1964; Lindermann, 1944; Kardiner & Spiegel, 1947; Hobfall, 2007).

Thirdly, this research addresses the issue of client and counsellor perceptions and attributions for change. Change was largely attributed to aspects of the counselling. Clients and counsellors, alike, found therapy techniques to have contributed to change, as well as features of the therapy relationship. However, consistent with other research, clients and counsellors typically showed disagreement in what they perceived to have contributed to change with clients valuing the personal qualities of the counsellor, whereas counsellors viewed the fact that they had experienced the earthquakes as being an important feature of the therapy relationship. This indicates that following crisis intervention, contributions of change appear centred on the counselling processes, although the relationship may be an important factor within that process.

**Recommendations for acute counselling services post-disaster.** The current research also informs recommendations to any agency that decides to set up such a counselling service in the immediate aftermath of a disaster. Immediate and brief staff training should include:

- Adapting techniques to address clients immediate needs of safety, normalisation and ventilation;
- Awareness of client complexity and how client past experiences can impact on presenting problems and thereby may require alternate level of service;

- Counsellor reflection and awareness of personal experience and its role within counselling processes;
- Counsellor reflection and awareness of personal responses to clients.

### **Limitations**

Firstly, this research is a small qualitative study, and it focuses on a relatively specific group of clients. The goal was to include participants who found their experience of post-quake counselling to be unhelpful, however no participants in this class responded, and those that did respond saying it was unhelpful indicated they did not want to participate. Therefore, this is likely to bias the study whereby the sample is limited to understanding the experiences of clients who perceive themselves as having changed as a result of counselling. In sending out invitations, many clients were displaced following the earthquakes so those who may have been more affected by the earthquakes were unable to participate.

Secondly, the clients who participated indicated that therapy was helpful and they have experienced change following their counselling. Being a qualitative study, however, it is not possible to know whether counselling was effective in producing change. Furthermore, it is not possible to know exactly what factors contributed to this change. Rather, this study refers purely to clients perceptions based on their behaviours, thoughts and feelings.

### **Future Research Directions**

Firstly, this study found that clients and counsellors did not discuss the contribution of client factors to change during acute post-quake counselling. Rather, much of what clients and counsellors found helpful were attributed to technique and therapist factors. This may have occurred for a number of reasons. Firstly, empirical evidence suggests that, within the context of psychotherapy, client factors contribute to the greatest amount of outcome variance

(Norcross, 2011). The context of therapy in this research was a post-disaster acute setting - different to what has been previously researched - so the question remains about the degree to which client factors contribute to post-disaster acute interventions. Additionally, clients and counsellors were not directly asked about client factors; rather, they were asked more general questions regarding what therapy factors contributed to change. Future work in acute settings may examine the importance of client's contribution to change by directly examining this issue, rather than allowing for spontaneous responses.

Secondly, further research should explore the extent to which counsellor disclosure in an acute post-disaster setting is helpful or hindering to counselling. Given counsellors had experienced many of the things that their clients had been through, counsellor disclosure appeared more evident in their counselling process. However, mixed responses among clients and counsellors about whether it was helpful or hindering indicate that more research is needed in this area. This is particularly important as it may help to inform acute trauma counsellors, particularly those who have experienced the disaster, for future crisis disaster interventions.

Finally, the current study asked counsellors about what they found to be helpful for their client, however, it may also be important to explore whether counselling post-quake was helpful or hindering for the counsellor. Counsellors from Christchurch still had to cope with the on-going impact of aftershocks and disruption, so it would be interesting to examine whether the process of counselling actually had a therapeutic effect for counsellors. In addition, the stories that counsellors were exposed to had the potential to be very raw, so research could explore counsellor processes and the ways in which they keep themselves safe in the context of acute disaster counselling.

## **Conclusions**

A multitude of different psychological difficulties have been associated with trauma exposure, however, it is a fairly finite subset of people who may experience extreme distress. For this reason, it is important to recognise differences in trauma responses and the appropriate support and intervention required to mitigate the development of psychological dysfunction within these groups.

This thesis set out to explore the experiences of clients and counsellors in immediate crisis intervention shortly after a major earthquake. It explored the experiences and perceptions of change during counselling for both clients and counsellor, all of which were exposed to the disaster. This study supported the idea of counsellors needing to adapt to the context of post-disaster counselling and addressing client's immediate needs. Sharing experiences with clients led counsellors to develop a greater sense of connection and understanding of their client, as well as showing more emotional responsiveness and self-disclosure. This was experienced as different to their normal therapy engagement. The implications of these counsellor responses were seen to be helpful but at times had the potential to be hindering for counselling. Clients valued their counsellor's techniques and personal qualities but often failed to identify what contribution they made to change processes.

The differing nature of counselling in post-disaster areas, as gauged by this study may help inform expectations and experiences regarding provision of post-disaster acute interventions. Furthermore, it is critical that people have a clear set of recommendations for intervention during the immediate and the mid-term post mass trauma phases and that intervention policy is based on the most recent research findings.

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## APPENDICES

### Appendix A: Client Invitation



## College of Science

Department of Psychology  
Tel: +64 3 364 2902, Fax: + 64 364 2181

Dear [client name]

You are invited to take part in an evaluation of the counselling service provided by the Canterbury Charity Hospital in response to the February 2011 earthquakes. The aim of the evaluation is to gain insight into the counselling experiences of individuals who attended the Charity Hospital in response to Christchurch's February 2011 earthquakes, so we can continue to improve our service. Your participation will not only provide us with a better understanding of peoples experiences during this unique time, but it will also provide feedback to us that may help improve our counselling services in the future. Should you decide to take part you will attend a one-off appointment with Alex Richards, from the University of Canterbury Psychology Department, who is working with us on this service evaluation. Here, she will ask you some questions about your experiences during your time as a client at the Charity Hospital. This one-off appointment will take no longer than 60 minutes. You will be given a \$10 petrol voucher to reimburse you for this travel cost.

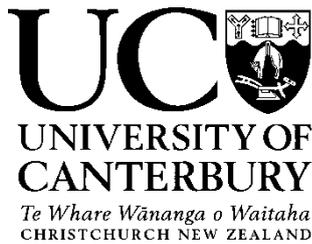
Please find attached a form which asks whether you a) consent to take part in the evaluation; and b) consent to knowing information regarding the extent to which the counselling service may have helped you after the quake. If you consent to potentially being involved in the evaluation, participants will be randomly selected and contacted in due course. If could please complete and return via post in the pre-paid envelope enclosed that would be greatly appreciated.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee and participants may withdraw at any stage and without penalty. If you have any further questions or wish to contact someone either before or after the evaluation, please contact Dr Martin Dorahy (Clinical Psychologist/Associate Professor, University of Canterbury) on (03) 3643416 or [martin.dorahy@canterbury.ac.nz](mailto:martin.dorahy@canterbury.ac.nz)

Kind Regards,

Carl Shaw Technical Coordinator  
Canterbury Charity Hospital Trust

## Appendix B: Client Consent to be contacted



CANTERBURY  
CHARITY HOSPITAL  
TRUST  
"By the Community - For the Community"

### College of Science

Department of Psychology  
Tel: +64 3 364 2902, Fax: + 64 364 2181

The Experiences of Clients in Counselling at the Charity Hospital following Christchurch's  
February 2011 Earthquakes

- a) Please indicate whether or not you consent to us learning more about the evaluation with a view to being involved.

YES, I would like to participate

NO, I would not like to participate

- b) If you consent to us knowing the following information, please circle on the scale below the extent to which the counselling you received from the Charity Hospital may have helped you during your experiences of the February, 2011 earthquakes:

1  
not helpful

2  
somewhat helpful

3  
very helpful

Name:

Address:

Contact Number:

## Appendix C: Counsellor Invitation



**CANTERBURY  
CHARITY HOSPITAL  
TRUST**  
"By the Community - For the Community"

## College of Science

Department of Psychology  
Tel: +64 3 364 2902, Fax: + 64 364 2181

Dear [counsellor name]

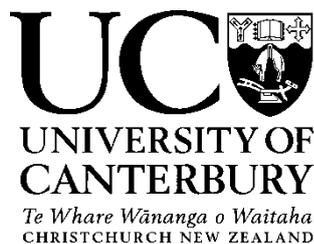
You are invited to take part in an evaluation of the counselling service provided by the Canterbury Charity Hospital in response to the February 2011 earthquakes. The aim of the evaluation is to gain insight into the counselling experiences of individuals who provided counselling at the Charity Hospital in response to Christchurch's February 2011 earthquakes, so we can continue to improve our service. Your participation will not only provide us with a better understanding of counsellors experiences during this unique time, but it will also provide feedback to us that may help improve our counselling services in the future. Should you decide to take part you will attend a one-off appointment with Alex Richards, from the University of Canterbury Psychology Department, who is working with us on this service evaluation. She will ask you some questions about your experiences as a counsellor at the Charity Hospital during this time. This one-off appointment will take no longer than 60 minutes. You will be given a \$10 petrol voucher to reimburse you for this travel cost.

Please find attached a form which asks whether you a) consent to take part in the evaluation; and b) consent to knowing information regarding the extent to which you believe the counselling service you provided at the Charity Hospital during that time may have helped your client/clients. If you consent to potentially being involved in the evaluation, participants will be randomly selected and contacted in due course. If could please complete and return via post in the pre-paid envelope enclosed that would be greatly appreciated.

This project has been reviewed and approved by the University of Canterbury Human Ethics Committee and participants may withdraw at any stage and without penalty. If you have any further questions or wish to contact someone either before or after the evaluation, please contact Dr Martin Dorahy (Clinical Psychologist/Associate Professor, University of Canterbury) on (03) 3643416 or [martin.dorahy@canterbury.ac.nz](mailto:martin.dorahy@canterbury.ac.nz)

Kind Regards,  
Carl Shaw  
Technical Coordinator  
Canterbury Charity Hospital Trust

## Appendix D: Counsellor Consent to be contacted



**CANTERBURY  
CHARITY HOSPITAL  
TRUST**  
"By the Community - For the Community"

### College of Science

Department of Psychology  
Tel: +64 3 364 2902, Fax: + 64 364 2181

The Experiences of Counsellors at the Charity Hospital following Christchurch's February 2011 Earthquakes

- c) Please indicate whether or not you consent to us, learning more about the evaluation with a view to being involved.

YES, I would like to participate

NO, I would not like to participate

- d) If you consent to us knowing the following information, please indicate on the scale below the extent to which the counselling you provided at the Charity Hospital may have helped the clients you saw following the February, 2011 earthquakes:

1  
not helpful

2  
somewhat helpful

3  
very helpful

Name:

Address:

Contact Number:

## Appendix E: Client and Counsellor Participant Information Sheet

### **Participant Information sheet**

**Title: Perceptions of change: Clients' experiences in counselling following the Christchurch Earthquakes.**

You are invited to take part in a research study. Before you decide it is important to read the following information to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

#### **What is the purpose of the Study?**

We are trying to better understand the experiences of individuals who received treatment for psychological disturbances following the Christchurch, 2011 Earthquakes. We would like to know about how clients' experiences within counselling may have contributed to their outcome, and we are also interested in client's perceptions of change.

#### **Do I have to take part?**

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive. You also have the right to skip any questions you do not want to answer.

#### **What will happen to me if I take part?**

Should you decide to take part you will attend a one-off focus group with a researcher who will ask you some questions about your experiences during your time as a counsellor at the Charity Hospital. You will also be asked to complete a questionnaire about the emotions you experienced. This will be a one-off interview and you will not be asked to come back. This appointment will take no longer than 75 minutes and you are more than welcome to bring Whanau along.

#### **What do I have to do?**

Please feel free to ask any further questions to either the researcher conducting the assessment, Sue or Phillip Bagshaw of the Charity Hospital, or Martin Dorahy (Clinical Psychologist/Senior lecturer, University of Canterbury).

#### **What are the possible disadvantages of taking part?**

You will be asked to describe events during a period of exceptional stress and, consequently, some people may find this distressing. Whilst not anticipated due to the focus groups examining the change process in counselling, it is possible that some participants may become distressed. This distressed will initially be managed in the group. The group facilitator (AR) will then follow-up at the end of the group to see if the participant would benefit from individual counselling at the CH or other service.

#### **What are the possible benefits of taking part?**

This information may provide a more detailed picture of the nature of your difficulties and therefore could be of benefit to your treatment. We cannot promise the study will help you but the

information we get might help improve the treatment of people who have experienced distressing events.

**Will my taking part in the study be kept confidential?**

Yes. All the information about your participation in this study will be kept confidential. You will not be required to put your name or any identifying details on any materials. Instead a number will be used to match all questionnaires together. The research team have a duty of confidentiality to you as a research participant and nothing that could reveal your identity will be disclosed outside the research site.

**Confidentiality policy for Research**

Whilst the information received from you during this research study will remain confidential, there are occasions when information about you can be passed on to relevant people without your permission. This is because the researcher has a statutory responsibility to protect you and the public from serious harm. Therefore information can be passed on to relevant people about you if:

- It becomes apparent during the research that you seriously have intentions to take your own life.
  
- It becomes apparent during the research that you seriously intend to harm someone else.

**Contact Details:**

If you have any further questions or wish to contact someone either before or after the study, please contact Dr Martin Dorahy (Clinical Psychologist/Senior lecturer, University of Canterbury) on (03) 3643416 or martin.dorahy@canterbury.ac.nz

You will have the opportunity to discuss your experience of participating at the end. If you would like a copy of the final results, please contact Martin Dorahy. It is the intention of the researchers to write this work up for publication in a mental health journal.

**Name of researchers**

Martin Dorahy (Clinical Psychologist/Senior lecturer, University of Canterbury); Neville Blampied (Head of Department/Associate Professor, University of Canterbury); Phillip Bagshaw (FRCS, FRACS, CHT chairman); Sue Bagshaw, (CNZM, FACHSHM); Alex Richards ( MSc student, University of Canterbury)

*This project has been reviewed and approved by the University of Canterbury Human Ethics Committee.*

## Appendix F: Client and Counsellor Consent Form

### Consent form

#### Title of Project:

**Experiences and Perceptions of change in counselling: Client and counsellor experiences following the Christchurch Earthquakes**

#### Name of researchers

Martin Dorahy (Clinical Psychologist/Senior lecturer, University of Canterbury); Neville Blampied (Clinical Psychologist / Professor, University of Canterbury); Sue Bagshaw (Registered Psychologist, Charity Hospital Trust); Phillip Bagshaw ( Registered Psychologist, Charity Hospital Trust).

Patient Identification Number:

Name of Researcher:

#### Please initial box

1. I confirm that I have read and understand the information sheet dated ..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my care or legal rights being affected.
3. I understand that if the researcher becomes aware that I have serious intentions to hurt myself or someone else, they will contact the relevant people.
4. I agree to take part in the following study
5. Please tick the following box if you would like your data passed onto your therapist
6. I consent that my data be merged with all the other data and become part of a publication in a mental health journal

\_\_\_\_\_  
Name of Participant

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Researcher/clinician

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

*This project has been reviewed and approved by the University of Canterbury Human Ethics Committee.*

## Appendix G: Client Interview Schedule

1. Can you tell me a little bit about yourself?  
Prompt: Where you're from, what you do, your interests/hobbies
  
2. I want ways did the February 22 Earthquake and subsequent aftershocks affect your everyday life?  
Prompt: Work, Interests, Relationships
  
3. Could you describe your thoughts and feelings during this time?
  
4. Could you describe what your experience of counselling was like?
  
5. What happened during your counselling sessions?  
Prompt: What would you mainly discuss, would you complete exercises?
  
6. How would you describe the relationship you had with your counsellor?  
Prompts: What feelings did you experience towards your counsellor?  
What did you think of your counsellor?
  
7. Can you describe any instances during your counselling that stood out to you?  
Prompt: Did you experience any moments of realisation?
  
8. Can you describe anything from your counselling experience that you found particularly helpful?  
Prompts: what features or factors of counselling do you think helped you?
  
9. Can you describe anything from your counselling experience that you found particularly unhelpful?  
Prompts: what features or factors of counselling do you think were unhelpful for you?
  
10. Has having accessed counselling made a difference to how you see yourself?  
Prompt: If so, how do you see yourself now as different from before you entered counselling?  
  
How would you say you have changed?  
  
If not, why do you believe the experience has not made a difference to how you see yourself?

## Appendix H. Counsellor Interview Schedule

1. Can you tell me a little bit about yourself  
Prompt: Where you're from, what you do, your interests/hobbies
  
2. How did the February 22 Earthquake and subsequent aftershocks affect your everyday life?  
Prompt: Work, Interests, Relationships
  
3. Could you describe your thoughts and feelings during this time?
  
4. Could you describe what typically happened during your counselling sessions at the CH following the Feb EQ?  
Prompt: Was there a particular technique that you thought may be appropriate?
  
5. How would you describe your relationship with your clients?
  
6. Can you discuss anything in particular that may have been helpful to your client?  
Prompt: Were there any particular events that made you come to these conclusions? Was there any particular aspect of your technique that you believe may have contributed to this?
  
7. Can you discuss anything in particular that may have been unhelpful to your client?  
Prompt: Were there any particular events that made you come to these conclusions? Was there any particular aspect of your technique that you believe may have contributed to this?
  
8. Has providing counselling during this time made a difference to how you see yourself?  
Prompt: If so, how do you see yourself now as different from before you provided that counselling service?  
  
How would you say you have changed?  
  
If not, why do you believe the experience has not made a difference to how you see yourself?
  
9. Could you describe any difficulties you may have encountered during your time as a counsellor at the CH?
  
10. In what ways did you experience your personal responses to the EQ's impacting on your counselling?
  
11. Are there any new learning's that you have taken from your experience counselling at the Charity Hospital?

**Appendix I. University of Canterbury Ethics Approval**

Ref: HEC 2012/126

7 September 2012

Alex Richards  
Department of Psychology  
UNIVERSITY OF CANTERBURY

Dear Alex

The Human Ethics Committee advises that your research proposal “The experiences and perceptions of change in clients and counsellors at the Charity Hospital following the February 22<sup>nd</sup> Christchurch earthquake” has been considered and approved.

Please note that this approval is subject to the incorporation of the amendments you have provided in your email of 6 September 2012.

Best wishes for your project.

Yours sincerely

Lindsey MacDonald  
**Chair**  
***University of Canterbury Human Ethics Committee***