Counselors' experiences working with children who exhibit externalized behaviors

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Abstract:

Counsellors who work with children exhibiting externalised behaviours may struggle to maintain therapeutic presence. Challenging client behaviours may trigger countertransference, thus influencing counsellors' presence in session. In this study, we examined the experiences of beginning counsellors working with children who exhibit externalised behaviours in counselling sessions. We used thematic analysis and identified six emergent themes related to countertransference.

Keywords: countertransference | externalised behaviours | children

Article:

1 INTRODUCTION

The therapeutic relationship between the client and counsellor is an important common factor, which appears to account for at least 15% of client improvement (Norcross & Lambert, 2018). The therapeutic relationship has been most widely defined as the collaborative connection between client and counsellor working towards commonly shared goals in counselling (Bordin, 1979; Porchaska & Norcross, 2018). The therapeutic relationship includes the specific elements of counsellor genuineness and the counsellor's therapeutic presence (Rogers, 1957). Therapeutic presence, including empathy, unconditional positive regard, acceptance and encouragement, is vital to the strength and effectiveness of the therapeutic relationship (Rogers, 1957), especially when working with children (Landreth, 2012). In child and adolescent counselling, the child counsellor's ability to remain 'present' and bring his/her 'self' into session provides safety, congruence and empathy for the child client to progress naturally towards growth (Landreth, 2012 , Ray, 2011). Child counsellors provide this safe environment through

therapeutic presence; however, when they are experiencing negative feelings towards their clients, client growth may be impeded as the counsellors are unable to genuinely display unconditional positive regard, acceptance and empathy.

Although important, counsellors often struggle to maintain unconditional positive regard and a strong therapeutic relationship when clients exhibit stressful or threatening behaviours. Feelings towards clients, both positive and negative, are inevitable and influence the treatment process and client outcomes as these feelings impact the therapeutic alliance (Gelso & Hayes, 2007). During stressful situations, it is considered natural to hold various prejudices and fears that often interfere with maintaining unconditional positive regard towards clients (Wilkins, 2010). Difficulty maintaining a strong therapeutic relationship and unconditional positive regard is often exacerbated in counsellors when working with challenging clients (Marshall et al., 2003) such as children exhibiting externalised behaviours in session. Challenging client populations, including child clients exhibiting destructive or aggressive behaviours in session, often induce higher stress for counsellors (Hastings, 2002). Additionally, increased counsellor stress and lack of awareness of various stress responses often leads to the counsellor experiencing negative emotions towards the client (Folkman, 1984; Hayes et al., 2011), also known as feelings of negative countertransference (Friedman & Gelso, 2000). The negative feelings experienced towards the client inhibit counsellors' ability to exhibit unconditional positive regard, which is the primary change agent in working with children (Harrison & Westwood, 2009; Ray, 2011).

1.1 Countertransference

Countertransference (CT) feelings can impede therapeutic presence and the therapeutic relationship if they are not managed appropriately (Hayes et al., 2011). Countertransference has many fragmented definitions; however, Gelso and Hayes (2007) created an inclusive definition defining CT as an inevitable process founded on unresolved conflict that leads to misdirected feelings towards the client that can be triggered by the counselling content, client's personality or the client's appearance. Gelso and Hayes (2007) believe that CT can either help or hinder the therapeutic relationship depending on the counsellor's awareness and ability to manage CT appropriately.

Countertransference can be both positive, in that the counsellor cares highly for the client but may become over involved with the client, and negative, including feelings of dislike, frustration, anger or resentment towards the client (Gelso & Hayes, 2007). Countertransference is most likely to occur when the counsellor's perceptions of reality or expectations of clients are not met within the counselling session (Rosenberger & Hayes, 2001), thus increasing the likelihood of occurrence when counsellors are working with challenging client populations. As counsellors work with challenging populations and experience increased stress, they are more likely to exhibit negative feelings of anger and sadness towards their clients (Folkman, 1984; Hayes et al., 2011). Child clients are often noted as challenging by counsellors due to their varied developmental understanding and differences in communication from adults (Landreth, 2012); therefore, the child's way of communicating through behaviours can elicit countertransference feelings within the counsellor.

1.2 Child communication and externalised behaviours

Children often communicate through actions and behaviours rather than words. For children, words act as symbols that do not hold the same level of meaning for children as they do for adults (Landreth, 2012). Due to the child's cognitive processes and developmental level, children are often unable to truly express the magnitude and intensity of their feelings verbally and may use behaviours to communicate their emotions and needs (Gerson & Rappaport, 2013; Landreth, 2012). However, counsellors often view child behaviours of expression as disruptive. Some of these disruptive child behaviours can also be defined as externalised behaviours, which may include harm towards others or self, stealing, destructing property or any behaviour that violates social norms (Keil & Price, 2006; McCart & Sheidow, 2016). Some examples of externalised behaviours often experienced in session with children are hitting, kicking, screaming, crying, destructive behaviours or oppositional behaviours. For example, consistent expression of externalised behaviours is common among children who have experienced an adverse life event (i.e. trauma, significant change, loss) (Gerson & Rappaport, 2013). However, the externalised behaviours that children use to communicate needs and feelings are also a cause of counsellor distress and negative CT (Kiel & Price, 2006; Linn-Walton & Pardasani, 2014).

Challenging and disruptive client behaviours can lead to counsellor distress (Hastings, 2002) and negative CT responses. When counsellors are distressed by clients' externalised behaviours, they may also experience negative feelings such as sadness and anger (Folkman, 1984). Such feelings make it difficult to maintain the therapeutic relationship and remain objective in session, which is an essential component when working with populations who display externalised behaviours (Marshall et al., 2003). Despite the stress of working with challenging populations (Hastings, 2002), there is a dearth of literature and training for counsellors regarding managing negative countertransference (CT) or negative feelings towards clients (Linn-Walton & Pardasani, 2014). The lack of attention to this issue in the counselling profession has led to inappropriate treatment approaches by helping professionals. Some of these inappropriate approaches or inappropriate coping skills to manage negative CT while working with challenging populations are as follows: (a) blaming the client for the negative feelings, (b) labelling clients as difficult, (c) minimising empathic responses, and (d) instilling fear and engaging in intimidation to manage client behaviours (Linn-Walton & Pardasani, 2014). Linn-Walton and Pardasani's (2014) findings highlight the importance of further research and training in managing negative CT responses. In conclusion, the critical area of concern is that children who may be the most in need of counselling may not receive quality counselling or the benefits of a strong therapeutic relationship and therapeutically present counsellor due to counsellors not possessing the skills needed to manage negative responses to this population. Therefore, the purpose of this study was to examine the experiences of beginning counsellors working with children who exhibit externalised behaviours in session to better understand how the counsellors are influenced by their clients. The research question guiding this study is: What are the experiences of beginning counsellors who work with children who exhibit externalised behaviours?

2 METHOD

2.1 Research design

We used thematic analysis (TA) in this study to identify patterns of meaning or themes within the data collected from the participants. Thematic analysis is a systematic procedure to generate codes and themes from qualitative data (Clarke & Braun, 2016) by identifying the emerging links through participant interviews (Glesne, 2016). Due to the alignment of the experiences reported by the participants, thematic analysis was chosen in order to cluster the data. Utilising an etic approach, the research team examined the data through the lens of Hayes' (1995) structural theory of countertransference.

2.2 Research team

All research team members are from the same counsellor education programme at a large public Southeastern University. More specifically, the research team consisted of one Caucasian male faculty member; one Caucasian male doctoral student; three Caucasian female doctoral students; and one Caucasian female doctoral candidate as an external auditor. Seven undergraduate students transcribed the participant interviews. The members of the research team provided various perspectives from different professional counselling backgrounds and experiences including mental health counselling, school counselling, marriage, couple and family counselling, and social work backgrounds. The lead researcher has a substantial amount of experience working with children exhibiting externalised behaviours; however, all members of the research team have experience working with children.

2.3 Participants

We solicited participants via email utilising a combination of snowball and criterion-based sampling methods (Creswell, 1998), using our professional relationships with other mental health professionals in the field across three states. We targeted beginning counsellors (1–5 years of counselling experience) who work with children exhibiting externalised behaviours in session (i.e. hitting, kicking, screaming, breaking) because beginning counsellors elicit higher levels of negative CT or experience stronger negative feelings towards clients than seasoned professionals (Rossberg et al., 2007). The term counsellor in this study not just denotes professionals in the counselling field but also includes professionals in similar fields, such as social work, that engage in individual and child counselling. Additionally, for qualitative research we chose a sample with similar characteristics (1–5 years of experience) to describe that subgroup's experience in more depth (Clark, 1999). The participants consisted of three licensed professional counsellors (LPC), four licensed professional associates (LPC-A) and two licensed master's social workers (LMSW) who work in a similar clinical capacity as a counsellor providing individual counselling services to children. Eight of the participants identified as Caucasian females, and one participant identified as a Caucasian male. The average age of all participants was 29.5 years with an average of 3 years of professional work experience. The average age of the participants' child clients ranged from 3 years to 12 years. The most common diagnoses of the child clients that the participants treated were oppositional defiant disorder (ODD), attention-deficit/hyperactivity disorder (ADHD), autism spectrum disorder (ASD), post-traumatic stress disorder (PTSD) and other trauma-related diagnoses. Diagnoses were provided and/or confirmed by the participants at the beginning of treatment. Additionally, the child clients treated by the

participants varied in gender, race and ethnicity and more than half of the participants work in low socio-economic areas.

2.4 Data collection and analysis

After IRB approval, we contacted various counselling agencies via email with a description of the study inquiring about their interest to participate. Once the volunteer participants agreed to participate, consent forms and demographic forms were completed and a date and time were scheduled to conduct the phone interview. We chose to have the same person conduct all telephone interviews to ensure consistency in interview protocols (Glesne, 2016). There were 11 semi-structured interview questions, and the interviews lasted about 45 min. All interviews were audio-recorded and transcribed by undergraduate students on our research team for data analysis (Stewart & Shamdasani, 1990).

Table 1. Structural model of countertransference (Hayes, 1995) and themes/subthemes of counsellor's experiences working with children exhibiting externalised behaviours

Stage/Theme	Subtheme	Examples
Countertransference origins		Counsellors' values of being in control or the expert. Counsellors' upbringing/expectations of how children 'should' act.
Countertransference triggers		Client characteristics—child client throwing, yelling, breaking things, engaging in aggressive behaviours, client's personality.
Countertransference manifestations	Counsellors' feelings in session	Feelings of anger, frustration, sadness, helplessness, exhaustion, anxiety, not wanting the client to come back.
	Counsellors' physiological reactions	Heart racing, tightening of chest, stomach, fists, anger and frustration towards parents.
	Counsellors' feelings towards client's parents	
Countertransference effects	Residual burnout	Mental and emotional exhaustion; not present for following sessions.
Countertransference management	Counsellors' perception of therapeutic relationship	Views child as a 'bully', hurts relationship and can enhance some relationships.
	Counsellors' self-efficacy	Feelings of low self-efficacy or competence to help child client.
Hesitation/validation seeking[a]	Counsellors' coping strategies in session	Walking out of the room and leaving the client, shortened session times, deep breathing.
	Counsellors' coping strategies after session	Consultation, scheduling distance between clients.
		Discomfort discussing topic of negative feelings towards clients.

[a] The hesitation/seeking validation is not a stage in Hayes' (1995) structural model of countertransference but an additional theme noted in the data.

Data analysis occurred in several stages as we followed the six phases of thematic analysis: (a) researcher familiarisation with the data, (b) generation of preliminary codes, (c) exploration of themes, (d) review of themes, (e) identification of themes by defining and naming them, and (f) a production of a report (Braun & Clarke, 2006). The research team members met biweekly and were paired together to read assigned transcripts several times before meeting to discuss any initial thoughts of potential codes. During initial readings, the research team utilised open coding methods to identify trends or links that emerged (Glesne, 2016). After three rounds of open coding, the trends that began to emerge focused heavily on client behaviours, counsellors' feelings towards clients and counsellor management of their feelings towards clients. Noting these patterns across all participants, the research team decided to move to an etic approach and

began coding the data through the lens of Hayes' (1995) structural model of countertransference as the data were illuminating all areas of this theory naturally.

After creating codes following Hayes' (1995) structural model and ensuring the integrity of the participants' experiences was coming through within these codes, combining and sorting the codes into potential themes allowed for the attachment of the data into thematic categories. We began to separate the data into major themes and subthemes. The subsequent themes and subthemes required re-examination with their connections to the coded data. Any changes to major themes and subthemes required another round of coding to verify connection to the entire data set until all themes and subthemes were agreed upon and fully represented the data.

2.5 Trustworthiness

When working with human subjects as the instrument of data collection, it is essential that neutrality be met and maintained by all researchers and rigorous data collection procedures be upheld (Patton, 2002). The research team acknowledged the potential influence of positionality and potential biases as the team has varied experience working with children and beliefs about supervision and self-care regarding countertransference. Therefore, prior to the analysis process, our research team took several precautionary measures to uphold rigorous and authentic analysis. The first step the team took to preserve credibility was to meet after each step to discuss and reduce potential biases. The group meetings allowed the researchers to explain and describe the phenomena the participants experienced directly from the data in an open and trusting environment. In addition to the group meetings, we also employed a counsellor education faculty member to act as an external auditor to monitor the portrayal of the emerging data. Although an external auditor is not typically used in thematic analysis, due to the team's overall experience working with similar populations, an external auditor was used to ensure fidelity of the study and results. Further, we engaged in member checking as all transcripts and final data analysis themes were sent to each of the participants to ensure that their experiences were captured fully and with fidelity. Seven of the eleven participants responded with approval. Lastly, all team members engaged in bracketing biases and journaling to reflect on various thoughts and feelings regarding the data.

3 FINDINGS

3.1 Theme 1: Countertransference origins

Based on Gelso and Hayes' (2007) definition of countertransference (CT), countertransference is inevitable as counsellors are people and all people have unresolved conflicts, also known as countertransference origins. Although CT is inevitable and frequent, counsellors may not always be aware of the origins of these feelings, behaviours or triggers (Hayes et al., 1998). However, taking the time to process various CT triggers or manifestations, some participants were able to identify possible origins of their CT. One participant mentioned that some of her CT feelings that were triggered by her client may have been connected to her childhood and upbringing when she stated, 'Part of me thinks with the way I grew up; getting spankings and stuff, I just want to say, "Oh my gosh this kid needs his butt beat!"'. In addition to childhood origins of CT, one participant identified a connection between her current parenting style and expectations of her

own children and her expectations of other parents. This participant's conscious and unconscious expectations triggered her frustration or angry feelings towards the parents of the child client when she stated, 'I think I look at it a lot in my personal life with him (her child). It makes me kind of angry at parents who don't do what they're *supposed* to do'. Lastly, another participant connected her frustration with the parents to her own experiences of being parented, stating that she 'grew up in a structured environment', and parenting strategies that 'seem common sense to me…it's not apparently common sense to everybody'.

3.2 Theme 2: Countertransference triggers

Countertransference (CT) triggers were identified in Hayes' (1995) structural theory of CT as experiences in the counselling session with clients that evoke a response in the counsellor connected to some unresolved concern from the counsellor's history (Hayes et al., 1998). The trigger could come from client material, personal characteristics of the client or client behaviours (Hayes et al., 1998). In this study, we found that the counsellor participants were most triggered by various client characteristics, such as behaviours, attitude and clients' expressions of feelings. For example, the counsellor participants in this study experienced CT triggers when clients become 'aggressive' and 'argumentative' in session. Another participant described the majority of her case load as having 'a lot of clients who have a lot of behavioural issues' and described feelings of frustration or anxiety triggered by clients 'actively destroying things like ripping up paper or throwing everything'. Another participant stated that it is 'hard' and feels 'something needs to be done' when her client's 'behaviour is so bad' due to the child 'swinging, trying to slap us'. In addition to feelings of fear or anxiety, maintaining therapeutic presence can be challenging when working with this population as another participant stated that at times they lose a holistic view of the client and 'view just the behaviours'. The clients' externalising behaviours in session, and the counsellors' conceptualisation of clients as having 'bad' behaviours and 'behavioural issues' served as CT triggers for the counsellor participants.

3.3 Theme 3: Countertransference manifestations

Countertransference manifestations can be defined as therapists' internal cognitions or emotions and external behavioural responses in session provoked by some unsettled matter from the counsellors' past (Hayes et al., 1998). More specifically, the internal responses included feelings of anxiety, counsellor's incorrect assumptions about the client and counsellors liking/disliking the client, while the external responses included withdrawal from or avoidance of clients, getting too personally involved with clients and physiological responses (Hayes et al., 1998).

3.3.1 Counsellors' feelings in session

Counsellor feelings in session was a prominent subtheme and connects to the internal responses defined within CT manifestations. Participants described feelings of 'frustration', 'anxiety', 'drained' and 'discouraged' provoked by certain externalised behaviours of clients in session. Some participants described these feelings as making them want to 'shut down' and feeling like they 'can't relax' in session. Another participant described feeling 'disheartened' and 'disappointed' because of the lack of client change stating, 'I don't even want to see the kid' due to feeling she is 'not making any difference in their lives'. Finally, a participant described feelings

elicited by her child client's emotional expression stating, 'In the moment, if they are taking it out on me, I get upset. Really, it just makes me sad'.

3.3.2 Counsellors' physiological reactions

In addition to internal thoughts or emotional responses towards the child clients, participants described having physical responses to clients by noticing feeling 'tense' in the session and feeling 'drained' or 'exhausted' after sessions due to the stress of the client interaction. Some participants stated their bodies feeling 'real rigid' when starting to get angry in session with a client with externalised behaviours. Participants also described 'my hands might tighten', 'start to sweat', 'my throat is kind of tight' or 'clenching my fists'. Other participants described their 'heart racing', 'feeling pressure build' and 'being almost at like a breaking point' in the session when clients became aggressive.

3.3.3 Counsellors' feelings towards client's parents

In addition to feelings and thoughts towards their clients, some participants noted another prominent internal CT manifestation: negative affective responses towards the child client's parents. The participants reported that the negative feelings and thoughts towards the child's parents often stemmed from the counsellors' perceptions of how the parents *should* be responding to the child's externalised behaviour. A participant described noticing that 'a lot of times the parents don't want to deal with the behaviours'. The participant stated, 'They [the parents] think if they put the kid in a therapy session then it's your job to fix it'. An additional participant described this response: 'Makes me kind of angry, at the parents who don't do what they're supposed to do. Who don't show love to their kids the way they should, or the way I feel like they should'. Another manifestation that arose was feelings of frustration because parents 'don't want to do any work on it [child behaviours] outside either'. In addition, participants described negative feelings towards parents who 'put them [the child] in the situation' that caused the externalised behaviours to occur. Another participant stated, 'I'm frustrated with the kids, but probably just as much with the parents…because that has a lot to do with how kids progress'.

3.4 Theme 4: Countertransference effects

The counsellor's impact after the session consistently emerged from the data and reinforces Hayes' (1995) structuring of CT. Hayes (1995) outlined the effects of how the presentation of CT hinders or promotes therapy. Hayes emphasises both negative and positive effects of CT within the therapeutic relationship and the client outcomes. When working with clients with externalised behaviours, the counsellor may experience negative affective reactions that may strain the relationship (Marshall et al., 2003). Traditionally, burnout is a negative occurrence researched among counsellors defined as physical and emotional exhaustion, negative self-concept and job attitude, and a loss of concern for feelings for the client (Pines & Maslach, 1978). Lee et al. (2007) constructed a model of counsellor burnout that included exhaustion, negative work environment, devaluing clients, incompetence and deterioration in personal life. While our data fit within Hayes' (1995) structuring of countertransference, new themes emerged such as residual burnout symptoms, the counsellor's perception of the therapeutic relationship and the counsellor's self-efficacy.

3.4.1 Residual burnout symptoms

Throughout the interviews, the counsellors described the effects of CT that immediately followed the session as a result of the client's externalising behaviours. These effects of CT described by the participants are similar to burnout symptoms but differ due to the immediacy of the symptoms setting in, as opposed to an effect that builds over time (Maslach, 2003). However, our research team is using the term *residual burnout* symptoms to mean 'emotionally drained' or 'mentally exhausted' immediately after the session due to the energy needed to remain in session. One counsellor stated, 'for me it is much more emotionally draining following those sessions. I feel like I am not as present through the rest of the day'. Another counsellor stated, 'I'm exhausted. That is really the best way to describe it. Very mentally exhausted…'. Such feelings are collectively described as an aftermath of the session or the behaviour resulting in *residual burnout*; however, they do not last longer than a few hours or more than a day.

3.4.2 Counsellors' perceptions of the therapeutic relationship

Another subtheme that emerged from the data was the counsellor's perception of the therapeutic relationship. Uniquely, this theme included both negative and positive perceptions of the therapeutic relationship. For example, one participant stated, 'I feel like I was struggling to really be in the therapeutic relationship with the client. And it wasn't for me, it wasn't necessarily I was getting agitated at the client – it was more like…"Oh goodness, what are the people in the lobby thinking right now?" because there was just so much noise'. Other counsellors described negative effects such as being frustrated, not wanting to engage with the client in following sessions, and having their feelings affect the therapeutic environment. Meanwhile, other participants described more positive effects such as the behaviour being valuable and a sense of trust between the counsellor and the client and an ability to be present during session. One participant proclaimed he felt the need to provide more for the client such as: 'just give them a safe environment. And have a really, really good, safe relationship with the client so they feel like they can do or say whatever they need to do; because most of the time they're not allowed to do that outside of your playroom'. While the experiences of perception were different among participants, the reflection of the relationship was consistent between both experiences and a consideration of what the behaviour and the CT meant for the counsellor.

3.4.3 Counsellors' self-efficacy

The third subtheme that emerged from the CT effects was the counsellor's self-efficacy. Several participants described feeling like their work is not making a difference, due to the ongoing externalised behaviours, and wanting to feel as though their work is making a difference, stating, 'I don't have that feeling that what I'm doing is making a difference, whereas if I have a kid come in with anxiety or depression or even outbursts of anger, most of these kids are well behaved and responsive to therapy sessions and I can see the gains that they make and I can tell that what we're doing in session is helping them'. Other participants described not feeling prepared, stating, 'What I'm not prepared to deal with is, when that doesn't work and when they're violent. Nobody teaches you how to deal with violent kids'. Overall, the participants questioned their abilities and the client's progress, and felt discouraged or overwhelmed.

3.5 Theme 5: Countertransference management

Countertransference management requires counsellors to be aware of the thoughts and feelings attached to the client and utilise them in a constructive manner (Pérez-Rojas et al., 2017). Alternatively, the lack of awareness on the part of the therapist to resolve CT during and after therapy may result in degenerative effects on the client (Gelso et al., 2002; Porchaska & Norcross, 2018). Further, the effects of CT on the therapist may result in distress before and/or after the session, increased anxiety and withdrawn interactions with the client (Shamoon et al., 2017). Therefore, obtaining information about the participants' coping strategies in and after sessions provided insight into the management strategies of the participants and areas for needed support.

3.5.1 Counsellors' coping strategies during session

The coping strategies used in session, whether positive or negative, became an apparent subtheme under countertransference management. Some management strategies involved takingaction, behavioural techniques or distraction to calm themselves, while others relied on breathing or reframing of the situation to calm themselves and better help their clients. Additionally, the participants' lack of self-efficacy to treat clients exhibiting externalised behaviours also influenced how they managed their feelings and the client in session. The participants explained their concern of being unprepared to be therapeutically competent when the child was 'aggressive' or 'ripping up and throwing things' by stating 'I'm not really equipped with much other than remaining calm and telling the child, in a calm voice, "you are safe, nobody is going to hurt you here", or "that hurts", "that's not very nice", "I don't like that"'. The participants' management of their own stress was a key finding as one participant stated 'I try really hard to not show any sort of reaction… I do my best to remain calm'. Another participant echoed her attempt at remaining calm when faced with her clients' externalising behaviours by 'ignoring the client and letting them have their tantrum and do whatever they want to do, as long as they aren't being violent…'. Another participant's response used to manage her frustration and the client's behaviour was to 'walk outside of the (counselling) room' leaving the client in the room alone and providing time for the participant to calm down and refocus. Further, a participant reported setting limits in sessions and remaining within those limits, stating 'I would try to set limits with the play room and give them three warnings…'. An alternative behavioural reaction involved one participant acknowledging the 'frustration' and using 'deep breathing' to cope during the session.

Another CT management technique reported involved the participant stating: 'I try to find something that I really like about that child and focus on that and use that to not have a negative attitude towards the session…' and 'I just empathize with them…'. Another participant similarly stated 'I try to see them as "okay, this is somebody's child, this is a piece of the family that struggling, and this is my opportunity"'. Other participants relied on deep breathing during the session for grounding: 'I do a lot of deep breathing, just trying to center myself' and using 'the breath' or 'drawing' in session to 'shift attention' when feeling frustrated with a particular client.

3.5.2 Counsellors' coping strategies after session

The participants implemented several CT management strategies to reduce the residual effects from the therapeutic sessions. For example, one participant mentioned using scheduling to cope as she stated: 'I think scheduling is important' as it provides time before and after particular clients to ensure the participant is ready to engage in another session. Another participant mentioned shortening how long they spent in session with the client as an important coping skill. The participant stated, 'instead of doing an hour, do 45 min and then 30 min just to see what they can and cannot handle because sometimes they're back there for too long'.

Planning was another major theme of coping. Several participants eluded to the importance of planning between sessions or using stress management techniques after or before sessions. One participant reported 'I usually plan more for those clients', while another reported planning alternative activities if needed. Another coping strategy involved a participant utilising 'pep talks' before initiating sessions.

Finally, several participants voiced their need to 'compartmentalise' client behaviour. One client elaborated: 'you do have to compartmentalise and just know that… you know, you did what you could for that session and you'll revisit it again next week… you just have to move on'. Another participant reported the need to maintain separation between work and their personal life. The participant stated: 'being able to kind of separate work from home and that kind of stuff, but yeah, I think it gets better with practice', as a way to allow themselves to reduce the negative effects of bringing work home. Another participant went further and stated 'I think it's important to just check your own emotional reactions to things and just think about *why* you're having that reaction'.

3.6 Theme 6: Hesitation/Seeking validation

There is limited literature on counsellors' negative feelings towards clients in counselling research, possibly due to the idea that it is difficult for counsellors to admit negative feelings towards clients as it causes dissonance between the counsellor's role as a helping professional (Kottler & Uhlemann, 1994). Although the difficulty of talking about their negative feelings towards clients or parents was not stated by any of the participants directly, our research team noticed a pattern of hesitation and stammering across all participants through their transcripts and in the audio recordings before answering questions regarding how the counsellors felt in session when their clients were acting a particular way. Additionally, the participants appeared to often seek validation after reporting how they coped or what they thought about their child clients, by continuously saying, 'You know?' before or at the end of their responses. For example, one participant sought validation after describing what is was like when the client entered the therapy room when she stated, 'It's kind of like inviting a bully in, you know?'; while another participant described her thoughts with hesitation before the client arrived attempting to connect to the interviewer, stating, 'Before the session I am, kinda, like, you know, I kinda hope they don't show up'. Sometimes the participants even began their responses with 'you know', appearing to need that confirmation of similar reactions before reporting their own experiences. For example, one participant said 'You know, wanting to get rid of them because that behaviour is unacceptable', as she discussed her feelings towards one client. Lastly, one of the participants

attempted to normalise the somatic and physiological responses of stress during sessions by continuous checking with the interviewer throughout their description: 'It's usually like a heat sensation. It's up through my core like from the stomach up to my chest, you know? Just kinda starts to whale, you know?' (Table 1).

4 DISCUSSION AND IMPLICATIONS

Based on the experiences shared during the individual interviews, the challenges of working with children exhibiting externalised behaviours in relation to therapeutic presence, therapeutic relationship, self-efficacy, and *residual burnout* were key concepts that emerged. All participants noted that working with this population affected them in some way and influenced their work with the current client or other clients throughout the day. Additionally, the experiences shared by all participants mirrored the Hayes (1995) structural theory of countertransference with specific emphasis on triggers, manifestations and management. Hayes (1995) developed a structural model of CT, which is used in clinical practice research to investigate and understand a variety of aspects of CT (Hayes, 1995). The structural theory of CT includes five aspects: (a) countertransference origins (i.e. counsellor unresolved conflicts); (b) countertransference triggers (i.e. client in-session behaviours, personality or content leading to CT); (c) countertransference manifestations (i.e. counsellor CT expressions, thoughts or feelings in session); (d) countertransference effects (i.e. counsellor CT response effects on therapeutic relationship and client outcome); and (e) countertransference management (i.e. ways counsellor manages and copes with CT). Hayes' (1995) structural theory of CT is important as it provides a path of the creation or origins of CT and its influences.

All participants reported feeling triggered by the client's behaviours exhibited in session and experiencing varying levels of manifestations of frustration, anger, low self-efficacy and exhaustion when they reported feelings of 'frustration' and 'anxiety', and being 'drained' and 'discouraged'. In addition to the internal manifestations of thoughts and feelings, all participants noted physiological sensations in the body such as 'my hands might tighten', 'I start to sweat', 'my throat is kind of tight', 'clenching my fists', or 'my heart was racing'. All participants noted the negative thoughts, feelings and body sensations were distractions and removed them mentally from the session with their client. Although a couple of participants were able to utilise positive coping or management skills such as awareness, reframing, positive client conceptualisation, and breathing to remain engaged and empathetic to the clients, the majority of the participants utilised management strategies that were not beneficial to the client such as ignoring the client, distraction from the session and client, leaving the client alone in the room or reducing session time due to not knowing what else to do. Additionally, all participants reported needing more information and training in their master's programmes and professional development to build competency in working with this population and increased self-regulation skills and space to process their triggers and manifestations. The findings of this study are similar to and support Linn-Walton and Pardasani's (2014) study examining helping professionals' feelings of dislike towards their clients, as the participants in their study emphasised engaging in non-helpful management strategies and were highly triggered by client behaviour or client personality in session.

The potential benefits of this study include greater insight into the experiences of beginning counsellors working with children exhibiting externalised behaviours, including their challenges and needs for working with this population. The experiences shared in this study highlight areas of need for better self-care for counsellors, new strategies for working with challenging populations and improved training for working with children exhibiting externalised behaviours in session. Findings from this study can contribute to enhancing counsellor training programmes to assist in developing coursework and internship-like experiences to improve counsellors' skills needed to serve challenging populations. Lastly, some participants noted their ability to remain aware of their own feelings and body sensations in relation to the client's behaviours and were able to reframe the experience in session to provide better insight into the client's life and feelings, thereby utilising CT in a positive way to enhance the understanding. Thus, this study has implications for using supervision to enhance counsellors' awareness of CT triggers and manifestations in session to enhance client conceptualisation and the therapeutic alliance (Hayes et al., 2011) and intercede before the counsellor engages in inappropriate management strategies. Additionally, this study can provide validation and support for other helping professionals struggling with challenging populations. Future studies could examine interventions to assist counsellors in managing CT in and out of session with similar or different populations. Other future studies could examine trainings within counsellor education to better prepare counsellors in training for working with challenging clients.

4.1 Limitations

Although the study findings aligned with Hayes' (1995) structural theory of CT during the analysis, no questions were asked to the participants, nor was there follow-up, regarding previous experiences that may lead to CT. Countertransference was not a part of the initial research question but emerged as a prominent theme throughout data analysis. Therefore, the origins of the CT are unknown due to the open-ended questions during the focus groups. Another limitation of the study is the lack of diversity in of the research team. All of the research team members have clinical experience working with children and externalised behaviours, thus leaving the potential for biases based on those experiences. Additionally, although there was cultural diversity among the child clients, the lack of racial and ethnic diversity of the research team and participants is a limitation due to the potential for limited interpretation of the child clients' behaviours. Therefore, a replicated study with a multicultural emphasis among the research team and participants is needed for future research.

Biographies

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