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Editorial By Philip Armstrong

I hope I find you all well and refreshed after your Christmas break and the Holliday season. Although the year has started off very well for ACA two disasters have over shadowed most things in Australia this month (February).

The season has started off tragically for many Australians with ongoing significant flooding in Northern Queensland and bush fires in Victoria. Many Australians have lost their homes and irreplaceable personal effects with an estimated 200 loosing their lives in fires. Many of these victims were children and young people who would have had little understanding of what was happening until the end. It is possible to reconcile with flooding in Northern Queensland as this is in the tropics and comes with the territory. Mother Nature is unpredictable and many of these regions have experienced many floods over the years. Having said that, these floods have been extreme with many areas being flooded multiple times over a short period of time causing much property damage. Fortunately there has been a minimal loss of human life in the floods primarily due to the locals being experienced and advanced warning through the weather bureau. There has been a significant loss in relation to live stock and crops which will have a major impact on incomes for farmers and locals who depend on the farming industry. Three people to date have lost their lives in the floods.

A national day of mourning was held on Sunday the 22nd of February.

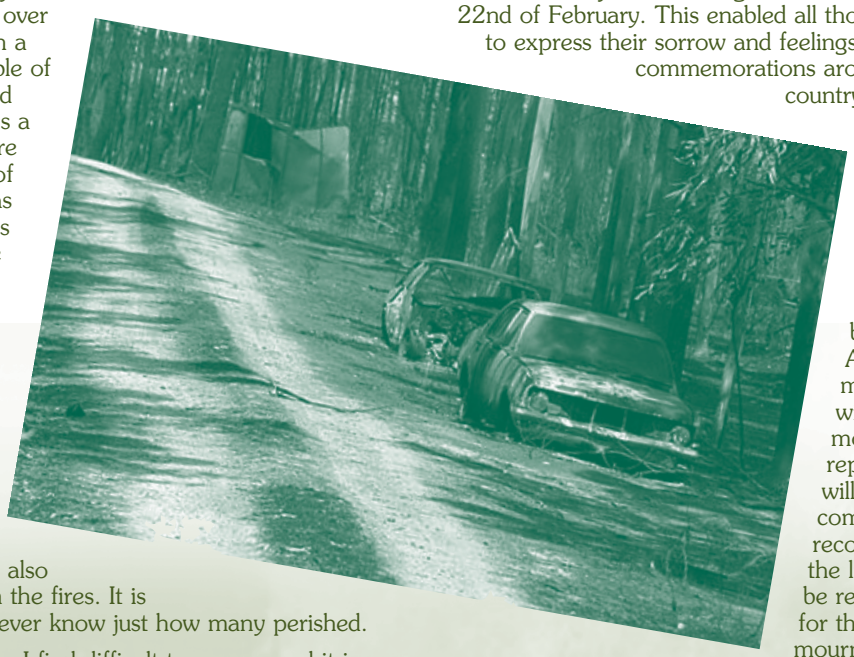
Unfortunately it is more difficult to reconcile the loss of human life in the bush fires where some of these were deliberately started by fire bugs. Mother Nature certainly did not help with record temperatures of 45 degrees (celcius) for many days leading up to the fires. Many of these areas were tinder boxes with extreme temperatures drying out much of the bush. The fires themselves were fanned by winds and continuing hot temperatures to the point where they evolved into fire storms. I can talk from personal experience that it is very difficult to imagine until you have been involved in a major bush fire just how dangerous it is. The speed a bush fire can move through the bush and tree tops is much faster than a human can run.

The radiating heat that comes from major bush fires can burn and drop a grown adult long before the flames engulf you. It can be impossible to shelter from the heat as enclosed spaces become ovens and bodies of water such as swimming pools boil. As a soldier I found myself fighting major bush fires with my first being in the Adelaide hills and last the Sydney fires of 2002. It is not until you experience at first hand the impact of the heat, smoke and speed of a bush fire can you understand how simple it is to become a victim regardless of well prepared you may think you are. Even though I have personally been involved in

fighting major bush fires it is difficult to even start to imagine the impact of facing the fire storms in Victoria as these were extreme. It is a testament to the Country Fire Authority that only one fire fighters was lost.

I have received some personal photos taken by people who lost everything in the fires except their lives. The one picture that really impacted on me was a car that was scorched by the fire. I have seen many houses and cars burned through bush fires but this was different. The glass in the windows of the car had melted with the wind shield melting to wrap itself around the steering column as though this was where it naturally belonged. The alloy wheels had also melted to become molten blobs of alloy under the car. The heat that would have been necessary to cause this would have been phenomenal. Many victims were found in the burnt out wrecks of their cars.

I simply cannot imagine being placed in a situation where I needed to make decisions for my and my family's safety by a fire travelling at over 60 kph and with a heat front capable of melting glass and alloy wheels. It is a miracle that there are any stories of survival. One has to also take ones hat off to all the fire fighter and emergency service workers who faced the fire head on to minimise the loss of life and damage to property. We also must not forget the animals that also lost their lives in the fires. It is unlikely we will ever know just how many perished.



The one question I find difficult to answer and it is one I have been asked by many and the media and that is "what motivates people to light fires in the first place". It is easy to fall back on what motivates pyromaniacs. However, the whole issue takes on a different perspective when it is people who know that lighting bush fires during heat waves are likely to end in the loss of life. It is a difficult question to answer and I would be interested in any one reading this column who would like to submit an article on the issue to do so.

To ensure that anyone who has been impacted on in any way has access to counselling services ACA has set up a Bush Fire register. The register is for the public to enable them to seek out free counselling services from counsellors who have experience in the area of trauma, grief and loss and critical incidents. All the counsellors who volunteered to be placed on the register have agreed to offer their services free of charge. Services range from face–to– face to phone services. There are strict criteria that counsellors must meet before being eligible to be placed on the register. One other area that has been of primary concern has been the impact of the fires on children.

Kids Helpline, Australia's premium phone counselling service for children have put on extra counsellors to answer calls from kids, parents, carers and other concerned members of the community. To facilitate Kids Helpline in delivering their vital services ACA in conjunction with a major sponsor, Counselling Academy, held a five day web based Mental Health Summit in the last week of February. The summit was a fund raising event with all monies going to Kids Helpline. Over $50,000 had been raised through the summit at the time of writing this editorial. I am sure this money will help Kids Helpline to deliver further services to those impacted on by the bush fires and Australian kids as a whole.

A national day of mourning was held on Sunday the 22nd of February. This enabled all those who needed to express their sorrow and feelings to attend commemorations around the country. I would like to extend condolences and best wishes to all those who lost family, friends, homes, pets and personal belongings from ACA and its members. Homes will be rebuilt and most property replaced, the bush will regenerate and communities will recover. However, the lives lost cannot be replaced and it is for these that we mourn the most. We can also offer thanks all those who fought the fires at the risk of their own lives and those who have since offered help in many ways from goods, services, money and simply by being there for those in need.

The one question I find difficult to answer and it is one I have been asked by many and the media and that is "what motivates people to light fires in the first place".

Philip Armstrong
Editor

ACA

Peer Reviewed

Alcohol Dependence: A Biopsychosocial Review for Practitioners

By Matthew Cornish BA (Hon) & Nadine Pelling, PhD

Abstract

Alcohol Dependence (AD) is a major concern with numerous individual, familial, and social consequences. Despite this practitioners and researchers hold various views regarding the diagnosis of, etiology concerning, and treatment for AD. In this review a summary of diagnostic criteria and biopsychosocial concomitants are presented. Due to space limitations various treatment approaches regarding AD are not discussed but will be presented in a companion article to follow later this year. Practitioners will find this review a helpful introduction to AD.

Introduction

Alcohol Dependence (AD) is a major concern in our society with 4.1% of the population in Australia (Proudfoot, Baillie, & Teesson, 2006) and 3.8% in the United States of America (Hasin, Bridget, & Grant, 2004) being diagnosed with AD. The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (American Psychiatric Association [APA], 2000) reports the current prevalence of AD to be approaching 5% of the general population. Alcohol related disorders, including AD and alcohol abuse, have been associated with a multitude of problems including emotional disorders, family dysfunction, homelessness, health problems, high arrest and incarceration rates, and economic costs associated with employee absenteeism and poor work productivity (APA, 2000; Babor, 1992; Graham & West, 2001; Helzer, 1987; Marsh & Dale, 2005; Polcin, 1997; Room, Babor, & Rehm, 2005; Saunders, 2006). Indeed, Rehm et al. (2003) demonstrated alcohol related disorders to be causally associated with over 60 different medical conditions, and involving not only quantity of alcohol consumed, but also patterns of irregular heavy drinking, in contributing to a global burden of disease. Accordingly, the social and economic cost of AD in Australia has been estimated to be $7.56 billion a year (World Health Organisation [WHO], 2004). These details highlight the magnitude of the difficulties associated with excessive alcohol consumption, borne at both individual and societal levels. AD is a complex disorder that shows resistance to treatment and is subject to relapse, thus practitioners need to be well informed regarding AD.

Examining the extant literature on AD there appears to be a number of discrepancies.

Examining the extant literature on AD there appears to be a number of discrepancies. First, it would appear that divergent opinion exists among researchers and practitioners alike with regard to

diagnosis, etiology, and treatment of AD (Helzer, 1987; Polcin, 1997; Saunders, 2006). Second, clinicians do not commonly practise what has been demonstrated to be effective in the current literature on treatment of AD. In addition, it has been demonstrated that AD is highly comorbid with other psychopathologies (e.g., Kushner, Abrams, & Borchardt, 2000; Lynskey, 1998; Petrakis, Gonzalez, Rosenheck, & Krystal, 2002), thus many clinicians, including those not specialising in substance use disorders, will be faced with clients presenting with alcohol related issues. Hence, the purpose of this review is to summarise the empirically supported biopsychosocial aspects of AD. Reviewing this information will enable practitioners to view AD diagnosis and treatment in a holistic manner. This review will present information on AD in a two part fashion including information concerning diagnosis and the biopsychosocial aspects of etiology or risk factors associated with AD. The various treatment approaches for AD will be reviewed in a following companion article.

Diagnosis

The main difficulty in conceptualising AD is deciding what will be included and excluded when defining the disorder. Issues pertaining to the definition of AD contribute to detection difficulties of AD, with many alcohol problems remaining undiagnosed, and receiving inadequate or no treatment (Polcin, 1997; Read, Kahler, & Stevenson, 2001; Saunders, 2006; Tam, Schmidt, & Weisner, 1996). In broad terms AD may be defined as "the repetitive intake of alcoholic beverages to a degree that harms the drinker in health or socially or economically, with indication of inability consistently to control the occasion or amount of drinking" (Keller, McCormick, & Efron, 1982, p. 20). However, definitions such as these have been criticized for not being precise enough for research purposes (Babor, 1992; Helzer, 1987). Narrow definitions have been advanced with greater specificity focusing on areas such as the amount of harm caused (APA, 2000), loss of the ability to control drinking (Jellinek, 1960), the amount and type of alcohol problems (Polich, Armor, & Braiker, 1980), and patterns of drinking (Rehm et al., 2003; Russell, Light, & Gruenewald, 2004), and yet these definitions have been criticized for not capturing the entire nature of the construct (Polcin, 1997; Rohan, 1982; Saunders, 2006). It appears as though definitional balance is in order.

Regardless of theoretical debate, the two foremost diagnostic tools available to both practitioners and researchers are the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)* (APA, 2000), and the *International Classification of Diseases (ICD-10)* (WHO, 1992). The APA (2000) recommends reference to the criteria for substance dependence when considering diagnoses of AD. The dependence syndrome is characterized by symptoms of physiological tolerance and/or withdrawal. Tolerance may be defined by either the need for a markedly increased quantity of the substance (i.e., alcohol) to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of alcohol (APA, 2000). Withdrawal is manifested by either a characteristic withdrawal syndrome, or alcohol is consumed to relieve or avoid withdrawal symptoms (APA, 2000). Indeed, Saunders (2006, p. 49) states that "dependence may be construed as an 'internal driving force' that results from repeated exposure to a psychoactive substance and which leads in turn to repetitive substance use which is self-perpetuating and typically occurs even in the face of harmful consequences." This statement, however, may be misleading and seem to excessively imply physiological symptoms are predominant in diagnoses of AD. The APA (2000), in addition to physical indicators of dependence, recognize that the features of quantity of consumption, control or lack thereof, time spent in activities associated with alcohol consumption rather than appropriate activities, social difficulties and occupational and recreational decline, and the continuance of drinking despite knowledge of its harms, are all essential criteria in decisions relating to the diagnoses of AD.

The variety allowed in the *DSM-IV-TR* diagnosis of AD, nonetheless reflects a single underlying construct (APA, 2000; Hasin et

This review will present information on AD in a two part fashion including information concerning diagnosis and the biopsychosocial aspects of etiology or risk factors associated with AD.

Alcohol Dependence: A Biopsychosocial Review for Practitioners (Continued)

al., 2004; Hasin, Muthuen, Wisnicki, & Grant, 1994; Langenbucher et al., 2000; Nelson, Rehm, Ustun, Grant, & Chatterji, 1999; Proudfoot, Baillie, & Teesson, 2006). To date the number of studies examining the validity of AD as a diagnostic construct has been greater within the framework of the *DSM-IV*, than that of research conducted with the ICD-10 system of classification. The *ICD-10* contains six main criteria for the diagnosis of AD, as compared to the seven criteria advanced in the *DSM-IV*. Nevertheless, in a comparative study of the two classification systems for substance dependence, Saunders (2006) concluded that both represent psychometrically robust measures, and that the differences are slight enough to not warrant major distinctions. In sum, the lone difference is that the *ICD-10* includes a cognitive item of craving as a category whereas the *DSM-IV* does not (Saunders, 2006).

Etiology

A review of the entire catalogue of information pertaining to the risk factors associated with the development of AD is outside the scope of the current review. Nevertheless, an examination of available literature has revealed a consistent range of biopsychosocial aspects relevant to the topic. Polcin (1997) suggests the substantial quantity of evidence in support of varying approaches to etiology has led to a general consensus that alcohol problems are multi-determined. Thus, it should be noted that the presence of one or more of the variables presiding within an individual does not necessarily lead to the development of AD. As with the determination of any behaviour, a multitude of variables must combine fittingly for said behaviours to occur. For example, the supported hypothesis of a genetic link to AD is not sufficient in itself to predict future alcohol problems, as there are many environmental and interpersonal factors to consider. As Tooby and Cosmides (2005, p. 34) state, "every single component of an organism is codetermined by the interaction of genes with environments." Thus, the etiology of AD is multidimensional and highly complex, containing biopsychosocial aspects.

As with the determination of any behaviour, a multitude of variables must combine fittingly for said behaviours to occur.

Biological Aspects

A review of the literature relating to the biological aspects of AD has shown to consistently note four main factors. These include genetic components, biochemical aspects, sex, and age.

Genetics. Strong evidence exists for a genetic diathesis in substance use disorders (e.g., APA, 2000; Beirut et al., 1998; Cadoret, Yates, Troughton, Woodworth, & Stewart, 1995; Merikangas et al., 1998). The extant literature discussing the genetics of AD increasingly supports the notion that there appears to be a genetic influence for at least some individuals with this disorder (Dick & Foroud, 2002; Heath, 1995; Kendler, Neale, Heath, Kessler, & Eaves, 1994; Oroszi & Goldman, 2004; Prescott & Kendler, 1999; Quickfall & el-Guebaly, 2006; Schuckit, 1987). This biological predisposition provides some support for the formulation of AD as a disease (Davies, 2003), being a fundamental tenet of the values underlying Alcoholics Anonymous.

The primary methods used to determine levels of genetic influence are twin and adoption studies. Essentially, twin and adoption studies examine shared genetic material while controlling for environmental influences. Twin studies have shown a greater likelihood that monozygotic (identical) than dizygotic (fraternal) twins will experience alcohol related issues if one twin has such problems, thus indicating a genetic component (APA, 2000; Heath, 1995; Kendler et al., 1994; Pickens et al., 1991). Adoption studies have also found an increase in the risk for AD when the offspring were adopted at birth into families with no alcohol related disorders (APA, 2000; Heath, 1995). In a review of the literature, Quickfall and el-Guebaly (2006) suggest the methodologies of these studies to be robust, well designed, and meticulously controlled in deriving estimates of heritability. However, they also note limitations including confined cultural sampling and subjective bias in the use of questionnaires to assess alcohol use histories. Nevertheless, it is suggested heritable factors play a 50-60% role in the development of AD (Quickfall & el-Guebaly, 2006), and it is apparent that the level of genetic liability is approximately equivalent for men and women. However, Kendler et al. (1994) point out that although women with a similar genetic predisposition to developing AD as men, they are less susceptible to the condition possibly due to greater gene-environment interaction at play to reach a risk threshold great enough to develop AD. Indeed, there seems to be stronger evidence that men are at a higher risk of developing AD as witnessed by genetic transmission from father to son (Prescott & Kendler, 1999; Quickfall & el-Guebaly, 2006; Schuckit, 1987). Nonetheless, the APA (2000, p. 221) suggests, "Higher risk is associated with a greater number of affected relatives, closer genetic relationships, and the severity of the alcohol-related problems in the affected relative".

Linkage and association studies search for the presence of chromosomal markers that occur with a higher than random distribution via the comparison of affected and non-affected individuals within families or other large groups (e.g., alcoholics and non-alcoholics) (Dick & Foroud, 2002). This field of research is interested in identifying explicit genetic regions of interest. While a specific gene (or genes) involved is yet to be found, some research suggests that a particular gene variant (A1 allele of the Dopamine D2 gene) is significantly more common in those diagnosed with AD than those not diagnosed (Blum et al., 1990). However, the general consensus among researchers is the existence of multiple gene interactions, each having a small effect (Quickfall & el-Guebaly, 2006). In addition, these genes seemingly contribute to the determination of neurotransmitter performance and enzyme activity.

Biochemical Research. Alcohol has widespread effects on the brain and can affect neurons, brain chemistry, and blood flow within the frontal lobes of the brain. Biological vulnerability to AD has been demonstrated via research revealing brain responses to alcohol involves changes in neurotransmission that play a role in maintaining drinking behaviour (Schuckit & Smith, 2000; Schuckit, Smith, & Kalmijn, 2004). Essentially, neurotransmitters influence the level of response to the intoxicating effects of alcohol. Decreased intensity of reaction to modest ethanol doses, decreased amplitude of certain brain waves of the event-related potential, and a different pattern of background cortical electroencephalograms all show a greater risk for developing AD (Schuckit, 1987; Schuckit et al., 2004). Schuckit and Smith (2000) suggest that low levels of response may predispose an individual to AD through reward reduction for a specific quantity of alcohol. In essence, the individual may progressively consume more in order to attain a state of intoxication in a cycle of physiological tolerance, and a need to further intensify the amount consumed. Arguably, chemical changes within the brain resulting from prolonged use of alcohol will find the brain striving for what it perceives to be equilibrium via the continuance of alcohol consumption (Helzer, 1987; Polcin, 1997). The net effect of these chemical imbalances is the appearance of depression, anxiety, and stress, which further exacerbates drinking behaviour. In addition, research has revealed differences in the biological makeup between the sexes and those of different age groups that may make an individual more prone to the development of AD (Russell et al., 2004).

Sex. The prevalence rate of AD is higher for males than females, with the male-to-female ratio as high as 5:1 (APA, 2000). This measured observation is ubiquitous in practically every culture (APA, 2000). Males tend to have a higher tolerance for the effects of alcohol due to biological composition consisting of higher percentages of body water, lower levels of body fat, and the ability to metabolise alcohol more rapidly (APA, 2000). Males may therefore experience decreased reactions from specific quantities of alcohol making it more likely to progressively consume more to develop tolerance. Thus, gender becomes an indicator for risk of developing AD. These gender ratio figures, however, can vary with age. Females tend to start drinking at a later age than males, but once AD develops in females the disorder apparently progresses more rapidly, known as telescoping (APA, 2000; Walitzer & Dearing, 2006).

This field of research is interested in identifying explicit genetic regions of interest.

Age. The APA (2000) reports the age at onset of AD to peak in the 20s to mid-30s, with the majority of those who develop alcohol related issues doing so by their late thirties. Research suggests that earlier the age of experimentation with alcohol, the greater the likelihood of developing later problems with alcohol (Bonomo, Bowes, Coffey, Carlin, & Patton, 2004; Marsh & Dale, 2005). Bonomo et al. (2004) found that teenage drinking patterns and other health risk behaviours in adolescence predicted AD in adulthood. Additional support comes from Oesterle, Hill and Hawkins (2004), who concluded from their research into adolescent heavy episodic drinking, that this style of drinking may pose significant long-term negative health consequences. Moreover, in a longitudinal study, Jennison (2004) found the short-term effects of binge drinking in college students posed significant risk factors for AD and abuse 10 years after the initial interview, in conjunction with evidence of academic attrition, early departure from college, and less favourable labor market outcomes. York, Welte and

Alcohol Dependence: A Biopsychosocial Review for Practitioners (Continued)

Hirsch (2004) found that men and lifetime pathological drinkers reported an earlier age at first drink than did, respectively, women or lifetime non-pathological drinkers.

Older persons may also be vulnerable to the development of AD. Age-related physiological changes in elderly people can result in increased susceptibility to the intoxicating effects of alcohol (APA, 2000). That is, brain changes, decreased rates of liver metabolism of alcohol, and decreased percentages of body water can cause older people to incur more severe levels of intoxication from lower quantities of alcohol consumption, and thus related problems (Merrill, Kraft, Gordon, Holmes, & Walker, 1990). Moreover, alcohol related problems later in life are also likely to be associated with other medical complications (APA, 2000; Merrill et al., 1990). Clinicians need be aware that many medical related issues in later life may imitate the symptoms of AD, thereby essentially masking the presence of alcohol related disorders.

Psychological Aspects

Psychological factors may include a need for relief of anxiety, ongoing depression, unresolved conflict within relationships, and low self-esteem. A review of the literature relating to the psychological aspects of AD has shown to consistently find four main factors of importance. These include cognitive functioning, emotional issues, comorbid disorders and personality.

The primary concern is that many individuals presenting with co-occurring diagnoses are often treated for psychiatric symptoms only and receive no specialized treatment for AD

Cognitive Functioning. Cognitive processes are critically implicated in the development of AD. Dodes (2002), citing research of Vietnam veterans and their ability to discontinue addictive behaviour outside of stressful wartime contexts, notes that addiction is a human issue that resides in people, and not the drug's ability to produce physiological effects. He deduces that "physical addiction is surprisingly incidental to the real nature of addiction" (Dodes, 2002, p. 77), and that a psychological drive is necessary to perform and continue addictive behaviour. Indeed, people's attitudes and beliefs are important (e.g., believing alcohol has many positive effects) in determining whether one will go on to develop AD. For example, Smith, Goldman, Greenbaum, & Christiansen (1995) found that for adolescents over a 2-year period, during which many first began to drink, expectancy of social facilitation and actual drinking experience influenced each other in a reciprocal manner. Higher expectancy of social facilitation from alcohol was related to higher subsequent levels of drinking. Additionally, cognitive distortions, including inaccurate social cognition, significantly predicted by childhood neurobehavioral disinhibition, in conjunction with psychological self-regulation, appear to demonstrate bias towards diagnosis of AD (Kirisci et al., 2004; Marsh & Dale, 2005).

Emotional Issues. Drinking to cope (e.g., emotionally) may predispose one to a future diagnosis of AD. Excessive consumption of alcohol may be used as a method to relieve unpleasant feelings of depression, anxiety and stress, over which the individual perceives themselves to be powerless. According to Dodes (2002, p. 4), "Virtually every addictive act is preceded by a feeling of helplessness or powerlessness. Addictive behaviour functions to repair this underlying feeling of helplessness. It is able to do this because taking the addictive action …creates a sense of being empowered, of regaining control – over one's emotional experience and one's life." In addition, research has found strong correlations between attention deficit hyperactivity disorder symptoms of impulsive, excitable, and novelty-seeking behaviours developed in the formative years and subsequent excessive drinking behaviour (e.g., Bates, 1993; Buckstein, 1995; Kaminer, 1994). High levels of aggression and evidence of conduct disorder in childhood and adolescence have also been confirmed as risks for the subsequent development of future AD (APA, 2000; Bates, 1993; Buckstein, 1995; Kaminer, 1994; Quickfall & el-Guebaly, 2006). It is uncertain, however, whether this correlation is causal or simply concurrent. Nevertheless, comorbidity should be noted.

Comorbid Disorders. AD has been associated with numerous other diagnoses including depression, anxiety, schizophrenia, and antisocial personality disorders (APA, 2000; Kushner, Abrams, & Borchardt, 2000; Lynskey, 1998; Marsh & Dale, 2005; Petrakis et al., 2002; Sher, Walitzer, Wood, & Brent, 1991). The foremost explanations proposed for AD comorbidities are causal in nature. That is, one condition creates an increased risk for the other. For example, the self-medication hypothesis proposes heavy alcohol and substance use may be an attempt to reduce undesirable symptoms (Kushner et al., 2000; Lynskey, 1998; Petrakis et al., 2002). Alternatively, it may be that AD, and associated social and interpersonal problems often caused by AD, places the individual at heightened risks of developing other disorders (Petrakis et al., 2002). Another theory proposes a shared etiological explanation whereby comorbidity may be the result of similar risk factors, or as an artifact of overlapping diagnostic criteria (Kushner et al., 2000; Lynskey, 1998). Regardless, the primary concern is that many individuals presenting with co-occurring diagnoses are often treated for psychiatric symptoms only and receive no specialized treatment for AD (Petrakis et al., 2002). Therefore, clinicians need to be aware of the implications for the treatment of individuals who present with disorders comorbid with AD.

Personality. Despite the painstaking search for a hypothetical 'alcoholic personality', the majority of investigations have failed to identify such a construct. Thus, there is widespread agreement refuting the existence of an 'alcoholic personality' (Bates, 1993; Polcin, 1997). Nevertheless, as seen with comorbid disorders, certain Axis II personality disorders, such as borderline and antisocial disorder, have demonstrated high correlations with AD (APA, 2000; Marsh & Dale, 2005; Verheul & van den Brink, 2005).

Sociological Aspects

AD may result as a response to social stressors. Indeed, it is well documented that social, environmental, and cultural factors play a role in the etiology of AD (APA, 2000; Polcin, 1997). Moreover,

Australian Centre for Grief and Bereavement

INTERNATIONAL EDUCATOR TOUR 2009

Dr. John R. Jordan, Ph.D.
Melbourne, Sydney, Canberra, Brisbane and Adelaide
23rd July – 7th August 2009

The Australian Centre for Grief and Bereavement is delighted to announce that Dr. John R. Jordan will be the 2009 International Educator.

Dr. John R. Jordan, Ph.D.

Jack Jordan is a licensed psychologist who specializes in working with loss and bereavement. As an ADEC Fellow in Thanatology and the Director of the Family Loss Project, Jack maintains an active practice in grief counselling in the Boston, MA and Providence, RI areas, with a specialization in work with suicide survivors. He is the Clinical Consultant for Grief Support Services of the Samaritans in Boston, the Professional Advisor to the Survivor Council of the American Foundation for Suicide Prevention, and a member of the International Workgroup on Death, Dying, and Bereavement. He was the recipient of the ADEC 2006 Research Recognition Award for his work in bringing together researchers and practitioners in thanatology. Jack provides training nationally through the American Academy of Bereavement, the American Foundation for Suicide Prevention, and the Suicide Prevention Resource Center. He has published clinical and research articles in the areas of bereavement after suicide, support group models, the integration of research and practice in thanatology, and loss in family systems. He is also the co-author of *After suicide loss: Coping with your grief.*

PROGRAM 1

21st Century Approaches to Grief Counselling and Therapy

This day will commence with a review of new perspectives in grief and loss, including the movement towards a new diagnostic category related to prolonged grief, new findings about the role of resilience in bereaved populations, the rethinking of the role of a continuing bond with the deceased and examination of the controversy about whether and for whom grief counselling is helpful. Dr. Jordan will then offer observations about the assessment of complicated grief and the key roles that grief counsellors can play for the bereaved.

TIME
9.30am – 4.30pm (both days)

COST PER DAY

Early Bird rate *(Registration by the 1st May 2009)*	**$220.00 per day**
Standard rate *(Registration after 2nd May 2009)*	**$250.00 per day**
Student rate	**$220.00 per day**
ACGB Member rate	**$200.00 per day**

Morning tea, lunch and afternoon tea provided

Registration closes 10th July 2009
(Registration is essential)

PROGRAM 2

Traumatic Loss: Bereavement After Sudden, Unexpected and Violent Death

This day will provide an overview and update on what we know about the impact of traumatic deaths such as suicides, homicides, and accidental deaths. Participants will also investigate new intervention models that are developing within the fields of traumatology and thanatology. While drawing primarily on the presenter's extensive experience working with survivors of suicide loss, the information presented will have wide applicability to work with people who have lost a loved one to any type of sudden or violent death. The workshop will be informed by research and clinical experience, and will include the use of didactic lecture, case discussion, audiovisual presentation and discussion with fellow workshop participants.

"Jordan is a consummate clinician, an approachable guy, an experienced trainer and an intelligent advocate and consumer of 'research that matters', being strongly disposed to bridging the worlds of science and practice"

- Robert A. Neimeyer, Ph.D., Department of Psychology, University of Memphis.

MELBOURNE
Conference Centre
Holmesglen College of TAFE
Cnr Warrigal and Batesford Roads
Chadstone VIC 3148
Day 1 - 23rd July 2009
Day 2 - 24th July 2009

SYDNEY
The Vibe Hotel
111 Goulburn Street
Sydney NSW 2000
Day 1 – 27th July 2009
Day 2 – 28th July 2009

CANBERRA
UCU Conference Centre
Building 1
Kirinari Street
University of Canberra
Bruce ACT 2617
Day 1 – 30th July 2009
Day 2 – 31st July 2009

BRISBANE
Mercure Hotel Brisbane
85-87 North Quay
Brisbane QLD 4003
Day 1 – 3rd August 2009
Day 2 – 4th August 2009

ADELAIDE
Ayers House
288 North Terrace
Adelaide SA 5000
Day 1 – 6th August 2009
Day 2 – 7th August 2009

If you would like to register or require any further information please contact the Australian Centre for Grief and Bereavement on (03) 9265 2100 or email info@grief.org.au

A detailed copy of our Programs and Services 2009 can be downloaded at **www.grief.org.au**

The Australian Centre for Grief and Bereavement is located at:
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Alcohol Dependence: A Biopsychosocial Review for Practitioners (Continued)

general consensus exists among researchers and practitioners as to the relevance these factors have in the development of AD. A literature review has revealed several factors associated with social aspects and the development of AD, including cultural factors, family and developmental issues, peer factors, and socioeconomic status.

Cultural Factors. The APA (2000, p. 219) states, "The cultural traditions surrounding the use of alcohol in family, religious, and social settings, especially during childhood, can affect both alcohol use patterns and the likelihood that alcohol problems will develop." Cultural factors include availability of alcohol and social acceptance of the use of alcohol. Those in cultures or social groups where heavy drinking is perceived to have minimal risk, a perception of high normative drinking, and indeed is accepted (e.g., those working in bars), are at increased risk of AD (Polcin, 1997). Social standards of alcohol consumption may partially explain some causal variability, whereby the prevalence of AD and problems correlates with the general level of alcohol use in a society (Hasin et al., 2004; Proudfoot et al., 2006; Room et al., 2005).

Those in cultures or social groups where heavy drinking is perceived to have minimal risk, a perception of high normative drinking, and indeed is accepted, are at increased risk of AD.

Family/Developmental Factors. Insecure attachment styles have been linked to a variety of psychological and behavioural complications in young people and adults, including alcohol related disorders (e.g., Caspers, Cadoret, Langbehn, Yucuis, & Troutman, 2004; Cooper, Shaver, & Collins, 1998; Rosenstein & Horowitz, 1996). Furthermore, severe family disturbance and dysfunction is implicated in the development of substance use disorders (Bellis, 2002; Goodwin, Fergusson, & Horwood, 2004; Molnar, Buka, & Kessler, 2001). Marsh and Dale (2005) suggest risk factors within the family environment may include having a fragile connection to the family unit and a lack of clear boundaries as a child. Additionally, as seen with the parental use of other drugs and substance use (e.g., Beman, 1995), the extent and consistency of alcohol use by parents may also predict problematic alcohol use of their offspring in the future (e.g., through the mechanisms of modeling, acceptability, exposure).

Peer Factors. Peer associations play an important role in the development of future AD (Goodwin et al., 2004). Peer networks can provide influential sources of support and reward. Sayette et al. (2004) found powerful effects of alcohol on group decision-making and suggests the application of social psychological theory and methods to the study of alcohol is warranted.

Socioeconomic Status. It has been suggested that higher levels of AD are associated with lower socioeconomic status, unemployment, and lower educational levels (Helzer, 1987). Such interpretations, however, should be made with caution, as it is difficult to separate cause from effect (APA, 2000). For example, Helzer (1987) points out that the variability may have more to do with the expression or ascertainment of the disorder, rather than the actual rate of occurrence. Indeed, status, or success, may be viewed as the wallpaper that covers up the cracks. Accordingly, Saunders (2006) would consign the higher status group to part of a substantial proportion of individuals that are not captured by current diagnostic criteria, and thus may never receive treatment.

Summary of etiological factors

In summation, many variables identified as risk factors interact with each other in determining the nature, onset and cause of AD. The APA (2000) suggests genetics play a significant role in determining future AD. A considerable part of the risk, however, comes from environmental or interpersonal factors that may include cultural attitudes to drinking and drunkenness, the availability of alcohol (including price), expectations of the effects of alcohol on mood and behaviour, acquired personal experiences with alcohol, and stress. Certainly, there is a greater likelihood of developing AD if a cocktail of risk factors are evident within an individual. Nevertheless, to facilitate the prescription of best practices regarding treatment and support for AD, knowledge of these various factors have become imperative for the clinician dealing with AD.

Conclusion

In conclusion, the development of AD that endures over time and across different contexts is shaped by a number of factors. Etiological theories of AD aim to address empirical questions concerning the underlying causes of this disorder. Despite the paucity of empirical evidence to support or refute the claims offered by proponents of disparate concepts of this disorder, the extant research provides an insightful and inspiring promise towards addressing this most complex of issues. As such, a biopsychosocial approach appears to offer the best method for identifying and treating AD holistically. The companion piece to this article will outline various treatments for AD also to be presented in a biopsychosocial manner.

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Peer associations play an important role in the development of future AD

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Despite the paucity of empirical evidence to support or refute the claims offered by proponents of disparate concepts of this disorder, the extant research provides an insightful and inspiring promise towards addressing this most complex of issues.

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Introduction to Motivational Interviewing used in a group approach to alcohol and other drug problems

By Dr. Jason M Dixon

Introduction to Motivational Interviewing used in a group approach to alcohol and other drug problems.

Motivational Interviewing (MI) is a client-centered semi-directive and evidence-based approach that has become widely used in the treatment of substance abuse and other psychological problems (Miller & Rollnick, 2002; Arkowitz, Westra, Miller & Rollnick, 2008). MI as a group approach has gained attention as a useful therapeutic intervention for substance abusing populations (Miller & Rollnick, 2002; Lincourt , Kuetell, & Bombardier, 2002; Anderson, 2001; Mattson et al., 1998; Foote et al., 1999).?This article is a brief introduction on how MI can be implemented in the group couselling context. Readers who are not familiar with small group dynamics should refer to Tuckman and Jensen(1977)for an overview of small group developmental stages and Corey (2008)for an in depth introduction to group counseling.

Group structure

Other group members are free to express the positive and negative aspects of their substance use and while maintaining a non-judgmental attitude toward other group members.

MI is based on Prochaska, Diclemente, and Norcross' (1992) transtheorectical Stages of Change model (SOC). In the SOC model clients are postulated to be at certain levels of readiness about behavioral change. These are *pre-contemplating* which is no insight or desire to change problem behavior, *contemplating* which is characterized by ambivalence over change for problem behavior, *preparing* which is characterized by concrete and near-future plans to change problem behavior, *action* which is characterized by implemented changed behavior, and *maintenance* which is continuing without the problematic behavior (Miller & Rollnick, 2002).

A series of therapeutic groups to match each stage of change can be implemented to resolve ambivalence, enhance group cohesion, and to create an environment for clients to move from one group to another. The core conditions of MI are:

1. Express empathy to understand the client's feelings and perspectives
2. Develop Discrepancy about where the client is and where he would like to be
3. Roll with resistance understanding that resistance is to be expected and not pathological
4. Support self-efficacy to enhance commitment and confidence to change

Counsellors adhering to the above mentioned therapeutic conditions assist clients to move to a new group and stage of change as they explore, develop, and resolve ambivalence over changing their substance use behavior and become 'ready' to progress to the next stage. Clients may need to move 'forward' or 'backward' through the groups as is as necessary.

Group MI process goals include creating an environment where rapport is established with the counsellor and other group members, 'change talk' is elicited and statements of commitment to change becomes manifest. It is important that what Miller & Rollnick (2002) calls the 'spirit' of MI become part of the group culture and that other group members approach the work that themselves and other group members do is with this attitude. In staying true to the spirit of MI the rules for all groups presented in this article create an environment where group members are collaborative, engage in a non-judgmental exploration of other members experiences with substance use, and autonomy for change remains with the individual group member.

The precontemplation group

The precontemplation group is suited to mandated, involuntary, and for clients who have no desire to change problematic behavior (Prochaska & DiClemente, 1982). The process introduced by the group counsellor includes encouraging group members to articulate the pros and cons of substance use in a semi-directive person-centered environment. One Technique that is appropriate at this stage is the *Decisional Balance* (Miller & Rollnick, 2002) exercise that clarifies the advantages and disadvantages of changing current substance use, and the advantages and disadvantages of continuing current substance use patterns. Working through the decisional balance is undertaken during group sessions and as a take-home assignment (see Herie & Watkin-Merek, 2006). Engaging in the decisional balance assists group members to develop discrepancy between how their lives could be and how they currently are if they maintain their current substance use behavior. Other group members are free to express the positive and negative aspects of their substance use and while maintaining a non-judgmental attitude toward other group members. In this stage the Counsellor will do well by using open questions, listening reflectively, affirming and supporting group member's work, and summarizing group member's experiences.

The group counsellor can provide harm reduction psychoeducational information to group members when appropriate. This could include printed information and/or dialogue on using substances more safely, identifying the risks of specific substances, substance use patterns, and resources to assist in preparing for withdrawal. It is essential that these resources be of good quality, easily understood and based on evidence from rigorous scholarly literature.

Each group member's stage of change is reassessed at the end of each session. Group members who are ready to move to the next group should be seen individually for a brief session to assist in debriefing from the group they are exiting, to prepare them for joining the next group, and to begin to explore the emerging ambivalence characteristic of the *Contemplation Stage*

The contemplation group

The primary focus in the *contemplation* group is to continue to develop discrepancy surrounding the problems associated with substance use (Miller &

Rollnick, 2002). Ambivalence should increase for members in this group. The group counselor engages members to assist each other in developing discrepancy while maintaining a non-judgmental and empathic environment. The main goal for the contemplation group is to assist members in resolving ambivalence. Eliciting *change talk* is the primary approach to assist members to resolve ambivalence. The Counsellor that elicits change talk models this behavior for other members to do so within the group. There are four kinds of change talk that clients can engage in:

1. Recognising the disadvantages of the status quo e.g. "Having black-outs and loosing my memory for three hours is serious!"
2. Recognising the advantages of change e.g. "I would not be belligerent if I didn't drink so heavily when things go wrong "
3. Expressing optimism about change e.g. "Now that I'm aware of what triggers my drinking I think I can avoid hitting the bottle so hard"
4. Expressing intention to change e.g. "This has got to stop or I will ruin everything!" (Miller & Rollnick, 2002)

A group member expressing intention to change is a good indication that they are becoming ready for the next group.

Group members that are reassessed on their readiness for the *preparation* group while taking care in avoiding premature decisions to engage in active behavioral change. Each group member's stage of change is reassessed at the end of each session. Group members who are ready to move to the next group should be seen individually for a brief session to assist in debriefing from the group they are exiting, to prepare them for joining the next group, and to begin to discuss preparing for and implementing action to change their substance use which is characteristic of the *preparation & action stage.*

The preparation & action group

In the previous groups members have engaged in enhancing the importance of and confidence in changing substance use. The preparation and action group is the starting point for group members to explore and strengthen commitment to a change plan and initiate the new behavior. The Counsellor is more directive toward group members by assisting them to identify problematic substance use situations and developing coping skills in response. Herie & Watkin-Merek's (2006) Structured Relapse Prevention (SRP) has much to offer and provides both take-home and in-group exercises including but limited to a weekly change plan exercise, a daily dairy format, situational confidence questionnaires. Although beyond the scope of this article, SRP offers a comprehensive package of techniques to address problematic scenarios and to enhance positive behaviors to enhance the overall well-being of group members.

Group members are free to explore failures and successes, present work from take-home exercises and encourage each other to enhance self-efficacy. Once members have gained sufficient confidence and a track record of their new behavior they are ready for the maintenance group.

The maintenance group

The emphasis of the maintenance group is self-help, encouragement and mutual support. Members are free to share successes and challenges of the new behavior they have implemented. Early detection of possible relapse is a goal of this group and that relapses are expected at this stage. Full relapse is an indication that a group member has cycled back through the SOC. A relapsing member may not cycle back all the way to the pre-contemplation stage, and so it is important to guide clients back to the group most suitable to their current SOC and an opportunity for work to continue with the client.

A word about harm reduction and abstinence

Harm reduction and abstinence approaches have been provided in the same clinical setting as an integrated harm reduction-abstinence approach (Futterman, Lorente, & Silverman, 2005). Group members can be attended to depending on their chosen treatment goals i.e. Reduction in use and risk minimised substance use or abstinence. Group members may change their goals from reduced use and harm reduction goals to total abstinence and vice versa. In all cases the client's autonomy and choice of treatment goals must be respected to stay true to the spirit of MI.

A group member expressing intention to change is a good indication that they are becoming ready for the next group.

A word about clients with enduring substance dependency and young people.

The group counseling approach presented in this article may be the best treatment for clients who have an extended history of failure to achieve abstinence after being treated with confrontational abstinence based approaches. These clients constitute an underserved population i.e. "the un-helpable client", and might best be served by an extended individual and group M.I. and a harm reduction psychoeducational program.

Adolescent and young adult clients who may tend to less likely abstain from substance use or comply with abstinence goals may also best be served through the M.I. group and harm reduction treatment modality. It should be noted that peer group forces and other drug culture forces in the adolescent and young adult stage of development might more often than not be unsuitable for abstinent based approaches.

Conclusion

Motivational Interviewing group counseling is an emerging treatment modality for clients with substance abuse and dependency issues. In this article group structure, goals, techniques and complementary modalities including integrated Harm Reduction and abstinence treatment goals and Structured Relapse Prevention has been presented. Attention has been given basic principles of MI group treatment. Suitability and implementation for special populations has briefly been addressed.

Introduction to Motivational Interviewing used in a group approach to alcohol and other drug problems (Continued)

Motivational Interviewing group counseling is an emerging treatment modality for clients with substance abuse and dependency issues.

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5. Written assignments/projects

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Basa Education and Counselling Services (BECS), is working in partnership with Results Training Australia a Registered Training Organisation (RTO # 60098) who will issue the Certificate IV in Counselling Supervision to those who demonstrate competency in this course."

AUSTRALIAN COUNSELLING ASSOCIATION (ACA)

The Australian Counselling Association (ACA), has approved and accepted this course as an appropriate accredited level of training for their counselling supervisors.

Essential entry criteria set by ACA - Extensive experience as a counsellor – clinical level practitioner with a minimum of 6 yrs experience and having a minimum of 100 of counselling supervision.

BOOKINGS AND ENQUIRIES

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The (69828) Certificate IV in Counselling Supervision is a self-directed learning program for experienced counselors interested in supervising other counselors.

Seven Steps for Giving Great PowerPoint Presentations By Angela Lewis

I have been giving PowerPoint workshops since PowerPoint was a pup, (so that means probably since the 1980s) and I still think it is a fantastic tool. However people are quick to criticise PowerPoint with derisive terms such as 'death by PowerPoint', however PowerPoint the product isn't to blame – it is how a person uses it.

Here's a quick suggestion list for how to make your presentations flow better and feel fresh, new and spontaneous.

1. Try to use as few slides as possible. What I hear you gasp….isn't it about showing off all my data? No it is not – the audience wants to feel special and engaged and they are more likely to feel that if you speak to them instead of fiddling with a mountain of slides. Use less slides and try to face and speak to the audience, even if you use cheat notes. And bonus - if you use less slides they are more likely to pay attention when you change to a new one as well.

Give the audience your handouts after the presentation is finished.

2. I'm sure you've heard this one before – don't read from the slide. Yes it is tempting to do that, but the way you can get around it is not to have every little detail on the slide – stick with key points and then flesh them out yourself during the presentation.
3. Don't cram too much onto the slide (see above), firstly because you'll want to read it and secondly because you don't want to exhaust the audience with too much data, which by the nature of you having too much on the slide will be difficult to read anyway. If you can't help it and have too much – well use another slide, talk about it or even use the whiteboard!

   Text Rules of Thumb:

   - Try for no more than 6 bullet points per slide.
   - If you are using numbers, use only one number per sentence as this helps the audience absorb the data.
4. You might like the 'Curlz' font and you may not like large fonts – however it isn't about you. Use legible fonts and font sizes because your goal is to communicate clearly. Test this out by sitting in the back row of the room where you will present and present to yourself just to be sure.

   Size Rules of thumb:

   - Body text between point size 28 to 34 with a bold font recommended if you need the colour of the text to stand out.
   - Heading size is defaulted to 44 and you should stick to around that size as well.
5. While Microsoft does make sound, animation and crazy pictures available to you, that does not mean you should have a transition, animation or sound on every slide. Be conservative when adding any of these elements – once or twice or randomly makes your work interesting. Having clapping, a bouncing title or zig zag bullet points at every turn is just plain annoying. Know your audience too – sometimes there is simply no place for animation or a duck hitting a computer on the head full stop, so save it for another time and another audience.
5. Engage with the audience – this means maintain eye contact, move around the room, use the whiteboard, vary your voice tone. If you are stuck staring at the back of someone's head while they repeat the words on the slide the chances are you will be texting or doodling instead of listening – why would it be any different for your audience?
6. Give the audience your handouts after the presentation is finished. If you give them out at the beginning you run the risk that they will not be as interested in listening to your presentation, as they will know all about it before you have begun or will be reading ahead and not even listening to you – which also makes you fair game for people jumping in with questions or tangents that you are intending to address later. You also risk confusion (or even boredom), if they have you reading the slide out loud, are reading it themselves on the screen and then reading it from the paper in their hands. Tell them you will give them a copy at the end and do so.
7. Just because you came with 25 slides doesn't mean you must show them. Presentations do go off track with questions and discussions (especially if you have engaged the audience) and sometimes a presenter finds they have lots of slides left but not much time. It makes better sense and makes you look more professional and less flustered if you simply skip some rather than racing through them at break neck speed.

Happy presenting!

ACA

Internet and Computer Resources By Angela Lewis

Welcome to a new year – my 10th I think with ACA!
Are you one of the many who use a flash drive or datastick (same thing, different name) these days? I mean, really, how can you resist – I have about 6 of them!
Hopefully you don't just yank the datastick out of the USB port, because that is not the right way and could end up ruining it.

There are actually a couple different ways you can do it with harming your datastick – just pick the method that suits you best. When you're ready to take your flash drive out, double click on the My Computer icon on your desktop and find the drive that your flash drive is listed under (It will usually be listed under a "Removable Disk" letter). Right click on that drive and choose **Eject**. You can then remove the datastick with no risks of ruining anything.

The second way (and this is the way I always do it), is to use your **Safely Remove Hardware** icon, located in your bottom system tray. Double click on that icon (it's a little green arrow with a little gray disk underneath it). Highlight the choice that says 'USB Mass Storage Device' and click on the **Stop** button. Next, find the entry for your flash drive and click on it so it's highlighted. Click OK. You will then see a little pop up window in the bottom of your screen telling you that it's now safe to remove the hardware. Once you see that, you can remove the datastick drive and go on your way. As you can see, both ways are very easy to do, but you need to make sure you do at least one of them, in order to keep your datastick safe!

Repetition Made Easy in Microsoft Word

Do you ever find yourself looking to repeat the last string of typing you did in Microsoft Word? Perhaps a phrase that needs to be repeated throughout a document or maybe it's a repetitious list of names. Instead of retyping or even copying and pasting, you could try this keyboard shortcut way.

Just place the cursor at the next insertion point where you expect to see the repeated text, hold down the Ctrl key and then press the letter 'Y' A copy of the text magically appears ☺.

Is there any way you can find out if your email address is being used on public Web sites?

Simply go to your favourite search engine, for example Google and type in your own email address. If your email address appears on any websites you will see a listing of those sites instantly. If your email address showed up on several different web sites, you might want to take a few seconds to think about all of the sites you visit. Do you do a lot of online shopping? Are you a member of any social networking sites? Do you sign up for newsletters, etc. regularly? If so, you were probably required to fill out some type of a form. It's a very common thing to do these days, but each time, you're running the risk of having your email address published on a public site.

www.123people.com. And while we are on the topic of checking out where your email address is being published, you can search for yourself and others and locate information such as images, email addresses, phone numbers, web links, news, documents, blogs, biographies, social networking sites such as MySpace or FaceBook.

You simply type the first and last name of the person you're looking for into the search field and then click on the gold arrow button. That will start your search. It will then search the Internet and compile all the results it found for that name.

The remainder of the websites presented this issue focus on the concept of group formation and dynamics as well as group counselling.

A good start on the topic can be made with this brief but succinct overview of counselling in groups, provided by the premier American library site Eric Digests. This article focuses on the key aspects of the subject without overwhelming the reader. http://www.ericdigests.org/1994/group.htm.

This very comprehensive resource for facilitation and group dynamics (plus many other interesting topics) is provided free of charge in a library format http://www.managementhelp.org/grp_skll/theory/theory.htm.

The **UCLA / School Mental Health Project** operates a clearinghouse link that provides a huge amount of free resource material. Click on this link http://smhp.psych.ucla.edu/qf/grpcounseling.htm and then follow the links to topics such as 'how to get the most out of group counselling', 'group counselling for people with mental retardation' and 'group counselling and psychotherapy.

Give the audience your handouts after the presentation is finished.

Or you may like to read an essay by Dr. Robert K. Conyne professor of counseling at the University of Cincinnati entitled, 'Understanding and Using Group Work' http://library.educationworld.net/a3/a3-42.html.

And for a completely different angle on group dynamics, take a look at Prada and Paiva's paper on creating a facsimile of group dynamics in the virtual environment, which makes for absorbing reading http://gaips.inesc-id.pt/gaips/shared/docs/prada-aisb2005.pdf.

Please note that all Internet addresses were correct at the time of submission to the ACA and that neither Angela Lewis nor the ACA gain any financial benefit from the publication of these site addresses. Readers are advised that websites addresses in this newsletter are provided for information and learning purposes, and to ensure our member base is kept aware of current issues related to technology.

AngelaLewis@optusnet.com.au.

In-Home Family Therapy Consultations By Dr John Barletta

Social conversation is made so family members experience me as friendly, approachable and down to earth.

For over 25 years in various professional roles I have seen countless parents and couples who have been concerned over a range of issues related to the mood, dynamics, connections and interactions in their family. Often most of the family members being discussed are absent from the session, for a variety of reasons, one of which is organising to have children or a spouse come to my consulting rooms during regular hours being cumbersome. This can disappoint and frustrate a therapist. In the beginning of my professional relationship with Dr Maurizio Andolfi from the Family Therapy Clinic in Italy (Accademia di Psicoterapia della Famiglia-Roma), I was reminded "therapy should be more like family life at home than a laboratory of research under a microscope" (Barletta, 2001). This prompted me several years ago to resume "home visits" (i.e., therapeutic consultations) for families.

Originally I learnt about the value of doing home visits in my work as a regional Guidance Counsellor (1991) with Brisbane Catholic Education. At times teachers or administrators would ask me to work with a child (with behavioural and/or emotional difficulties) and they invariably added, "Wait 'til you meet the parents then you'll know why the poor kid has problems!" This comment and the causal connection roused my curiosity as it embodied the notion of children reacting to the environment in which they found themselves. Although some colleagues cautioned me about being too keen for such house calls (e.g., professional distance; personal safety), I found it was an excellent way to enhance engagement, minimise reluctance, increase openness and facilitate a greater perspective of the real life of a family. It is this bigger picture of a family, by seeing where they live, how they connect and who does what in the home that helps build a more accurate sense of the climate and strengths of relationships. Although my work as a Family Therapist has a different focus to my previous work as a Guidance Counsellor, many of the principles and outcomes are similar.

Although experienced therapists will not need suggestions as to how to enter a family to begin professional work, given this area is idiosyncratic, I will explain how the process works for me.

To begin, I offer to visit the family in their home as a way of providing support on the continuum of care in a familiar context. Often I schedule visits in the early evening during the week or mid-morning Saturday, as these are frequently the most convenient for all involved, a time when all key members can be present and reasonably relaxed. All members of the family are informed I will be visiting and that we'll need at least 90 minutes together. Being punctual for such appointments is critical. Social conversation is made so family members experience me as friendly, approachable and down to earth. They choose where we sit that is most comfortable for a lengthy discussion, such as at the dining room table or in the lounge. At this early stage, as rapport is building, it is important I am seen as more than an affable visitor but not as an authoritarian intrusion.

I explain I am a Psychologist who specialises in working with people seeking better ways of

communicating and relating. I affirm what they are embarking upon in this consultation is a positive step in the development of the family, but I also caution our time together may get a bit tough as people will be encouraged to speak freely. Rules, boundaries and roles are then negotiated. I ask each person I have not met prior to the day questions like, "Do you know why your parents have been seeing me? What have you been told about my visit today? Why do you think I am here?"

Clarifying expectations and revealing unchecked assumptions is critical to allay anxieties and start the relationship authentically. I try to avoid colluding with parents by not focusing exclusively on their wishes expressed in previous contact. My goal is to facilitate the family's ability to experience each other in new ways and increase their openness to different ways of interacting. Consulting like this is clearly a great way for everyone to get to know each other better and I am always aware it is their collective issues need to addressed. Having everyone together gives the family the chance to all deal with the history, current situation and future plans simultaneously. The value in this consultation is the attention is on the family as a unit not with an "identified patient."

I am often pleasantly surprised that even young family members in this familiar context are empowered to speak directly about issues that are important to them in ways that go above individual conflicts and resentment, and allow them to feel and communicate in more mature ways. It is an opportunity for them to be reinforced in their learning about the link between choices, consequences and responsibility without feeling they are being chastised or lectured. These sessions almost invariably prompt expressions and acceptance of forgiveness as awareness increases.

My role in these family visits is as a catalyst, facilitator, collaborator and consultant not as diagnostician or psychotherapist and typically label myself to them as a "consultant to the family." I also remind them I am generally only connected to the family for a short time and it is each of them who is in it for the long haul. This is done to increase their openness, motivation and commitment. I believe it is paramount they see the resources, strengths and capacity they have to get the family back on track in my absence. Any therapist entering a family in crises must be careful not to destabilize or weaken the family.

To continue the process I ask what has been happening in the family to cause unhappiness and what members of the family would like to be doing differently? I have found it is important not to rush to set goals, but to spend as much time as necessary to allow everyone to feel they have had their say ("axe-grinding" included) before collectively agreeing where might be a useful direction to proceed.

There is a huge advantage in seeing a family in their own home. Being in their territory means there are a range of things I can take note of and use when helpful in the dialogue. This includes:

- Who answers the front door,
- What the family was doing when I arrived,
- Who offers me a drink (or the refill),
- Where we sit and the seating positions,
- How they take care of young children not participating,
- Whether pets are part of the household,
- What people do and say when we have a rest-break,
- Whether a ringing phone is answered,
- What people wear and how they present themselves,
- How the home is decorated (e.g., religious, sporting, cultural items),
- What the family plans to do when I depart, and
- Who walks me to the door or car and what is said.

My belief is a therapist who feels comfortable providing family therapy would be well-equipped to do home visits, provided there is a willingness to travel to clients, provide extended consultations and be part of the family unit in ways that are different from a traditional clinical setting (Note: The fee is quite costly for such a home visit). I have also found my training as a Mediator and Teacher has held me in good stead at times when it comes to decisions requiring members to consent to a new routine or to explain and model a technique that will help them move forward.

In the final stage of the meeting, developed plans are reviewed and an evaluation of the get-together is conducted. When concluding a family consultation I thank them all sincerely for allowing me into their home, I let them know that the family home is a very special place and to allow me visit has been my privilege. I also mention, as I do with most clients in my private practice, how I will continue to think about what has been discussed and the plans that have been made, asking if it is okay for me to write to them within a couple of days with additional ideas that I think might be additive. At times I also suggest they write to each other, if this emerges to be potentially useful. Occasionally, I will ask a parent if it is all right for one or more of the children to email me with some specific feedback about a strategy we discussed. This adds to the importance of the position of younger members in the system. I have never had a family, or individual, refuse these offers/requests for correspondence. Ongoing contact with the family, albeit for a brief period, shows my interest and concern, and increases responsibility and motivation for performing the plans discussed. I encourage them to have me return when they believe it would be additional help.

These sessions almost invariably prompt expressions and acceptance of forgiveness as awareness increases.

House calls are very useful, particularly for those who know family matters.

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Dr. John Barletta, Ph.D., MAPS, QAFT, a Clinical Psychologist and Family Therapist has consulting rooms at Grange (QLD) where he enjoys helping people with relationships (www.johnbarletta.com).

ACA

Counselling and the Cultural Grid of Intelligibility

By Aurelia Satcau

In a leftist vein, cultural theory coined the term 'grid of intelligibility' to incite exploration into a mechanism of shaping and re-shaping, constructing and de-constructing our very own view of the world – the way, that is, we make the world intelligible; and, more, how we end up believing it is an act of pure self-determination. These theorists' conviction is that nothing is ever left pristine, clean and authentic in our making and re-making of the image of the world today. In other words, our very act of representing and extracting meaning from the reality and the world around is consciously altered and deceiving and this is rather an effect of an all purposeful act. For us, counsellors, a question remains: how instrumental, how decisive becomes the counselor as teacher/facilitator/healer/confidant in shaping, altering or even generating client's view of the world, their Weltanschaaung. How much are we, counselors, responsible with the 'reality construction' which, ironically, our very clients end up dragging after them once they enter our consulting room?

How aware, then, is Counselling of the risk it takes in having to balance well two worlds – client's and counsellors's – colliding irreversibly sometimes, antagonistic and estranged, when cultural bias and sheer 'incompatibility' remain rampant and uncontained. But, reversibly, so is the risk of the two worlds collapsing onto each other, caught in the dangerous game of a symbiotic contract, all absorbing and all-embracing – a motherly embrace where infant's world is slowly disappearing into the vortex of womby waters: in an act of 'depersonalization' boundaries are lost and effaced in a long, maternal embrace.

Culture must be able to confer each group particularity enough to become distinctive and unique.

Yet. be it the painful segregation of the two, when client and counsellor simply can not adjust together (a 'cultural blockage'?) or, reversibly, the enmeshment to the point where the relation becomes dangerously (co)dependant, Counselling should rather remember the oath of loyalty to establishing healthy, clear-cut relationships between therapist and their client.

Abundant literature, starting with the 'mother-infant' bond, was dedicated to the loss of personal ground when two entities cannot differentiate between them – the client as the 'needy' infant with the counsellor as the 'Great Mother', engulfing and reigning supreme; or, vice-versa, with counsellor-infant extracting from their client all nourishment and bliss. Transference and countertransference are both alarm-bells especially in our world of loneliness and alienation of today.

Counsellor and client becoming dangerously one – that, it seems, was never emphasized too much. And yet, as I noted earlier, what happens when two worlds collide, torn apart, saturated with the impossibility to communicate and resonate with one another. Could it be 'culture', as perfect agent of distress inside counselling's most stable, genuine and enduring relation: the 'therapeutic alliance?' Then what chance is there to mend this chasm, opened when love, understanding, concern and interest are gone, or never were there, or they are rather invisible.

'Where are you from?', or 'What language do you speak at home?' – in the Australian cultural landscape of everyday communication these interogatives become rather household preoccupation with identifying the other, the different, the one in the alien zone. Unifying and 'homogenizing' of the human factor which are amongst Rogerian attributes of unconditional love, empathy and care are thus irreversibly lost on the agenda of some professionals. The failure to establish the integrity and continuity of communication marks the failure of therapeutically establishing an alliance – the therapeutic alliance. This question must be asked here: What preponderance may culture have in the occurrence of such inability and rift? Is there any possibility that cultural 'incompatibility' or 'ignorance' remain strong on the agenda of failed therapies? And if so, to what extent may culture become instrumental in understanding and catering for what makes a therapeutic instance work in the relation between counsellor and their client? But first, we must look for a definition of 'culture'.

What is 'Culture'?

There is a plethora of definitions of 'culture', all exhaustive in their attempt to extrapolate systems as vast as 'anthropology' and 'philosophy', to the more minute and immediate daily routine such as clothing, adornment and articulating language in the process of communication. Such expansion of the concept should not, however, disengage the need to operate structurally inside this conglomerate but in the last instance a simple list could just do the trick, showing 'culture' as the kaleidoscopic mega power it really is in our very lives: knowledge, values, beliefs, experiences, meanings and hierarchies; patterns of behavior, operative in rendering one (cultural) group distinctive from another; symbols and artifacts denominative of rites and practices as embodiment of culture as shared tradition and customs and vision of the world; communication, language, religion, sport, dreams, patterns of living, etc. Culture must be able to confer each group particularity enough to become distinctive and unique.

At the same time, culture represents the expression of a 'coded' language much the same with that of initiates, and whose deciphering again group people together around apparently mundanes such as food and colours, from religious practices and sports down to media constructing and maintaining all of the above. The notion of 'popular culture' comes into play here, showing how values, needs and interests of a society are captured inside a phenomenon such as 'mass consciousness' via a labyrinthine of corridors: literature, television, film, journalism, video-games, etc. These would, in turn, help create certain 'grids of intelligibility' responsible for much of people's shaping as social and relational entities, but as individuals as well. So much so, that counsellor taking up a new client find themselves instantly in the proximity of such colossal aggregate of patterns, tendencies, predispositions, potentialities and actualizations, more or less explicit, more or less manifested in the 'then' and 'there' of the counselling session. It is therefore important to remember the therapeutic relationship is a two-way street, where counsellors and clients alike bring together cultural material in an attempt to define who they are and who they become with each and every such encounter.

With strongly multicultural, multiracial macro-communities such as the American or the Australian, feeding of a network of practices and applications and with a definition of 'identity' rather hybrid and loose, it becomes inevitable that a significant power disbalance is manifesting at the interface of dominant/minority groups. It is therefore of great urgency that Counselling and Psychotherapy address this issues responsibly, but this cannot possibly manifest in practice unless a thorough and exhaustive theory of 'multiculturalism' permeates and informs the main discourse within this industry. Australia, unfortunately, does not seem to contribute much, as Counselling in this country, it must be said, suffers greatly at the hand of its own opacity to what makes Australia what it is: a deeply multicultural nation, with a unique demographic profile and thus a particular social and cultural environment. A substantial attitudinal shift has indeed been experienced in the last few decades in this country in regard to power games at the multiracial, multiethnic and multicultural levels, figuring strongly on mainstream social and political agendas. In the area of Counselling, however, this need to urgently address culturally appropriate helping interventions remains still an issue of good lectureship as in 'much is said but little is done', unless classical approaches to multiculturalism in Counselling such as Gerald Corey's and other American Counselling theorists', are once more unveiled and paraded as good, systematic theoretical ground, but with little practical implementation. Borrowing from the American model on the ground of strong similarity with the Australian social and cultural landscape, is no solution. It is my conviction that unless multiculturalism, with its ubiquitous, mercurial nature is engaged in major discussions on the past, present and future of the relation between Counselling and Culture in Australian cultural theory, the risk that Counselling may well become another oppressive instrument of our society deserves indeed attention.

It is the case that counsellors, from amidst their eternal bliss of a 'good listener', 'good Samaritan' , may well be tempted to ignore that what the very substance of this work lays bare is none other than the 'human factor', alive and kicking with their multifarious facets and in their kaleidoscopic presentation, with the uniqueness of a rich and enduring identity making the beauty of what is Australian, Australian indeed.

In Race, Culture and Counselling: The Ongoing Challenge (2006), Collin Lago cumulates four 'healing' functions in his holistic model of counselling, where 'dialogue', 'spirituality', 'medicine' and 'behaviourism' are four main venues of the great enterprise of 'healing'. 'Priests' and 'Spiritual Healers' (Spirituality), 'Counsellors' and 'Psychotherapists' (Dialogue), 'Doctors', 'Surgeons', 'Homeopaths', etc. (Medicine) and 'Behavioural Psychiatrists' (Behaviourism) all operate as reinforcers of a legacy where 'Wise Elders', 'Shamans', 'Witch Doctors' and 'Priests' of the past were embodying the generative term 'healers'. What we should read in Lago's model is the call to Counselling's role in advancing a rather 'transcultural' model apt to embrace multiculturalism best and address its ardent issues. Psychologists and therapists who can tap into the incalculable power stored in images, messages, modes of discourse, symbolism and iconography of popular culture benefit a reservoir of unlimited resource for growth, change and ultimately 'healing', argues Lago.

As cultivated behavior and the rich tapestry of a cumulative deposit of beliefs and values rather characterize the most precious of the therapeutic alliance – our client, we, professionals, should never underestimate the powerfulness of culture in the Multicultural Counselling paradigm. Borrowing from William A. Howatt's listing of multicultural issues and terminology only help exercise and develop awareness into this important area of research and practice – accommodation with the following conceptualizations may indeed add depth to any attempt at understanding 'culture' as an important 'inside' to the Counselling process: acculturation, ethnicity, race, ethnocentrism, ethos, minority, society, multicultural pluralism, pluralistic society, etc. Howatt quotes from Sue and Sue (1990): ìAs mental health professionals, we have a personal and professional responsibility to (a) confront, become aware of, and take action in dealing with our biases, stereotypes, values and assumptions about human behavior; (b) become aware of the culturally different client's world view, values, biases, and assumptions about human behavior; and (c) develop appropriate help-giving practices, intervention strategies and structures that take into account the historical, cultural and environmental experiences/influences of the culturally different clientî (Sue and Sue, 1990, in William A. Howatt, 2000, pg. 21). Howatt goes on to argue against the dangers of underuse of the health and social services agencies destined to attend ethnic and minority groups. This failure, he contends, must be explained by these providers' lack of expertise and ultimately disinterest in dealing with culturally 'different' populations. Issues of underuse and premature termination of therapy are to be related with a lack in sensitivity and understanding, to the extent that oppressive and discriminatory practices may result from working with culturally 'different' clients. But such misappropriation of Counselling, insists Howatt, is only the result of deficient cultural awareness and the need to adjust Counselling theory and practice to meet the special needs of diverse populations. (Howatt, op.cit., p.20).

A substantial attitudinal shift has indeed been experienced in the last few decades in this country in regard to power games at the multiracial, multiethnic and multicultural levels, figuring strongly on mainstream social and political agendas.

And if American Counselling landscape may appear to the innocent desert-like and problematic, while our Australian, a little gem of a precious 'melting-pot', robust and freshly breathing the air of cooperation and cohabitation, we should rather think twice.

Aurelia Satcau, Melbourne, 2009

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Aurelia Satcau is a Counsellor, Cultural Theorist and Author. She has academic degrees in Philology, Literature, Cultural Studies & Film Theory, Counselling and Education.

Register of ACA Approved Supervisors

NEW SOUTH WALES					
Cate Clark	Albury	02 6041 1913 or 0428 411 906	Grad Dip, Mental Health, Supervisor	$75	Face to Face, Phone, Group
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Jennifer Cieslak	Bathurst	02 6332 4767	Mast. Couns., Grad Dip Couns, Supervisor Trng	$77	Face to Face, Phone, Group
Patricia Newton	Dee Why/ Mona Vale	02 9982 9988 or 0411 659 982	RN, Rmid, Grad Dip Couns, Cert CISMFA Trainer, Cert Supervision	$100	Face to Face & Group
Carol Stuart	Bondi Junction	02 9387 7355	Dip. Prof. Counselling, Supervisor Trng, Workplace Trainer	$88, $70 (conc.)	Face to Face, Phone
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Lyndall Briggs	Kingsgrove	02 9554 3350	Dip. Clin. Hypno., Clin Supervisor,Master Practitioner of NLP, Dip. Nutrition, Cert. IV Workplace Training & Assessment	$66	Face to Face, Phone, Group, Skype(Web)
Erica Pitman	Bathurst	02 6332 9498	Supervisor Training (ACAP) Adv Dip App Soc Sci (Counselling) Reg. Mem, PACFA, Clinical Mem. CAPA, Cert IV Workplace Training	$85	Face to Face & Phone
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Samantha Jones	Lindfield	02 9416 6277	Clinical Hypnotherapist, Supervisor Trng	$90 Ind, $40 Grp	Face to Face, Group (2hrs)
Lidy Seysener	Mona Vale	02 9997 8518	Cert Couns & Psychotherapy Prof Sup (ACCS), Masters NLP	$150	Face to Face, Phone, Group
Gordon Young	Manly	02 9977 0779	Dip Hypnotherapy, Dip Couns, NLP Trainer, BA (Hons). Supervisor training	$77	Face to Face, Phone, Group
Brigitte Madeiski	Penrith	02 4727 7499	Dip Prof, Couns. Dip Womens Dev, Dip PSC, Superv. Trg (AIPC)	Neg.	Face to Face, Phone, Group
Sue Edwards	Alexandria	0413 668 759	Dip Prof Couns, Supervisor Trg (ACCS), CMCCA, CPC, Dip Bus Admin, Cert Train & Asses.	$88	Face to Face, Phone, Group
Patriciah Carley	NSW	02 9606 4390	Dip Couns., Dip. Cl. Hypno, Supervisor, Mentor, EN NLP	$90	Face to Face
Elizabeth Lodge	Silverdale	02 4774 2958	Dip. Coun, Dip. Psych, Dip. Hyp	$70	Face to Face, Phone, Group
Grahame Smith	Singleton	0428 218 808	Dip Prof Counsel (Workplace)(Realationships), Dip Career Guidance, Supervisor Training (AIPC), Cert IV Training & Assessment	$66	Face to Face, Phone, Group, Web
Donald Marmara	Sydney	02 9413 9794	Somatic Psych. Cert. Dev. Psych	$120	Face to Face, Phone, Group
Dr Randolph Bowers	West Armidale	02 6771 2152	PhD., Med Couns. CPNLP,GCHE, BA,CPC, CMACA, RSACA	$80	Face to Face, Phone, Group
Jacqueline Segal	Bondi Junction & Castle Hill	02 4566 4614	MA Applied Science, Supervisor Trg (AIPC)	$120	Face to Face, Phone, Group
Karen Daniel	Turramurra	02 9449 7121	Expressive Therapies & Sandplay Therapy, Supervisor. Traing., (ACCS)	$90 1hr/$150 2hrs	Face to Face
Rod McLure	Bondi Junction	02 9387 7752	Supervisor Training (ACCS), Psychotherapist	$110	Face to Face, Phone, Group
Brian Edwards	Forresters Beach	0412 912 288	B. Couns UNE, Dip Counselling	$65	Face to Face, Phone, Group
Brian Lamb	Hamilton	02 4940 2000	B Couns, Supervisor Training	$88	Face to Face, Phone, Group
Roy Dorahy	Hamilton	02 4933 4209	Supervisor Training	$88	Face to Face, Group
Lorraine Dailey	Maroota	02 9568 0265	Masters Applied Science Supervisor Clinical	$90	Face to Face, Phone, Group
Heidi Heron	Sydney	02 9364 5418	CMACA, BA Psych (Hons), PsyD Psych, NLP Trainer, Clinical Hypnotherapist, AIPC Supervisor	$120 ind/ $75 grp/2 hrs	Face to Face, Phone, Group, Web
Michael Cohn	NSW	02 9130 5611 or 0413 947 582	B.Com, LL.B, Grad Dip Couns (ACAP), Master Couns (UWS)	$100	Face to Face, Phone, Group
Deborah Rollings	Sutherland	0404 884 895	BA (Social Work)	$90	Face to Face, Phone, Group
Leon Cowen	Lindfield	02 9415 6500	M.Adult Ed, BA, B.Ed, Cert IV (train), Cert Supervisor: Cert. Counselling, A.D.C.O.,Clinical Member A.A.R.C & Clinical Member AHA, Accredited Marriage and Family Counsellor - Therapist - Supervisor & Trainer	$150	Face to Face, Phone, Group
Sandra Rutledge	NSW	02 4446 0452	CCC Supervisor training	$77	Phone
QUEENSLAND					
Christine Perry	Albany Hills & Beerwah	0412 604 701	Dip. T., B. Ed. MA Couns, Cert IV Ass & Work Trng	$66	Face to Face
Carol Farnell	North Maclean	0410 410 456	B Psych (H), B Bch Sc	$100	Face to Face, Phone, Group
Rev. Bruce Lauder	Fitzgibbon	07 4946 2992 or 0437 007 950	Bach Theology	$75	Face to Face, Phone
Myra Cummings	Durack/Inala	0412 537 647	Dip Prof. Couns. Prof. Supervisor Training (AIPC)	$66	Face to Face, Phone
Cameron Covey	Eumundi	07 5442 7107 or 0418 749 849	Grad Dip. (Couns.), BA (Beh.Sci), Prof. Sup (AIPC)	$88 Org $66 Ind	Face to Face, Phone, Group
Judy Boyland	Springwood	0413 358 234	Dip Prof Couns., Supervisor Trg (ACCS) Cert. Reality Therapist, M Ed	$75	Face to Face, Group
Philip Armstrong	Grange	07 3356 4937	B. Couns., Dip Psych, SOA Supervison (Rel Aust)	$88 Ind $25 Grp	Face to Face, Phone, Group
Bob Pedersen	Hervey Bay	0409 940 764	Dip. Pro.Couns., Dip. Chr. Couns.	Neg.	Face to Face, Phone, Group
Gwenda Logan	Kallangur	0438 448 949	MA Couns., B. Soc Sc., IV Cert Workpl Ass & Trng, JP (C/Dec)	$100	Face to Face, Phone, Group
Boyo Barter	Wynnum & Coorparoo	0421 575 446	MA Mental Health, Post Grad Soc Wk, BA Wk, Gestalt	$80 to $95	Face to Face, Phone, Group
Beverley Howarth	Mitchelton	07 3876 2100	Dip Prof. Healing Science, CIL Practitioner	$120	Face to Face, Phone, Group
Kaye Laemmle	Bundall	07 5570 2020	Dip Prof. Couns., Bac.Soc.Sci. Counselling, Realationships & Communication, SOA Supervision (Re.Aust)	$85	Face to Face, Phone, Group
Dr. David Kliese	Sunshine Coast	07 5476 8122	Dip. Prof. Couns. Prof. Sup (AIPC), Dip Clin Hyp.	$75	Face to Face, Phone
Dr. John Barletta	Grange	0413 831 946	PhD, Psych Board Accreditation, Grad Dip Couns, Registered Psychologist	$130	Face to Face
Yildiz Sethi	Hamilton	07 3862 2093	B.Ed. Grad Dip Couns, Dip Hypnotherapy, B Ed, Grad Dip Couns, Dip Hypnotherapy, NLP Pract, Family Constellations, Brief Therapist, Prof. Sup, Educator ACAP	$80 Ind $40 Grp	Face to Face, Phone, Group
Dawn Spinks	Birkdale/Capalaba	0417 633 977	BA Hons (Psych & Education), MPH, MACA (Clinical)	$110	Face to Face, Phone
Dr. Jason Dixon	Grange	0416 628 000	PhD, M.Soc.Sc (COUNS), Cousellor Education and Supervision/Community Mental Health Counselling	$121	Face to Face, Phone, Dist (via video conferencing)
Dorothy Rutnarajah	Point Vernon	07 4128 4358	Master of Counselling	$110	Face to Face, Group
Catherine Dodemont	Grange	07 3356 4937	B SocSci (ACU), Mcouns, ACA accredited Supervision Workshop, TAA40104, Pre-Marriage Educator (Foccus), CMACA	$95	Face to Face, Phone, Sml Group, Long Dist, Phone
Edward Riley	Hope Island	07 5530 8953	B.Ed. MPA, Grad Dip SocSci (Counselling), MA, Clinical Membership, QAFT	$80	Face to Face, Phone, Group
Roni Harvey	Springwood	07 3299 2284 or 0432 862 105	Master Counselling, Dipl Appl Sci Comm & Human Serv, Cert IV Workpl Ass & Tray, JP skype	$70	Face to Face, Phone, Group
Alison Lee	Maroochydore	0410 457 208	Masters Gestalt Therapy	$100	Face to Face, Phone, Group

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
QUEENSLAND					
Lyn Baird	Maroochydore	07 5451 0555 or 0422 223 072	GD Counsell, Dip Psych, SOP Supervision, Ma Soc.Sc (Pastoral Counselling), RN, Dip CCFT, Cert IV TAA	$77	Face to Face, Group
Sharron Mackinson	Caboolture	07 5497 4610	Dip Couns, Dip Clinical Hypnotherapy, NLP Pract, Cert IV WPA&ST	$80 Ind $25 Grp	Face to Face, Phone, Group
Frances Taylor	Tanah Merah	07 3388 1054 or 0415 959 267	Dip. Prof. Couns., Dip Clin Hypnosis, Dip Multi Addiction	$70	Face to Face & Phone
VICTORIA					
Deborah Cameron	Albert Park	03 9893 9422 or 0438 831 690	M.Couns (Monash), SOA Supervisor Training, M Spec Ed (Spnds) (Deakin) B.A/ (S.Sc) (Deakin)	$99	Face to Face, Phone, Group
Claire Sargent	Canterbury	0409 438 514	BA Hons Psychologist	$110	Face to Face, Phone, Group
Veronika Basa	Chelsea	03 9772 1940	BA Dip Ed., MA Prel Ling., Dip Prof Coun., Supervisor Trng	$80 Ind $35 Group	Face to Face, Phone, Group
Miguel Barreiro	Croydon	03 9723 1441	BBSc (Hon) Psychologist	$90	Face to Face, Phone, Group
Carol Moore	Old Reynella	08 8232 7511	Dip. Prof. Couns. B. Bus HRD, Prof Supervisor	$99 Ind $35 Grp	Face to Face, Phone, Group
Carol Hardy	Highett	03 9558 3980	Dip App Science (Couns) Grad Cert Bereavement Cert IV Asst & W/place Training & Adv Dip SO Therapy, Prof Supervisor	$75	Face to Face, Phone
Geoffrey Groube	Heathmont	03 8717 6953	Dip. Prof. Couns., Prof. Supervisor Trg (AIPC)	$75	Face to Face, Phone, Group
Elena Zolkover	Hampton	03 9502 0608	ACA Supervisor, Loss & Grief Counsellor, Adv Dip Couns Swinsburn, BSW Monash	$80 Ind $20 Grp	Face to Face, Phone, Group
Molly Carlile	Inverloch	0419 579 960	RN, B.Ed. Stud., Dip Prof Couns, Supervisor AICD Dip	$100	Phone
Berard Koe	Keysborough	0403 214 465	Teach Cert, BA Psych, MA Past Couns.	$70	Face to Face
Hans Schmid	Knoxfield	03 9763 8561	Dip. Prof. Couns. Prof. Superv. Trg. (HAD)	$70	Face to Face, Phone
Sharon Anderson	Nunawading	03 9877 3351	Registered Psychologist	$90	Face to Face, Phone, Group
Sandra Bowden	Rowville	0428 291 874	Dip. Prof. Couns., Prof. Supervisor Trg (ACCS)	$60	Face to Face & Phone
Judith Ayre	St Kilda East	03 9526 6958	Dr Coun & Psych, Dip Clin Hyp., Gr.Dip Coun., Gr.Dip Conf. Res., B.A.	$70	Face to Face
Barbara Matheson	Narrewareen Ferntree gully	03 9703 2920 or 0400 032 920	Dip. Appl Sc (Couns.) AAI, Prof. Sup (ACCS)	$70 Grp $20 Discnt for FVC membs	Face to Face, Phone, Group
Rosemary Caracedo-Santos	Ocean Grove	03 5255 2127	Dip Prof Couns, Cert IV Health Clinical Hypnosis	$66 Ind $35 Grp	Face to Face & Phone
Joanne Ablett	Phillip Island	03 5956 8306	M Counselling, Back Ed, Dip & Adv. Dip. In Expressive Therapies, Prof Spvsr	$80	Face to Face, Phone, Group
Zoe Krupka	Seddon	0408 880 852	Cert Prof Supervision	$100	Face to Face, Phone, Group
John Hunter	Kew East	03 9721 3626	Bach Counselling, Supervisor Trg	$100	Face to Face, Phone
Christopher Caldwell	Sassafras	03 9755 1965	Reg Psych	$90 Ind $30 Grp	Face to Face, Group
Donna Loiacono	Nunawading	03 9877 3351	Reg Psych	$90	Face to Face, Phone, Group
Graeme Riley	Gladstone Park	0423 194 985	Master of Ministry; Graduate Diploma Pastoral Counselling; Diploma of Ministry; Clinical Pastoral Education (1891,1988,1987)	$75 Ind $100 Grp	Face to Face, Group
SOUTH AUSTRALIA					
Dr Odette Reader	Norwood	0411 289 869	Cert IV Training & Assesment, Adv Dip TA	$110	Face to Face, Phone, Group
Kerry Cavanagh	Adelaide	08 8221 6066	B.A. (Hons), M. App. Psych.	$130	Face to Face, Phone
Adrienne Jeffries	Erindale	0414 390 163	BA Social Work, Dip Psychosynthesis	$100	Face to Face, Phone, Group
Moira Joyce	Frewville	1300 556 892	B. App Sc (Soc Wrk), Cert Mediation, Cert Fam Ther, Cert Couple Ter, Supervisor Trng	$100	Face to Face, Phone, Group
Anne Hamilton	Gladstone	08 8662 2386 or 0416 060 835	RN, RPN, MHN, Grad Dip H Counselling, Supervisor (ACA), Master NLP, Coaching and Timeline Therapy	$90	Face to Face, Phone, Group
Dr. Nadine Pelling	Adelaide	0402 598 580	M.A. Ph.D Psychologist & Counsellor	$100	Face to Face, Phone, Group
Maurice Benfredj	Glenelg South	08 8110 1222	Grad Dip Hlth Couns, Dip Couns and Comm, Adv. Dip. Appl. Soc Sc, Bed, MA	$90	Face to Face, Phone, Group
Carol Moore	Old Reynella	08 8232 7511	GradDipSocSc(Couns); B Bus (HRD; Dip.Prof.Couns.Prof Super Trg.	$99/hr Ind $35/2hr Grp	Face to Face, Phone, Group
WESTERN AUSTRALIA					
Christine Ockenfels	Lemming	0438 312 173	MA. Couns., Grad Dip Couns. Dip.C. Couns. Sup Trng (Wasley)	$66	Face to Face, Phone
Dr. Kevin Franklin	Mt Lawley	08 9328 6684	PhD (Clin Psych), Trainer, Educator, Practitioner	$100	Face to Face
Carolyn Midwood	Sorrento/ Victoria Park	08 9448 3210	MA. Couns. NLP, Sup Trg, Dip Prof Couns. Cert IV Sm Bus Mgt	$110	Face to Face, Phone, Group
Eva Lenz	Fremantle	08 9418 1439	Adv. Dip. Edu. Couns. M.A., Religion, Dip Teach	$80 $60 Con HltCareCrd	Face to Face, Phone, Group
Lillian Wolfinger	Yokine	08 9345 0387	Professional Supervision	$60	Face to Face, Phone
Beverley Able	Scarborough	08 9341 7981 or 0402 902 264	Registered Psychologist	$110	Face to Face
Deidre Nye	Gosnells	08 9490 2278 or 0409 901 351	Supervisor Training	$80	Face to Face, Phone, Group
John Dallimore	Fremantle	0437 087 119	COA Of Supervision (CCC) B. Couns B. Appl. Psych	$90	Face to Face, Phone, Group
Hazel Jones	Currambine	08 9304 0960	Supervisor Training	$Neg	Face to Face, Phone, Group
TASMANIA					
David Hayden	Howrah	0417 581 699	Dip Prof Counselling, Supervisor Trg (AIPC)	$80	Face to Face, Phone, Group
NORTHERN TERRITORY					
Rian Rombouts	Parap	08 8981 8030	Dip Mental Health, Dip Clin Hypno, Supervisor Trg	$88	Face to Face, Phone
Margaret Lambert	Brinkin	08 8945 9588 or 0414 459 585	Dip.T, B.Ed, Grad.Dip.Arts, Grad.Dip.Psych., B. Beh.Sc.(Hons).	$80 Ind $130 Grp	Face to Face, Phone, Group
ACT					
Brenda Searle	Canberra/Region	02 6241 2765 or 0406 370 302	Grad Dip of Community Couns., Adv Cert of Clinical Hypnotherapy, Dip of Prof.Couns, Supervisor Trg (AIPC)	from $50 to $80 (nego)	Face to Face, Phone, Group
SINGAPORE					
Hoong Wee Min	Singapore	65 9624 5885	MA Social Science, Supervisor Trg	$100	Face to Face, Group
Laurence Ho Swee Min	Singapore	65 9823 0976	Masters of Arts (Applied Psychology), Grad Diploma in Solution Focused Brief Therapy,	$70-$90	Face to Face, Group

Want to be Published? Then submit an article to Counselling Australia

CONTRIBUTOR'S GUIDELINES

Why? Get publishing points on the board, being published is part of most career advancements for professional counsellors/psychotherapists, particularly those who wish to advance in academia. All peer reviewed articles are eligible for OPD points and publishers can claim on their CV's to have been formally published.

Counselling Australia is now calling for articles and papers for publication. Counselling Australia is a peer reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285). Counselling Australia is designed to inform and discuss relevant industry issues for practicing counsellors, students, and members of the Australian Counselling Association. **Note publishing dates:** The journal is published quarterly every March, June, September and December.

Counselling Australia has an editorial board of experienced practitioners, trainers and specialists. Articles are invited to be peer reviewed and refereed or assessed for appropriateness by the editor for publishing. Non-editorial staff may assess articles if the subject is of a nature as to require a specialist's opinion.

Authors are to notify the editor if their article has been published prior to submission to Counselling Australia.

Editorial Policy

Counselling Australia is committed to valuing the different theories and practices of counsellors. We hope to encourage readers to submit articles and papers to encourage discussion and debate within the industry. Through contributions we hope to give contributors an opportunity to be published and foster Australian content. To provide information to readers that will help them to improve their own professional development and practice. Promote to readers the Australian Counselling Association and its commitment to raising the professional profile and status of Counsellors in Australia.

Previously Published articles

Articles that have been previously published can be submitted as long as permission for reprint accompanies the article.

Articles for peer review (refereed).

- Submitted with a covering page requesting a peer review.
- The body of the paper must not identify the author
- Two assessors who will advise the editor on the articles appropriateness for publication will read refereed articles.
- Articles may be returned for rewording, clarification for correcting prior to being accepted.
- Attach a separate page noting your name experience, qualifications and contact details.
- Articles are to contain between 1500 and 5000 words in length.
- Articles are to be submitted in MS Word format via email or floppy disk.
- Articles are to be single-spaced and with minimal formatting.

Conditions

- References are required to support argument and should be listed alphabetically.
- Case studies must have a signed agreement by the client attached to the article for permission for publication. Clients must not be identifiable in the article
- The author must seek permission to quote from, or reproduce, copyright material from other sources and acknowledge this in the article.
- All articles are subject to our editing process and all authors will be advised of any necessary changes and sent a copy prior to the proofing of the journal for publication.
- Authors are to notify the editor if their article has been published prior to submission to Counselling Australia.
- Only original articles that have not been published elsewhere will be peer reviewed.
- Counselling Australia accepts no responsibility for the content of articles, manuscripts, photographs, artwork, or illustrations for unsolicited articles.

Deadline

Deadline for articles and reviewed articles is the 7th of February, May, August and November. The sooner articles and papers are submitted the more likely they are to published in the next cycle.

ACA

Diary Note

2009 Conference

Australia Dreaming: "Coming Together"

Joint ACA – PACFA Conference 2009

Where? Hyatt Hotel, Canberra
When? Fri 2nd & Sat 3rd of October 2009

Help us to celebrate the much anticipated first joint ACA/PACFA conference by marking these dates in your 2009 diary. Experience Canberra during Floriade and spend some time in our Capital city exploring its attractions.

Separate activities for spouses and children will be available to enable you make this a unique family experience.

Accommodation, travel packages and sight seeing tours are being negotiated to suit all budgets.

Pre and post conference activities are planned.

A call for Papers/Abstracts has been sent out through each association's network. All abstracts and papers will be peer reviewed.

Sponsorship and exhibition enquiries welcome.

For further information contact:
Philip Armstrong CEO of ACA - philip@theaca.net.au
Colin Benjamin CEO PACFA - colin@pacfa.org.au

For on line membership information and details about . . .

the Association for Counsellors in Australia

please visit the

ACA Website

at

http://www.theaca.net.au

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