Volume 9 Number 2 **Winter 2009**

COUNSELLING AUSTRALIA

Australian Counselling Association Journal
ACA AUSTRALIAN COUNSELLING ASSOCIATION

Save Thousands A Year Off Your Mandatory Ongoing Professional Development

Thousands Of Your Peers Access Their Mandatory OPD Via One Of The Largest OPD Mental Health Portals In The World. It Gives Them Access To The Broadest Range Of Courses And Saves Them An Average Of $1,500 And 25-Hours EVERY Year.

Dear Member,

Ongoing Professional Development **is a mandatory** requirement of ACA membership. Yet we realize finding high quality programs to attend can be challenging. Programs of interest are not always offered in your proximity. Even if they are, they're often cost prohibitive. And not to mention the imposition of sacrificing a day or evening of your time.

You have an alternative. It's an alternative that hundreds of your ACA peers are ALREADY utilising. Counselling Academy (CA) is one of the largest professional development educators in mental health in Australia. They have a huge range of programs, conveniently accessible via the web, providing you with flexible training options, saving you significant amounts of time and money.

Here are some of the reasons why Counselling Academy is your best OPD option...

Access Courses 24/7

You can access Counselling Academy courses 24 hours a day, 7 days a week.

No More Arguments With The Family!

Never again will you have to sacrifice a day or evening to a professional development event, so there's more time to do other important things.

Only The Highest Quality Courses

CA has over 25 curriculum developers with qualifications that include PhD's, Masters and Post Graduate specializations in Clinical Psychology and Counselling.

Enhanced Learning Experiences

Courses utilise the latest IT advancements. Many courses blend video and text content to enhance your experience.

Continuous Development

CA releases a new course on average every 14-days. That's 26 new courses that are available to you each year. Your interests are always covered with topics ranging from Child Development, Trauma, Grief, to specialist therapy areas like CBT, Reality and Gestalt.

High Quality; But Low Investment

Quite simply, there is no better way to access such a huge range of programs at such a reasonable investment. Traditional workshop delivery is expensive (all up, can cost you hundreds). CA course costs are amortised across hundreds of students, resulting in high quality training for a much lower fee.

Limited Offer:
Claim Your FREE Therapy Course Now!

Each course includes 6 hours training, video demonstration, and online assessment.

Go to www.counsellingacademy.com.au/aca and follow the prompt directions.

ACA RECOGNISED PROFESSIONAL DEVELOPMENT

counsellingacademy

Statement from the Chief Executive Officer of the Australian Counselling Association:
"Ongoing Professional Development (OPD) is a mandatory requirement for members, and in fact members of almost all professional associations in Australia. We make OPD mandatory to ensure the ongoing development of practitioners and subsequently the integrity of their service to clients. I believe Counselling Academy is one of the most cost effective and practical means for members to access high quality, reasonably priced OPD in a very broad range of areas."

| **Philip Armstrong**

Counselling Australia

Published by
Australian Counselling Association Pty Ltd
PO Box 88
Grange QLD 4051
Telephone: 1300 784 333
Facsimile: 07 3356 4255
Web: www.theaca.net.au
Email: aca@theaca.net.au

Editor
Philip Armstrong

I.T. Educator
Dr. Angela Lewis
PhD Education

Printed by
Cross & Hamilton Printers

Front Cover by
Bodal Graphic Design Pty. Ltd.

ISSN 1445-5285

CONTENTS

Regular Articles

Features

Editorial By Philip Armstrong

I have been watching with interest the issue of regulation of counselling/psychotherapy under the Health Professionals Council in the UK. The issue seems to be very emotional with some very solid arguments for and against. A group called the Alliance for Counselling and Psychology have sprung up to fight the present proposals. This group is made up of counsellors and psychotherapists from each of the major professional bodies in the UK and encompasses many modalities. The diversity of the group and its members is significant which would reflect this issue concerns quite a broad group of professionals. The arguments coming from both sides of the spectrum are very compelling and from an outsiders perspective each side does make some very important points. If you are interested in these arguments May's edition of Therapy Today, Vol 20 Issue 4, published by the British Association for Counselling and Psychotherapy has a very good balance of articles outlining several arguments from each side. The situation of regulation itself is very different in the UK from Australia and my following comments should not be misconstrued to be taken that I am in any way making comment on the current situation within the UK. These comments are strictly in relation to the Australian scene.

Counselling is certainly not a profession where by its practitioners by and large would be considered to be a danger to the general public in relation to harm through poor practices.

The reason this issue has once again sparked interest in me is for several reasons the primary one being that this issue is discussed with great gusto here in Australia. Many seem to think regulation is a silver bullet which will end all the woe's of the profession and simply by default see counselling projected to the heights of being a respectable and recognised industry. Therefore we should be aiming for regulation for no better reasons than for our ego and pocket. I believe as an industry we are more than capable of achieving these things on our own merits for better reasons of a higher nature. Not that I believe the profession is not already seen in a positive light. One important factor many ignore is that for a profession in Australia to be regulated in the first instance it must first of all be seen as being a danger to the general public. Counselling is certainly not a profession where by its practitioners by and large would be considered to be a danger to the general public in relation to harm through poor practices. Albeit there are still a small number of charlatans masquerading as counsellors who have few if any qualifications.

There is certainly no guarantee that by being regulated we would be any better off than we are now in relation to employment and private practice. Social Work is not regulated nationally unlike psychology yet as a profession it has been able to self regulate standards for employment and practice as well as

being eligible for rebates to offer counselling services against the Better Access Initiative. Social Workers are recognised by many government departments such as Veterans Affairs and for insurance work through Work Cover as well being eligible for provider numbers against many Private Health providers. Social Work is a very good example that regulation is not required to achieve a good standing, improve employability or to be recognised by government or other organisations for rebates. In most cases membership to the Australian Association of Social Workers at the appropriate level is all that is required. Many look to psychology to justify regulation however it should not be forgotten that in 1965 when psychology was first regulated in Victoria the intention was to close down the Church of Scientology. More a reflection of meeting government agenda's than about standards, this was trumped by the Scientologists who simply declared themselves a religion and that was that.

Another argument used to support regulation is that regulation protects the public from poor practice by introducing mandatory training standards and complaints mechanisms. Personally I would put the ACA complaints system up against any regulated one. Only recently a GP was reregistered (provisionally) to be able to enter back into general practice with restrictions even though he has been convicted not once but several times for inappropriate sexual behaviour towards patients. I am aware of several psychologists and psychiatrists who have been found guilty of having sexual relationships with clients yet have maintained their registration after short periods of suspension. ACA has deregistered two members in the last 2 years for the same actions. The outcome for being found guilty for sexual misconduct with clients for ACA members is life deregistration. Although I have no input into complaints proceedings or outcomes I applaud the ACA complaints board on there consistency in this regard and if regulation meant watering down the current complaints system I believe the public would support us in that this would not be in their interest. Counsellors would not be fulfilling their duty of care to accept that sexual misconduct with clients should be deemed appropriate which is the message sent when short suspensions are deemed adequate, regardless of whether counselling is undertaken or not. The public are in no way being protected in these cases and regulation seems by default to lead to less severe outcomes for perpetrators. Hardly an argument that regulation protects the public let alone instils high standards.

ACA

The introduction of the legislation did have the effect of stopping personality testing by the Scientologists.

Why Counsellors Would Want to Formally Track Clients' Treatment Response

By Michael J. Lambert, PhD, Brigham Young University

Even in clinical trials that support the value of a particular intervention with a particular disorder, a sizable minority of clients find no benefit and a small group of clients deteriorate.

Psychotherapy of various orientations and formats has been found to be effective across a variety of client disorders. The extent and richness of this finding extends over decades of research, thousands of treated individuals, hundreds of settings, and multiple cultures. Counsellors should be encouraged by the mass and breadth of empirical results that clearly demonstrate that the treatments they provide reduce distressing symptoms, resolve interpersonal problems, restore work performance, and improve life quality for the majority of those who seek treatment (Lambert & Ogles, 2004).

Nevertheless, it is also clear that counselling can occasionally be harmful or result in no detectable progress in a minority of clients. Estimates of the number of clients who deteriorate while in treatment are difficult to obtain, but a fair estimate is between 5 and 10% (Lambert & Ogles, 2004). Just as positive counselling outcomes depend largely on client characteristics, so too do the negative changes that occur in clients who are undergoing counselling. Even so, positive as well as negative client change can be affected by counsellor actions and inactions.

Despite the relatively small proportion of treatment failures, preventing negative outcomes is a topic of considerable importance. The current climate of enhancing client outcomes has placed a primary emphasis on studying and documenting effective treatments for specific disorders and increasing the likelihood that an "empirically supported" or "evidence-based" treatment will be offered to the client. Unfortunately, offering the right treatment for the right disorder is not a remedy that has a proven track record at reducing client deterioration. Even in clinical trials that support the value of a particular intervention with a particular disorder, a sizable minority of clients find no benefit (somewhere around 40%; Hansen, Lambert, & Forman, 2002) and a small group of clients deteriorate.

The problems of non response and negative response are central issues for health care providers and policy makers as economic pressures force reductions in

services. External pressures for cost containment (economic pressures) immediately expose two important provider vulnerabilities: (1) Counselling service delivery is largely driven by theory-based practices rather than empirical research, and (2) The inability of clinicians to make accurate judgments about client worsening. These vulnerabilities lead to a paradox. In general, the judgments by counsellors about how to help and about how counselling is progressing, tend to be overly positive and rarely indicate that a client is having an unfavourable treatment response (worsening while under care). In some ways, this is a positive phenomenon. It suggests considerable optimism, confidence, and hope within the counsellor about his/her own intervention methods and there effects, attitudes that have been shown to be related to positive client outcome. This optimism allows counsellors to work hard in the face of difficult client behaviours and severe dysfunction and to remain determined in the face of minimal or small improvement. But it also allows counsellors to ignore, to some degree, client worsening. For example, considerable clinical lore has built up around the idea that it is to be expected that clients will get worse before they get better, despite the fact that this is rarely the road to recovery and, in fact, is an indicator that portends a final negative outcome. The positive traits of theory allegiance and confidence may make it difficult for counsellors to appreciate the importance of negative treatment response and take appropriate steps to ward off treatment failure.

Research is needed to investigate the extent of the problem. To investigate counsellor accuracy in predicting negative treatment outcomes Hannan, et al (2005) asked a group of 48 counsellors (26 trainees and 22 licensed psychologists) at a university outpatient clinic to predict which of their clients were likely to end counselling worse off than when they started. The specific question was: 1) In your clinical judgment alone, predict this client's end of treatment outcome. This client will (choose one prediction) Recover, Improve but not recover, Make no progress in treatment, Get worse. Therapists were informed both verbally and in written form previous to the study that deterioration rates in the clinic had remained relatively constant at 8% over the preceding years, and that the primary interest in administering the questionnaire was to see if counsellors could indeed predict that important percentage of clients who worsen during counselling. Counsellors made predictions over a three week time period with predictions made for a counsellor on either one, two, or three occasions.

Counsellor prediction of negative outcome was compared with outcome based on client self-reported mental health status as measured by the Outcome Questionnaire-45. The Outcome Questionnaire (OQ-45), is a 45-item measure developed specifically for the purpose of tracking and assessing client's symptomatic states, degree of interpersonal problems, and role functioning. It was created to be brief (take 5-minutes) and to be administered repeatedly in a therapeutic setting (Lambert, et al., 2004). The OQ-45 is a well-established instrument that has been validated and widely applied across the world. It has excellent reliability and correlates highly with other measures of disturbance such as the Beck Depression Inventory.

Actual OQ-45 data collected by Hannan, et al indicated that 40 clients (7.3%) out of a total of 550 counsellors deteriorated by the end of counselling but that counsellors rarely predicted deterioration. In fact, they predicted only 3 (less than 1%) of 550 clients would deteriorate, and only one of the three clients predicted to deteriorate did so, a hit rate of 1/40 (2.5%). In contrast, actuarial methods based on the OQ-45 applied for the purpose of making the same predictions were able to accurately identify31 of the 40 clients (hit rate of 78%) who deteriorated. These sobering results reinforce the notion that counsellors need assistance from independent methods to alert them to the fact that interventions are not having their intended effects and that deterioration may be forthcoming for some clients. Just as physicians cannot treat a wide variety of physical conditions without routine monitoring of vital signs—such as blood sugar levels, counsellors cannot effectively manage psychological problems without systematically monitoring client mental health vital signs.

Developing actuarial methods for predicting treatment failure. The first step aimed at improving outcomes for poorly responding clients involved the development of a signal-alarm system that could identify the failing client before termination occurred (Finch, Lambert, Schaajle, 2001). In order to accomplish this goal the progress of over 11,000 clients was measured after each session of counselling and then subjected to statistical analysis that led to the development of average improvement on a session-by-session basis. Recovery of clients undergoing counselling could then be modelled.

Considerable clinical lore has built up around the idea that it is to be expected that clients will get worse before they get better, despite the fact that this is rarely the road to recovery and, in fact, is an indicator that portends a final negative outcome.

Decision rules were used to classify client treatment response at every session of therapy as being within the range of expected response, better than expected, or, most importantly, at an alarmingly slow rate. As the first step in reducing client deterioration rates we classify each client's treatment response as on track (giving either a green or white signal) or as not on track, giving either a yellow or red signal, depending on how far away from the expected positive response a client is at a given session.

These decision rules proved capable of identifying clients who eventually deteriorated by the time they left treatment. In a study of 492 consecutive clients who received counselling 36 (7.3%) were reliably worse/deteriorated at termination. The algorithms correctly identified all 36 (100%) during the course of treatment (86% of whom were identified by the third treatment session; Lambert, Whipple, Bishop, et al., 2002). In this study, any client who deviated far enough from average recovery at any session of treatment as to warrant a yellow or red signal was predicted to have a final negative outcome. In this study if an alarm was given the client had a one in five chance of having a positive outcome, compared to a 50/50 chance if no alarm was given by the algorithms. Unlike some medical decisions where the cost of over identification of signal cases may result in intrusive and even health threatening interventions, the signal-alarm in counselling merely alerts the counsellor to the possible need for reconsidering the value of ongoing treatment, rather than mandating specific changes.

Why Counsellors Would Want to Formally Track Clients' Treatment Response (Continued)

Our primary question was: Does formal feedback to therapists about likely treatment failure improve client's outcomes?

Giving feedback to counsellors. The next step required to reduce treatment failure involved controlled experiments to test the consequences of supplementing clinical practice with feedback. There is little point in predicting an event unless this information can help to alter the course of the event. Feedback information from the decision rules was given to counsellors prior to each session of treatment along with a graph of client progress and a written message.

The current method of providing feedback is displayed in Figure 1. This screen is from the OQ-Analyst computer software. It depicts the clinician feedback report on a fictional client, John Doe, provided to the counsellor prior to the 4th counselling session. The horizontal line at a score of 64 represents the cut-off for entering the ranks of normal functioning. The dark, slightly vertical line is the line of average recovery for clients with an initial score of 90 (John Doe's intake score). The dark line with the diamonds, that drops at the second and third session points and then goes up to a score of 117, is John Doe's progress line. Within parenthesis at session two and three is a "G" indicating that at these points in time the client was on track but not recovered. At the session 4 point the alert status changed to red, indicating the client was a signal-alarm case. Below the graph is the written feedback message for this case at this point in time, a message that suggests concern about eventual outcome for this case.

Five large-scale studies aimed at evaluating the effects of providing such research-based feedback on client progress have been conducted in the United States (Harmon, et al. 2007; Hawkins, Lambert,

Figure 1

Percent of Signal-Alarm Cases in Treatment as Usual or Feedback Condition Meeting Criteria for Clinically Meaningful Outcome at Termination

Outcome Classification	TAUa n (%)	T-Fbb n (%)
Deterioratedc	64 (20%)	47 (12%)
No Change	184 (58%)	194 (49%)
Reliable/or Clinically Significant Changed	70 (22%)	156(39%)

aTAU = patients who were signal-alarms and whose therapist was not given feedback

bT-Fb = patients who were signal-alarms and whose therapist received feedback

cWorsened by at least 14 points on the OQ from pre-treatment to post-treatment

dImproved by at least 14 points on the OQ or improved and passed the cut-off between dysfunctional and functional populations.

Vermeersch, Slade, & Tuttle, 2004; Lambert, Whipple, Smart, et al., 2001; Lambert, Whipple, Vermeersch, et al., 2002; Whipple et al., 2003), with two such studies underway in Australia. Each of the studies required about one year of data collection and evaluated the effects of providing therapists with feedback about a client's improvement through such progress graphs and warnings about clients who were not demonstrating expected treatment responses (signal-alarm cases). Our primary question was: Does formal feedback to therapists about likely treatment failure improve client's outcomes? We hypothesized that: clients identified as signal-alarm cases (those predicted to have a poor final treatment response) whose counsellor received feedback would show better outcomes than similar clients whose counsellor did not receive feedback.

The studies shared many things in common: 1) Each included consecutive cases seen in routine care regardless of client diagnosis or co-morbid conditions (rather than being disorder specific); 2) random assignment of client to experimental (feedback) and treatment as usual conditions (no feedback); 3) counsellors provided a variety of theoretically guided treatments with more counsellors adhering to cognitive behavioural and eclectic orientations followed by psychodynamic and experiential orientations; 4) the same therapists saw both experimental (feedback) and treatment as usual (no feedback) cases, thus limiting the likelihood that outcome differences between conditions could be due to therapist effects; 5) the length of therapy (dosage) was determined by client and counsellor rather than by research design or arbitrary insurance limits.

The results of giving feedback to therapists versus treatment as usual (no formal feedback) reached statistical significance in each study, had an effect size of about .40, and resulted in clinically meaningful changes as summarized in Table 1.

Given the large samples and replications of the individual studies in this summary, the current findings seem compelling. Providing feedback to counsellors about clients who are failing to have a positive response to therapy has an important positive impact on client well being, including cutting the rate of deterioration in half. We do not fully understand why feedback is so powerful. We believe that a fundamental reason is that the actuarial information provided by feedback is not available to the therapist through intuition. This supposition is supported by the fact that feedback indicating that a client is having a positive treatment response (a few generally held by counsellors) does not bolster outcomes for these "on track" cases. Evidence across studies suggests that therapists tend to keep signal-alarm cases in treatment for more sessions when they receive feedback, reinforcing the notion that feedback increases therapist interest and investment in a client.

Evidence across studies suggests that therapists tend to keep signal-alarm cases in treatment for more sessions when they receive feedback, reinforcing the notion that feedback increases therapist interest and investment in a client.

In addition to relying on alerting counsellors to setbacks to positive outcomes our most recent work involves providing clinicians with problem-solving tools for cases at risk for treatment failure. These tools rely on an assessment of the therapeutic alliance, motivation, social support, and negative life events connected to suggestions for interventions should any of these areas prove to be problematic. Our approach to enhancing client outcomes, rather than being prescriptive, relies on counsellor resourcefulness and clinical judgment to help the client return to a positive treatment response.

Given that each of the studies that have been undertaken delivered feedback just as would be done in routine practice and that they have had rather dramatic effects on client outcome it is past time that these or similar methods become a part of routine clinical practice. The practical difficulties of adding monitoring, feedback and decision support activities to busy practices can be an important barrier to implementation. Fortunately, recent developments in information technology make the possibility of instantaneous feedback to clinicians and clients easy to implement. A software program that is well suited to this task is the OQ-Analyst which incorporates the feedback system used in our research program. With the use of this software, clients take the tracking/outcome measure via a hand held computer. After completing the

Why Counsellors Would Want to Formally Track Clients' Treatment Response (Continued)

questions the device is placed in its sync or used with a wireless connection and feedback is instantaneously presented on the therapist's computer prior to the clients' scheduled appointment. A feedback report for the client can also be generated with the click of a button. Similar methods have been employed by other researchers within the United States (e.g.,; Lueger, et al., 2001; Miller, et al., 2005) and in Australia (Page & Newnham, E., 2008) Research on the effects are just beginning to emerge.

The results of the research summarized in this review suggest the value of implementing monitoring of treatment response, applying statistical algorithms for identifying problematic client response, and providing timely feedback to therapists as promising methods for enhancing client outcome and improving the quality of care. Hopefully counsellors will take advantage of such advances for the sake of their clients.

The results of the research summarized in this review suggest the value of implementing monitoring of treatment response, applying statistical algorithms for identifying problematic client response, and providing timely feedback to therapists as promising methods for enhancing client outcome and improving the quality of care.

References

Finch, A.E., Lambert, M.J., & Schaalje, B.G. (2001). Psychotherapy quality control: The statistical generation of expected recovery curves for integration into an early warning system. *Clinical Psychology and Psychotherapy*, 8, 231-242.

Hannan, C., Lambert, M. J., Harmon, C., Nielsen, S. L., Smart, D. W., Shimokawa, K., et al. (2005). A lab test and algorithms for identifying clients at risk for treatment failure. *Journal of Clinical Psychology: In Session*, 61, 155-63.

Hansen, N. B., Lambert, M. J., & Forman, E. V. (2002). The psychotherapy dose-effect and its implications for treatment delivery services. *Clinical Psychology: Science and Practice*, 9, 329-343.

Harmon, S. C., Lambert, M. J., Smart, D. W., Hawkins, E. J., Nielsen, S. L., Slade, K., & Lutz, W. (2007). Enhancing outcome for potential treatment failures: Therapist/client feedback and clinical support tools. *Psychotherapy Research*, 17, 379-392.

Hawkins, E. J., Lambert, M. J., Vermeersch, D., Slade, K., & Tuttle, K. (2004). The effects of providing patient progress information to therapists and patients. *Psychotherapy Research*, 31, 308-327.

Lambert, M. J., Morton, J.J., Hatfield, D., Harmon, C., Hamilton, S., Reid, R. C., Shimokowa, K., Christopherson, C., and Burlingame, G. M. (2004). *Administration and Scoring Manual for the Outcome Questionnaire -45.* Sal Lake City, UT: OQ Measures (www.oqfamily.com).

Lambert, M. J., & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behavior change* (5th ed., pp 139-193). New York: Wiley.

Lambert, M. J., Whipple, J. L., Bishop, M. J., Vermeersch, D. A., Gray, G.V., & Finch, A. E. (2002). Comparison of empirically derived and rationally derived methods for identifying patients at risk for treatment failure. *Clinical Psychology and Psychotherapy* ,9, 149-164

Lambert, M. J., Whipple, J. L., Smart, D. W., Vermeersch, D. A., Nielsen, S. L., & Hawkins, E. J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, 11, 49-68.

Lambert, M. J., Whipple, J. L., Vermeersch, D. A., Smart, D. W., Hawkins, E. J., Nielsen, S. L., & Goates, M. K. (2002). Enhancing psychotherapy outcomes via providing feedback on patient progress: A replication. *Clinical Psychology and Psychotherapy*, 9, 91-103.

Lueger, R. J., Howard, K. I., Martinovich Z., Lutz, W., Anderson, E. E., & Grissom, G. (2001). Assessing treatment progress with individualized models of expected response. *Journal of Consulting and Clinical Psychology*, 69, 150-158.

Miller, S. D., Duncan, B. L., Sorrell, R., & Brown, G. S. (2005). The partners for change outcome management system. *In Process: A Journal of Clinical Psychology*, 61,199-208.

Page, A. Newnham, E. (2008). Assessing outcome in inpatient care. Perth Clinic,University of western Australia.

Whipple, J. L., Lambert, M. J., Vermeersch, D. A., Smart, D. W., Nielsen, S. L., & Hawkins, E. J. (2003). Improving the effects of psychotherapy: The use of early identification of treatment failure and problem solving strategies in routine practice. *Journal of Counseling Psychology*, 58, 59-68.

Professor Michael J. Lambert, PhD –

Brigham Young University

Michael J. Lambert, PhD is a Professor and holds an Endowed Chair in Psychology at Brigham Young University, teaching in the Clinical Psychology Program. He has been in private practice as a psychotherapist throughout his career. His teaching includes classes in psychotherapy, psychotherapy supervision, and clinical research methods. His research spans 35 years and has emphasized psychotherapy outcome, process, and the measurement of change. He has edited, authored, or co-authored 9 academic research-based books, and 40 book chapters, while publishing over 150 scientific articles on treatment outcome. He is co-author of the Outcome Questionnaire a measure of treatment effects that is growing in popularity He has given over 200 presentations across the world, many of them invited addresses.

Dr Lambert received the Brigham Young University's highest honor for faculty research, the Maeser Award, in recognition of his cumulative research accomplishments. He was the recipient of the Distinguished Psychologist Award from Division 29 (psychotherapy) of the American Psychological Association, and the Academic Excellence Award form the Utah Psychological Association. In 2003 he was the recipient of the Distinguished Career Research Award by The Society of Psychotherapy Research for his lifetime contributions to research on professional practice. He recently completed a 5-year appointment as Associate Editor of the Journal of Consulting and Clinical Psychology, making editorial decisions on 100 manuscripts per year. In 2004, he edited Bergin and Garfield's Handbook of Psychotherapy and Behavior Change, the most authoritative summary of the effects of psychological treatments.

ACA

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:
First Floor, McCulloch House, Monash Medical Centre, 246 Clayton Road Clayton Vic 3168
Telephone: (03) 9265 2100 **Freecall:** 1800 642 066 **Facsimile:** (03) 9265 2150 **Email:** info@grief.org.au **Website:** www.grief.org.au

Angry Men in Australian Society: Is Counselling Enough? By Hilary Bond PHD

School of Human Services (Counselling),
University of Southern Queensland, Australia

Synopsis: *This article argues that counselling alone may not able to deal with the manifestations of anger among males in Australian society. The article suggests that counsellors may need to use an eclectic approach that may include any pertinent counselling approach, nutritional advice and an approach such as hypnotherapy, which can delete childhood life- scripts, generational life-scripts of condoned, but unacceptable patriarchal and learned behaviour, which is run as unconscious programmes in some Australian males from low socio-economic and disadvantaged socio-cultural groups?*

INTRODUCTION

Manifestations of anger in Australia have increased sharply in the last thirty years (Nugent, 2008; Fusion Australia, 2007; St Vincent de Paul, 2006). Fusion (2006) suggests that juvenile and adult offenses have increased due to under-parenting. This paper, rather than researching severe conduct disorder and criminal psychosis investigates males who agree to change their verbally and physically abusive behaviour in domestic situations.

This paper suggests that angry abusive behaviour where children and women live in fear is passed down from generation to generation, by controlling men.

Behavioural change psychotherapist, Nugent (2008) suggested that learned behaviour from childhood surfaces unconsciously in men's abusive behaviour to their spouse and children. A psychotherapist; Nugent (2008) realised that even "some of my upbringing" was coming out in my behaviour (p.1) so he began his counselling business for angry men. This paper also suggests that angry abusive behaviour where children and women live in fear is passed down from generation to generation, by controlling men. This second and third generation post-traumatic stress disorder can also exist in men who are the sons and grandsons of who have been to war and have not been debriefed.

Worse still St Vincent de Paul argues that an increase in social and economic disadvantage, especially with single-parents, who are forced by the government to work, after their children are aged six has caused many angry young people to roam the streets and end up in prison (2006). This certainly has occurred on the Gold Coast and lower socio-economic areas in Brisbane in the last five years (Personal Communication, 2004). Although seem to be different situations they spring from a common cause; that of modelling or learned behaviour. The young male learns from the foetal stage and early childhood that violent behaviour is condoned by peers, the media, fathers, even mothers.

Howe (2005) states that traumatic relationships in childhood, particularly attachment related trauma, are highly predictive of poor self-organisation, impaired mental health and problem behaviour (p. 182). Adults with this background have behaviour that is unconscious, unexamined, unaware behaviour which goes on day after day in an almost robotic and automatic state. Howe (2005) argues that traumatised children grow up to be people who feel in constant danger and they even may feel persecuted from within by an alien self, formed as a result, formed as a result of a helpless, hostile caregiver (p.182). Berne (1966), who originated Transactional Analysis calls this state the "critical parent", however if it is too severe it may manifest in schizophrenic behaviour where the person hears internal voices. This study, however, seeks to refrain from analysing schizophrenic behaviour. People who have low self-esteem and live in constant fear as a result of childhood traumatisation may attack as well as withdraw. Howe (2005) maintains that when one "sees through anger [one] senses an unhappy, frightened person" (p. 275).

Ancestral Energies (2007), a counselling organisation who deal with young African men who are alienated from themselves by the school system and society. They argue that anger is like an iceberg - the anger is the 10% of the iceberg we can see above the water line. "The 90% below the water line consists of pain, fear and unmet needs. When we deal with these, the anger goes" (p.1).

LIFE SCRIPTS AND AUTOMATIC PROGRAMS

Sensitive understanding of the emotional states of those adults who have been children who were traumatised points to an understanding that these adults will believe that in times of need that others will be unavailable, will punish you, reject you, and abandon you (Howe, p. 274). This may become a life script, indeed a self-fulfilling prophecy that you will loose your job constantly that partners may abandon you and your life is in a constant state of collapse. So angry people or frightened people, who really are two sides of the same coin in Berne's victim-rescuer-abuser paradigm may automatically force these unstructured situations.

Can one de-programme these unexamined and unconscious life scripts or negative perceptions of one's world? Yes, we may do so with gentle, gradual and long-term cognitive-behavioural therapy where one therapeutically matches the attachment type (Tyrell et al, 1999; Holmes, 2001), but this study prefers to observe the effect of hypnotherapy on these life-scripts.

Berne (1966) argues that "Transactional Analysis" is underpinned by the philosophy that people can change and we all have a right to be in the world and be accepted. Therefore, this paper will first look at the scripts that could be unconsciously running as continual unconscious self-talk or a state of unexamined behaviour. "You don't deserve to exist" is common "critical parent script" where behaviour feelings and thoughts may be copied from parents. "I am not alive" is a "child script where behaviours, feelings and speech are replayed from childhood. If a client's mother had some traumatic pre-birth experiences, or the birth was difficult or even life threatening, this may have an effect on the way we experience the world, even at the somatic level. In this case the client emerged sensing that life is unsafe and might, go unconsciously into, "I am not OK and You are not OK either". An angry man may have been bullied as a child and he has learned that bullying makes you feel strong and in control. Their script then

is " I am OK and You are not OK" This may cover up our belief that they are really not OK, however people just see the anger, not the low self-esteem, the fear and the pain.

Words, tone, tempo of speech, expressions, postures, gestures, breathing, and muscle tone provide clues for diagnosing ego states. We can use phenomenological diagnosis as this occurs a client continually re-experiences the past instead of just remembering it. This means that diagnosis is undertaken by self-examination. This is sometimes accurate and sometimes very inaccurate as the Child ego state may be afraid to allow our Adult to know what is going on.

This is where hypnotherapy can change the scripts over a few sessions. Hypnotherapy accesses the subconscious mind through the theta brainwave and the old negative life-scripts will be deleted. The subconscious mind is responsible for repressing memories with unresolved negative emotion. The memory will be repressed with the emotion intact until it can be resolved. The repressed negative emotions are trapped in the body, and in many cases can cause blockages to the flow of communication through the neural network pathways of the body. Lorna Simmons, an experienced hypnotherapist (2007) argues, "The subconscious mind maintains a person's moral code, according to his/her personal values and beliefs" (p.3). If you were continually told until you were seven that you were "no good, bad or evil by caregivers, nuns or parents then your subconscious will set up experiences for you all through your life where people see you as bad and you may act as "bad", so it naturally follows that the subconscious mind will think that you will have to be punished (Simmons, 2007).

CONCLUSION

By changing the life-scripts or negative programs that are stored from the early part of our lives we change our attitudes, expectations and our behaviour. We also mysteriously change the behaviour of other people, because the unconscious mind no longer programmes us to be punished, be angry or be uncontrolled. Clients than become trusting and let down their defences and feel safe to explore their emotions further and begin to live an aware and examined life.

Hypnotherapy accesses the subconscious mind through the theta brainwave and the old negative life-scripts will be deleted.

REFERENCES

Berne, E. (1966). *Games People Play.* http://www.businessballs.com/transactionalanalysis.htm

Falzon, J. (2006). *The Americanization of Welfare.* St Vincent De Paul. ACOSS Conference 2006, Sydney. www.vinnies.org.au/UserFiles/File/The%20Right%20Hand%20of%20the%20State.pdf -

Holmes (2001).*The Search for the secure base: Attachment theory and psychotherapy.* London: Bruner/Routledge.

Howe, D. (2005). *Child Abuse and Neglect: Attachment, development and intervention.* London: Palgrave-Macmillan.

Jones, J. (2004). Personal Communication at his house at Currumbin).

Nugent, D (2008). Men's Education Towards Anger and life. http://www.heavymetalgroup.com.au/exp_help-angry-men.htm

Tyrell, C., Dozier, M., Teague, G & Fallot, R. (1999). Effective Treatment relations for persons with serious psychiatric disorders: The important of attachment states of mind. *Journal of Consulting and Clinical Psychology*, 67. ppp.725-33.

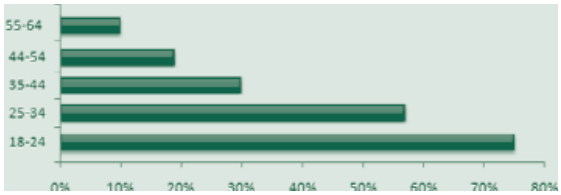
ACA

Internet and Computer Resources By Angela Lewis

WHAT IS TWITTER?

The sorts of things people 'twitter' about seem to be mostly inane, like 'I hate work today, can't wait to get home', or 'did you watch Home and Away last night, awesome episode'.

Twitter is the latest Internet fad that allows a person to write up to 140 characters of instant update (like a text) onto a webpage; keeping their friends (and the world at large) up to date with what they are doing at any given minute of the day. The sorts of things people 'twitter' about (twitter in this case being the verb that describes writing a twitter post), seem to be mostly inane, like 'I hate work today, can't wait to get home', or 'did you watch Home and Away last night, awesome episode'. While it is very popular with the under 25s, politicians also use it to push out messages and those in the media use it as a way of plugging movies, concerts or music releases (even Andre Rieu twitters as I discovered when I searched for his name). But, if like me readers are wondering who could be bothered getting the latest updates on what friends or acquaintances just ate for lunch or what they just played on their iPod…well I guess that means we are all just too old (or have busy lives)! But if you are interested, go sign up or take a look at www.twitter.com.



Social Media (FaceBook, MySpace, Twitter) use by age (courtesy of Whitesmoke.com)

IT Workers and Asperger's Syndrome

I receive regular updates and emails from TechRepublic, an online trade publication and social community for IT professionals. They provide a venue for IT folk to blog and discuss various issues related to IT. One very interesting thread began some time ago after Toni Bowers published the story 'The connection between IT and Asperger's Syndrome', which began as follows:

> *It's sometimes called the "Geek Syndrome. Medically, Asperger's is one of several autism spectrum disorders (ASDs) characterized by difficulties in social interaction and by restricted, stereotyped interests and activities, and obsessive or repetitive routines.*

Because those with Asperger's tend to gravitate toward things rather than people, there seems to be a greater number of IT people with Asperger's than in the general population.

There was a huge response from IT professionals around the world, with many saying they also believed this to be the case (and some even nominating themselves as possible Asperger's sufferers). Having worked with IT folk for many years, I can also see how easily the 'geek' could be stereotyped in this way and while the article was a discussion piece and not grounded in research it certainly provides food for thought and debate.

Word Hint: Synonyms in a Flash!

Looking for another way to say it? Nothing coming to mind? Well, let Word help you out with a synonym (in both XP and 2007 versions).

1. Right click your mouse over the word you would like to change (you don't have to select the word - just right-click over it and you'll get the same result).
3. At the bottom of the menu that pops open, you will see Synonyms. When you choose it, a list of possibilities will open.
4. Choose something from the list, or if there is nothing appropriate choose Thesaurus to get more options.

Excel Hint: To the Bottom Right Now!

As I'm sure most of you know, if you are working in Microsoft Excel, holding down the Ctrl key and then pressing the Home key will take you to the upper left corner of your worksheet (this is cell A1).

But do you know where Ctrl + End might land you?

Well, a rather useful place - the bottom right corner of your data area. This is the end of the worksheet space that you have actually used.

It's a two key quick jump from the beginning to the end!

And if you happen to press the End key by itself, then you are very quickly moved to the beginning of whatever row you are in.

if you are working in Microsoft Excel, holding down the Ctrl key and then pressing the Home key will take you to the upper left corner of your worksheet (this is cell A1).

Websites

www.asca.org.au .ASCA is a national organisation which works to improve the lives of adult survivors of child abuse throughout Australia.

www.nswrapecrisis.com.au The New South Wales Rape Crisis Centre is a state-wide 24 hour telephone and online crisis, support and referral service for anyone who has experienced sexual violence.
http://www.aifs.gov.au/acssa/research/csa.html. Research papers on the topic of adult survivors of child sex assault, collated by the Australian Institute of Family Studies

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.

ACA

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
Martin Hunter-Jones	Avalon Beach	02 9973 4997	MA, A d. Ed Ba Psych, Philos	$100	Face to Face, Phone, Group
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
Heide McConkey	Bondi Junction	02 9386 5656	Dip Prof, Couns. Prof. Sup (ACCS)	$99 ind, $33 Grp	Face to Face, Phone, Group
Gary Green	Brighton Le-Sands	02 9597 7779	MA Couns. (Psych.UWS), Grad Dip Couns.(Spo.Perf. Psych.ACAP) Dip T.A(ATAA), Cert IV Assess. Work. Train.(ISA), Cert IV Ret. Man. (ISA)	$150	Group and Phone by Nego
Thomas Kempley	Green Point	0402 265 535	MA Counselling, Supervisor Training	$55	Face to Face, Phone, Group
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
Robert Scherf	Tamworth	02 6762 1783 or 0403 602 094	Registered Psychologist	$120	Face to Face, Group
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. CI. 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

Book Review

Revitalising Retirement: Reshaping your Identity, Relationships, and Purpose. By Schlossberg, Nancy K.

Nothing Changes if Nothing Changes By Dawn Spinks.

Revitalising Retirement: Reshaping your Identity, Relationships, and Purpose.
By Schlossberg, Nancy K. (2009)
Washington. APA

What does 'retirement' mean? How does it impact people in the 21st century when life expectancy is well into the 80s, organised work is temporary, and serial monogamy and stepfamilies may well be the dominant relational and family system? According to this book, it is about life transitions, characterised by discontinuous changes in phases of lived experience.

The idea is that you map your **I**dentity, **P**urpose, and **R**elationships against defined profiles by following choreographed cognitive-behavioural steps. These profiles are **A**dventurer, **C**ontinuer, **S**earcher, **S**pectator, **E**asy **G**lider, **R**etreater and the ubiquitous **O**ther. This, according to the author is your **P**sychological **P**ortfolio. The definition of this will lead you to '**M**attering', a form of applied meaning. I could not get mine to start with capital letters. Why does the author capitalise such concepts, when it objectifies complex human experience to skills and competencies, belying their true richness? But then, this book manages to reduce thousands of years of human spiritual development embodied in the Kabbalah to 'universal questions from ancient times'.

So, for whom did the author write this book? For my clients, it is too simple. It makes the typical self-help presumption that they are idiots. There is definitely an Australian-American cultural clash. Keep it for the smug end of your self-help collection or for your counselling coffee table along with 'More meaningful lives than yours'. And yet, this book is an invitation to explore transition psychology as a class of human experience which if handled well can make 'the retirement years, the wonder years'. We do not need the demographers to tell us that transitions are yet another existential immutable we, yet alone our clients face. Notwithstanding its pop psychology, the author's simple but profound message that there is 'no template for our futures' is one reason to read it.

Reviewed by Stan Korosi, McounsHs, (Latrobe University) Professional Member ACA.

Nothing Changes if Nothing Changes
By Dawn Spinks.
Published by Spinks & Associates, Brisbane

http://nothingchangesifnothingchanges.com.au

Reviewed by Dr. Travis Gee, Dept. of Psychology,

University of Southern Queensland.

Nothing Changes if Nothing Changes is ostensibly a niche book aimed at a specialty market, and yet, it has an appeal that makes it a useful addition to many different bookshelves. Not least of these are those shelves belonging to novice counsellors who are themselves getting a handle on managing client questions and expectations, and of the many different professionals –lawyers, social workers, and yes, even doctors – who provide the referrals.

The subtitle, *"A Practical Guide to Choosing the Right Counsellor,"* is an apt description of this book and the primary market at which it is aimed, namely, the lay person who is wondering about the counselling process. As the subtitle suggests, it is a work intended to demystify the process of selecting a counsellor, and a bit of a "road map" for those embarking upon the journey of growth and self-discovery in the company of a suitable counsellor.

Clearly written in easily-understandable language, Ms. Spinks takes the reader through the decision to find a counsellor, and lays out many of the more important features of the process that the average client can expect. Brief, non-technical case studies are used to illustrate the kinds of changes that are essential to success in the counselling process, and prospective clients are even

Sometimes the words seem addressed more to counsellors themselves, than to confused contemplators of counselling. However, that seems an unavoidable feature, given that it is the professionals themselves who must look at how they relate to clients, and select those with whom they will work, and those that they will refer onwards. Indeed, the thrust of the book is to inform not only the prospective client, but those engaging in the referral process, who may need this information as well.

As might be expected, when the author steps outside of her area of expertise to distinguish counsellors from other mental health care providers, some errors and omissions creep in. For example, the idea of hypnotherapy as a means to recovering repressed memories is given far more credit than the profession itself would grant to the notion, without cautionary phrases (aside from an inadequately explained tip-of-the-hat to False Memory Syndrome).

Minor flaws aside, *Nothing Changes if Nothing Changes* is a unique and original contribution to the industry. Robert Burns once wrote

> "O wad some Pow'r the giftie gie us.
> To see oursels as others see us.
> It wad frae monie a blunder free us.
> An' foolish notion."

Ms. Spinks' book turns the mirror on us counsellors as a peculiar and sometimes intimidating species, at least to the uninformed, but through informing them, eases the transition into making significant life changes.

Table of contents

Pelling, Bowers and Armstrong

The Practice of Counselling

Armstrong

Establishing an Allied Health Service

ORDER FORM

Title	ISBN	Price AUD	Price NZD	QTY	TOTAL
The Practice of Counselling	0 17 012978 0	$72.95 (GST incl.)	$82.05 (GST incl.)		
Establishing an Allied Health Service	0 17 013295 1	$29.95 (GST incl.)	$33.70 (GST incl.)		

☐ I would like to have a Thomson representative contact me.

Name _____

Delivery address* _____

Postcode _____ Telephone _____ Fax _____

Email _____ Authorised signature _____

Enclosed is a cheque for $_____ (payable to Nelson Australia Pty Limited) or debit my

☐ Bankcard ☐ Visa ☐ Mastercard ☐ Amex for $_____ My account no. is ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Expiry date _____ Signature _____

Please allow $11.00 freight cost on Australian orders and $15.00 for New Zealand orders. * We cannot deliver to PO Box addresses.

THOMSON

THOMSON LEARNING NEW ZEALAND
Toll-free Phone 0800 449 725
Toll-free Fax 0800 442 104
COL6644

THOMSON LEARNING AUSTRALIA
Level 7, 80 Dorcas Street
South Melbourne VIC 3205
Phone 1300 790 853 Fax 1300 790 852
www.thomsonlearning.com.au/higher

Exiting the Faith: The Dynamics of Spiritual Abuse

By David Ward

The notion of abuse has regularly been explored in the literature in recent years. The therapeutic community's knowledge of physical, sexual and emotional abuse has expanded enormously and with it, subsequent counselling models. Spiritual abuse, while gaining increasing prominence as an issue in therapy, nonetheless lags behind in research and appropriate treatment options. This paper will outline some dynamics of spiritual abuse, the effects of such abuse and considerations for counselling victims of such abuse.

The dynamics of spiritual abuse

Spirituality is a broad concept that includes '…the acknowledgement of a transcendent being, power, or reality greater than ourselves' (Miller & Martin 1988 p.14). When spirituality becomes toxic or abusive, many dynamics found in other forms of abuse are also experienced as Wehr (2000 p.49) points out:

> Spiritual abuse is a misuse of power in a spiritual context…[it] involves a confusion of kinds of power because it is a use - really a misuse - of *social power* (status automatically conferred by virtue of one's gender, race, or class) and/or *political power* (status and authority because of one's position at the top of a hierarchy) in a *spiritual context*. This social or political power then parades as *spiritual power* and carries spiritual weight and authority (emphasis original).

The difficulty of course is deciding by what rule of thumb do we label a group or spiritual leader 'abusive' or 'deviant'? Some writers such as Hume (1996) look for specific 'danger markers' such as charismatic leadership, separatist practices and apocalyptic cosmology. Other frameworks have explored toxic systems from a political context (Lifton 1961) to more contemporary religious systems (Singer 1995a, Hassan 2000). The frameworks these researchers offer are typically utilised in gaining an understanding of the so-called 'cults' in society which have steadily increased in numbers over the last thirty years (Schwartz & Kaslow 2001). My experience has been that it is not uncommon to meet a parent who is concerned about the 'brainwashing' that their child is experiencing in the 'cult'. As I have sometimes discovered, the group might be a charismatic, unorthodox group but benign. My thesis in this paper is that the individual belief system should not be the point of concern. The community is free to accept or reject any system of religious beliefs it chooses.

The *behaviour* of the group or leader and the effects are more relevant to a counsellor. Unfortunately even the concept of 'behaviour', however unorthodox it may appear, remains an intangible concept. Nevertheles, one variable that can act as a general therapeutic guide is that of 'control'. Admittedly, where one draws the line is impossible and like many areas in the therapeutic professions, there are many 'grey areas'. Nonetheless, when the therapist can identify a number of controlling elements, it should be a warning sign of possible psychological and spiritual abuse.

Hassan (1988; 2000) has researched such control processes and has distilled the spiritually abusive experience into four components of control; Behaviour control, Information control, Thought control and Emotional control. While the word 'control' is used, the term does not imply that the mindset of an individual caught up in a destructive group parallels that of a robot with little or no capacity to think for oneself. Individuals react to spiritually abusive dynamics in diverse ways, interacting with their own unique personality and personal history.

Past clients who have experienced behaviour control have reported practices such as being expected to withdraw from family and friends while equally being expected to spend increasing amounts of time selling products or going door-to-door proselytising. This included dropping out of University if demanded by the group.

In terms of information control, I have met many individuals who were forbidden to read anything critical of the group and forbidden under threat of expulsion if they were to converse with ex-members. They have also informed me that personal information is often gathered during the initial stages of recruitment, and later used to induce guilt or fear.

I have found that the thought control dynamic involves the internationalisation of the group's doctrine through thought stopping techniques (chanting, meditating), and a re-defining of terms according to group dogma. For one such sect, 'Gentile' was the name given to anyone outside of group and 'theocratic warfare' was the term used to make lying to outsiders permissible. No critical questioning of the group is allowed and only thinking that is in line with group ideology, is encouraged.

Spiritual abuse, while gaining increasing prominence as an issue in therapy, nonetheless lags behind in research and appropriate treatment options.

These facets of control consequently lead to an emotional control where an individual's feelings are manipulated according to the group's demands. I have recognised that two emotions, guilt (not measuring up, past affiliations) and fear (of those outside, fear of losing one's 'salvation') are particularly common and emotionally harmful components of this facet of control.

Spiritual abuse can be a rather elastic and imprecise notion. While one can draw parallels with some 'mainstream' faiths or religious movements, again the barometer is the notion of control. Discouraging the use of TV and radio is one thing; deciding whom one is to marry and when to have children is another. Discouraging the eating of meat is one thing; not allowing a life-saving blood transfusion is another. Deikman (1996 p.321) has noted this point:

> Identifying these basic behaviours permits one to replace the question, "Is this group a cult?" with the more practical one, "To what extent is cult behaviour present?" The latter question is more useful because in the field of the transpersonal, as elsewhere, there is a continuum of groups ranging from the most benign and least cult-like to the most malignant and destructive".

Spiritual abuse then, is the unethical manipulation and exploitation of individuals within a spiritual context. It is also suggested that spiritual abuse may contain a number of facets incorporating the physical,

Exiting the Faith: The Dynamics of Spiritual Abuse (Continued)

emotional, behavioural and cognitive domains with an overall spiritual configuration. As such, when the configuration becomes toxic, the effects can truly be polyfaceted. The consequent need for a wide technical repertoire for victims of spiritual abuse is reflected below in the effects of spiritual abuse.

Some effects of spiritual abuse

Leaving a spiritually abusive environment is akin to a 'rape of the soul'. It parallels a broken relationship with all the typical emotions of anger, grief, shock and denial. However, it may go much further. For those who have been burned at the lower end of the continuum, anger, mild depression and disillusionment may be the outcome. For others the consequences may be more far reaching. For these individuals, it is a collapse of a worldview, a cosmology. It is a collapse of all the answers you *thought* you had about why we exist and our place in the cosmos, only to find out it was a sham. Below are some of the more common difficulties experienced upon leaving a toxic group.

The sense of Self is wounded

Ofshe & Singer (1986) have differentiated 'central' elements of self as opposed to 'peripheral' elements of self in discussing spiritual woundedness. They posit that because cultic or spiritually abusive systems deal in the very 'core' issues of human existence, once the experience disintegrates, a psycho-spiritual fragmentation occurs. Likewise, related literature suggests that victims of prolonged emotional and psychological strain, brought about by such forces, undergo a personality transformation to cope with the self-fragmentation (Boulette & Anderson 1985). Terms such as 'identification with the aggressor' and 'Stockholm syndrome' have been coined to represent that radical transformation of personality in the face of trauma, as one individual describes:

> *Now I couldn't sleep at night because my mind wouldn't shut off. I heard multiple voices chattering, arguing, whispering, sometimes for days and nights. I felt I had fragmented into hundreds of "me's", each having its own perspective and arguing with one or more other "me's"* (Whitfield 1994 p.231).

Research is increasingly pointing to the need for the therapist to align oneself with the clients' theory of change if treatment is to be effective.

A deep sense of grief and loss

As previously mentioned, spiritual abuse can be likened in some ways to a broken relationship though it encompasses much more. The loss may include issues such as the loss of family if the family of origin has disowned the person, the loss of being a member of the 'elite' or 'God's chosen ones' and the loss of easy black and white answers to life's questions. For others it may be the loss of spirituality/cosmology or the sense of loss of special customs/rituals particular to the group. The writer below gives some sense of this experience:

> *The loss of the best years of my life, the loss of the opportunity to have children of my own, and the loss of building a career are bitter pills to swallow. I can see now that in giving myself completely and unconditionally to the cult leader and his beliefs and practices, I gave myself up* (Whitfield 1994 p.233).

More extensive psychological damage

For some individuals where the spiritual abuse extends to physical or sexual abuse, the trauma can be more acute. Formal diagnoses are not uncommon such as post traumatic stress disorder (Leslie 2000), relaxation-induced anxiety disorders and psychoses (Giambalvo 1993). In one study by Lalich (1997), 40% of a female sample of ex-members experienced sexual abuse. A past client shared with me the following experience:

> *"Pam" joined an apocalyptic 'doomsday' group that had its headquarters in an American desert while on a holiday from her native New Zealand. After 3 years in the group, she informed the leadership that her workload was too strenuous and needed time away. She was told that those who cross a five mile radius of the groups' home would be attacked by invisible forces deep from outer space and go insane. Six months later she was asked to leave when her psychological condition deteriorated. She was put on a plane back to New Zealand whereupon shortly after arrival she experienced a psychotic episode and jumped from a two-story building* (Personal communication).

Triggering emotional states

In my caseload with this client population, I have found that an individual can experience unpleasant feeling states ranging from the mild to the terrifying. They can include a general sense of unease to a full panic attack upon exposure to stimuli that reminds the individual of the group. Below are some of these thoughts expressed by a past client of mine:

> *"Andrew" left an eastern religious sect with his parents and one of his sisters after growing up in the group. An older sister however stayed for some months after the rest of the family left. At that stage, they were both finishing High School and attending at the same campus. The very sight of his sister would precipitate a panic attack which were so common they eventually compelled him to move to a new school* (Personal communication).

These brief examples give some sense of the variegated issues that this client population can bring to therapy. It is suggested that due to the diversity of issues this client population experiences, the therapy necessitates a pragmatic and flexible approach. As the client examples in this paper show, the therapist may need to address cognitive difficulties, family of origin conflict as well as existential themes in the one client. The challenge is to have a base knowledge of a range of counselling models and well as a fundamental proficiency in them. It is therefore fitting and necessary to examine what models we use to assess and intervene in cases of spiritual abuse. Research is increasingly pointing to the need for the therapist to align oneself with the clients' theory of change if treatment is to be effective (Duncan & Miller 2001). It is also suggestive that early treatment gains are both necessary for, and predictive of, long-term outcome (Miller et al 2000). These factors alone encourage therapists to develop therapeutic elasticity with our clients. The following paragraphs shall now briefly

Basa Education & Counselling Services

(69828)

CERTIFICATE IV in COUNSELLING SUPERVISION

NATIONALLY ACCREDITED TRAINING

Course Designer & Developer: **Veronika Basa**

In partnership with: Results Training Australia, RTO (#60098)

& Institute of Human Development

(69828) CERTIFICATE IV IN COUNSELLING SUPERVISION

Nationally Accredited Training

The (69828) Certificate IV in Counselling Supervision is a self-directed learning program for experienced counselors interested in supervising other counselors. It embraces the methodology of learning delivery which empowers you, as the learner in the learning process.

Delivery Modes

The Workplace Learning Model - suited to those who are working as counselling supervisors and want to gain formal qualifications within their workplace.

The Distance Learning Model (DL) - suited to those who are unable to attend the Workshop and/or Workplace Learning Programs due employment, distance or time.

The Recognition of Prior Learning (RPL) - suited to those who have extensive experience in counselling supervision and are able to demonstrate competency via their workplace experience.

The Workshop Learning Model - suited to those who enjoy learning with peers in an interactive learning environment with adult learning principles and accelerated learning techniques.

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

2009 Time Table

City	Date	Month	Closing Dates (Enrolments & Payments)
Melbourne	6th - 11th	April	16th Feb
Brisbane	6th - 11th	July	16th May
Sydney	21st - 26th	Sept	8th Aug

Course Content

1. Working within a counselling supervision framework
2. Issues in Supervision
3. Supervision Interventions
4. Self Evaluation
5. Supervision Tools/Instruments

Study Materials

We provide the required learning materials to complete your studies. The course recourses are designed to assist your comprehension, research skills and other skills relating to counselling supervision and counselling supervision models, to enable you to confidently and competently perform counselling supervision.

Assessment

Assessments of your competency against the required Units of Competency include:

1. Demonstration
2. Observation
3. Questioning (oral/written)
4. Authenticated evidence of relevant work experience and/or formal/informal learning.
5. Written assignments/projects

Results Training Australia (RTO # 60098)

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

Basa Education & Counselling Services
ABN 80 098 797 105
GPO Box 359 Chelsea Vic 3196
03 9772 1940 - 0418 387 982
Email: info@becsonline.com.au
Web: www.becsonline.com.au

Exiting the Faith: The Dynamics of Spiritual Abuse (Continued)

survey three models that can be useful in addressing spiritual abuse.

Systems-oriented models

A systemic lens with a family therapy model can be useful (Becvar & Becvar 1996). One of the advantages of a systems-oriented model is the premise that neither the individual nor the family are singularly blamed for any issue. Both family and individual are seen through a holistic lens and problems are understood via the interactions. In terms of spiritual abuse, this can certainly be advantageous. Singer (1995b) has cautioned the family therapist however, against the belief that there had to be something intrinsically dysfunctional about the individual or the family in order for someone to join a toxic spiritual group. This betrays an ignorance of the dynamics of spiritual abuse and may parallel a 'blaming the victim' for individual or family.

Positively, family therapy may increase helpful family communication, contain painful feelings and redirect the family member who has experienced spiritual abuse toward healthy developmental health (Sirkin 1990). It can help family members in expressing themselves and to respond with sensitivity and openness. My experience has been however, that this skill is rarely seen in families that have been affected by spiritual abuse. Outbursts such as, "Our son's been brainwashed!" and "Your father's health has worsened since you left!" will simply increase tension between family members. I have found that controlling emotions is particularly important, especially when the family member threatens to return to a toxic group. Many cults instill the belief that they will be persecuted for upholding group ideology and any perceived threat from the family will reinforce the 'us versus them' mindset and halt productive communication. This is therefore an opportunity for the therapist to model open, non-judgemental communication to the family. Reminiscing about happier times with the family member can remind the individual that not all experiences with the family of origin were bad; something the group may well have suggested (Ward 2002).

The Cognitive-Behavioural model

The cognitive-behavioural models are also useful, particularly when stories such as the one below is shared:

> *For a while I was bothered by triggers, things that reminded me of the group. The smell of incense for example, would trigger me to feel as though I were chanting again. Music was also a stimulus that carried me back to feeling connected to the Swami. While a disciple, I had been encouraged to direct all my emotional feelings toward him. No emotion toward another person or thing could be tolerated… Now while driving, love songs on the radio would send me into a crying jag* (Kelly 1994 pp.89,90).

This case example briefly demonstrates some of the cognitive difficulties that so many individuals experience upon leaving a spiritually abusive environment. Common triggers that individuals may experience can include:

- Language that was used by the group that now resurfaces distressing memories
- Dissociative states brought about by numerous stimuli such as sights, sounds or smells
- Difficulties with memory and reduced critical thinking
- Various anxiety states and depressive episodes

(Tobias 1994)

Cognitive behavioural therapy (CBT) is often the treatment of choice for such problems and has been demonstrated to be clinically useful for a range of presenting issues, particularly depression and a range of anxiety disorders (DeRubeis & Crits-Christoph 1998). The work of Ellis and Beck is amoungst the best well known (Meichenbaum 1995). Ellis' work (Ellis 1995) focuses on the irrationality of thinking and the consequent emotional/behavioural problems. Beck's model essentially addresses a range of self-defeating cognitive structures via a teaching model whereby the individual is taught more realistic and flexible thinking (Dobson & Shaw 1995). As mentioned, the victim of spiritual abuse may experience a number of issues for which the cognitive therapies have been shown to be valid and reliable treatments.

Psychodynamic models

Paralleling the other models, the psychodynamic paradigm also has something to offer. Another example from the author's past caseload will help illustrate:

> 'Mark' was thirty-two when I met him. He was born in an extremely restrictive religious group that forbade computers, birthday and Christmas parties, non-group friends and tertiary education. He was in the group for the first twenty-five years of his life before he could not tolerate it anymore and left. Upon leaving, he was ostracised by his family and friends who remained in the group to this day. Mark found it difficult to be a man in his thirties. He expressed a desire to go out and enjoy many activities that were forbidden in the group though he was considerably older than most of his younger friends. He also expressed a desire to find a partner and 'settle down' and yet the feedback he received from the occasional girlfriend was that he was 'too immature' and 'not ready for a serious relationship' (Personal communication).

The above illustrates a common scenario for those who have grown up in spiritually abusive environments. They report a home life that is rule-bound and shame-based. Family unity and happiness are based on performance. The family virtually lived in fear of God shortly judging the inhabitants of the Earth and feeling that they were not measuring up despite giving long hours to group-related activities. These group-related activities left little time for anything else such as hobbies and having fun with friends.

There are many facets to the psychodynamic model as well as important variations (Karon & Wildener 1995) that are valuable for this issue. Ego defense mechanisms were explored with Mark, such as denial of certain elements of his experience and reaction

Both family and individual are seen through a holistic lens and problems are understood via the interactions. In terms of spiritual abuse, this can certainly be advantageous.

Exiting the Faith: The Dynamics of Spiritual Abuse (Continued)

formation for repressed impulses from his earlier years. The psychodynamic notion of developmental tasks is also very useful. Erikson's theory (1963) in particular was valuable here in understanding the unfinished developmental business for Mark that manifested themselves in his relationship difficulties. Exploring and normalising these unmet developmental tasks proved very helpful. Attachment theory (Bowlby 1969) is also useful in assessing needs of such clients. There is increasing evidence to suggest that secure early attachment precedes individuation and identity later in life (Marcia 1988). Clients such as Mark may have experienced attachment difficulties and exploring the client's attachment history can then inform my work. This is particularly important given that for some individuals growing up in a spiritually abusive environment, a number of developmental and relational needs may have been given second priority to the demands of the group (Langone & Eisenberg 1993).

Conclusion

This paper has suggested that spiritual abuse is a genuine phenomenon that affects an individual deeply at a number of levels. It therefore requests a broad-based counselling approach. Three models of therapy that can be utilised in cases of spiritual abuse have briefly been explored. There are many other models for the counsellor to choose from in helping victims of spiritual abuse. Pastoral counselling, Humanistic approaches and Transpersonal models all have facets that could prove useful in counselling. Individuals who have experienced spiritual abuse often feel isolated and confused about their experience. This paper has touched upon some of some of these experiences in the hope of better informing counsellors.

Individuals who have experienced spiritual abuse often feel isolated and confused about their experience. This paper has touched upon some of some of these experiences in the hope of better informing counsellors.

References

Becvar, D.S., & Becvar, R.J. 1996, *Family theapy: A systemic integration*, Allyn & Bacon, 3rd edn, Needham Heights.

Boulette, T.R., & Anderson, S.M. 1985, "Mind Control" and the Battering of Women, *Community Mental Health Journal*, vol.21,no.2, pp.109-118.

Bowlby, J. 1969, Attachment and loss: Vol.1 *Attachment*, Basic Books, New York.

DeRubeis, R.J., & Crits-Christoph, P., 1998, Empirically supported individual and group psychological treatments for adult mental disorders, *Journal of Consulting and Clinical Psychology*, vol.66, no.1, pp.37-52.

Deikman, A.J. 1996, Treating former members of cults, in Scotton, B., Chinen, A. & Battista, J. (eds), *Textbook of Transpersonal Psychiatry and Psychology*, Basic Books, New York, pp.316-326.

Dobson, K.S. & Shaw, B.F. 1995, Cognitive therapies in practice, in in Bongar, B., & Beutler, L.E., (eds), *Comprehensive Textbook of Psychotherapy*, Oxford University press, Oxford, pp.159-172.

Duncan, B.L. & Miller, S.D. 2001, Using the client's theory of change: research and practice, *Psychotherapy in Australia*, vol.8, no.1, pp.16-23.

Ellis, A., 1995, Rational emotive behaviour therapy, in Corsini, R.J. & Wedding, D., (eds), *Current Psychotherapies*, 5th edition, F.E. Peacock, Illinois, pp.162-196.

Erikson, E. 1963, *Childhood and Society*, Norton, New York.

Giambalvo, C. 1993, Post-Cult Problems: An Exit Counsellor's Perspective, in Langone, M., (Ed), *Recovery From Cults*, New York, WW Norton, pp.148-154.

Hassan, S., 2000. *Releasing The Bonds*, Freedom of Mind Press, MA.

Hassan, S., 1988. *Combatting Cult Mind Control*, Park Street Press, Rochester.

Hume, L., 1996. A Reappraisal Of The Term 'Cult' And Consideration Of 'Danger Markers in Charasmatic Relgious Groups, *Colloquium*, 28 1:35-52.

Karon, B.P. & Widener, A.J. 1995, Psychodynamic therapies in historical perspective: nothing human do I consider alien to me, in Bongar, B., & Beutler, L.E., (eds), *Comprehensive Textbook of Psychotherapy*, Oxford University press, Oxford, pp.24-47.

Lalich, J. 1997, Dominance and Submission: The Psychosexual Exploitation of Women in Cults, *Cultic Studies Journal*, vol.14, no.1, pp.4-21.

Langone, M.D., & Eisenberg, G. 1993, Children and cults, in Langone, M. (ed), *Recovery from Cults*, WW Norton, New York, pp.327-342.

Lifton, R., 1961. *Thought Reform and the Psychology of Totalism: A Study of Brainwashing in China*, WW Norton, NY.

Kelly, J.F. 1994, The unmasking of a spiritual junkie, in Tobias, M.L. & Lalich, J. (eds), *Captive Hearts, Captive Minds*, Allen & Unwin, St Leonards, pp.86-91.

Leslie, B. 2000, Postcult recovery clients: An examination of the dynamics of exploitative persuasion and counselling needs, *New Zealand Journal of Counselling*, vol.21, no.1, pp.19-34.

Marcia, J.E. 1988, Common Processes Underlying Ego Identity, Cognitive/Moral Development, and Individuation, in Lapsley, D.K., & Clark Power, F., (eds), *Self, Ego, and Identity: Integrative Approaches*, Springer-Verlag, New York, pp.211-225.

Meichenbaum, D.H. 1995, Cognitive-behavioural therapy in historical perspective, in Bongar, B., & Beutler, L.E., (eds), *Comprehensive Textbook of Psychotherapy*, Oxford University press, Oxford, pp.140-158.

Miller, S., Duncan, B., Johnson, L. & Hubble, M. 2000, Toward an outcome-informed therapeutic practice, *Psychotherapy in Australia*, vol.6, no.2, pp.30-36.

Miller, W.R. & Martin, J.E. 1988, Sprituality and behavioural therapy; toward integration, in Miller, W.R, & Martin J.E. (eds), *Behaviour Therapy and Religion*, Sage, London, pp.13-23.

Ofshe, R., & Singer, M.1986, Attacks on Peripheral versus Central Elements of Self and the Impact of Thought Reforming Techniques, *Cultic Studies Journal*, vol.3, no.1, pp. 3-24.

Schwartz, L., and Kaslow, W. 2001, The cult phenonmenon: A turn of the century update, *The American Journal of Family Therapy*, 29, 1:13-22.

Singer, M., 1995a. *Cults in Our Midst*, Jossey-Bass, San Francisco.

Singer, M.., 1995b. Cults: Implications For Family Therapists, In Mikesell, R., Lusterman, D. and McDaniel, S., (Eds), *Integrating Family Therapy*, APA, Washington, pp.519-527.

Sirkin, M. 1990, Cult Involvement: A Systems Approach to Assessment and Treatment, *Psychotherapy*, vol.27, no.1, pp.116-123.

Tobias, M.L. 1994, Guidelines for ex-members, in Langone, M. (ed), *Recovery from Cults*, WW Norton, New York, pp.300-324.

Ward, D. 2002, Cults and the Family, *Australian and New Zealand Journal of Family Therapy*, vol.23, no.2, pp.61-68.

Wehr, D.S. 2000, Spiritual abuse: When good people do bad things, in Young-Eisendrath, P. & Miller, M.E. (eds), *The Psychology of Mature Spirituality*, Routledge, London, pp.47-61.

Whitfield, H, E. 1994, Recovering from a cult, in Tobias, M.L. & Lalich, J. (eds), *Captive Hearts, Captive Minds*, Allen & Unwin, St Leonards, pp.230-233.

David Ward B.Soc.Wk, B.A., Grad.Dip.(Cple.Thpy), MAASW

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

ACA AUSTRALIAN COUNSELLING ASSOCIATION

Australian Counselling Association Pty Ltd - ACN: 085 535 628

PO BOX 88
Grange QLD 4051
Thomas Street
Grange Qld 4051

telephone: 1300 784 333
facsimile: 07 3356 4709
email: aca@theaca.net.au
web: www.theaca.net.au