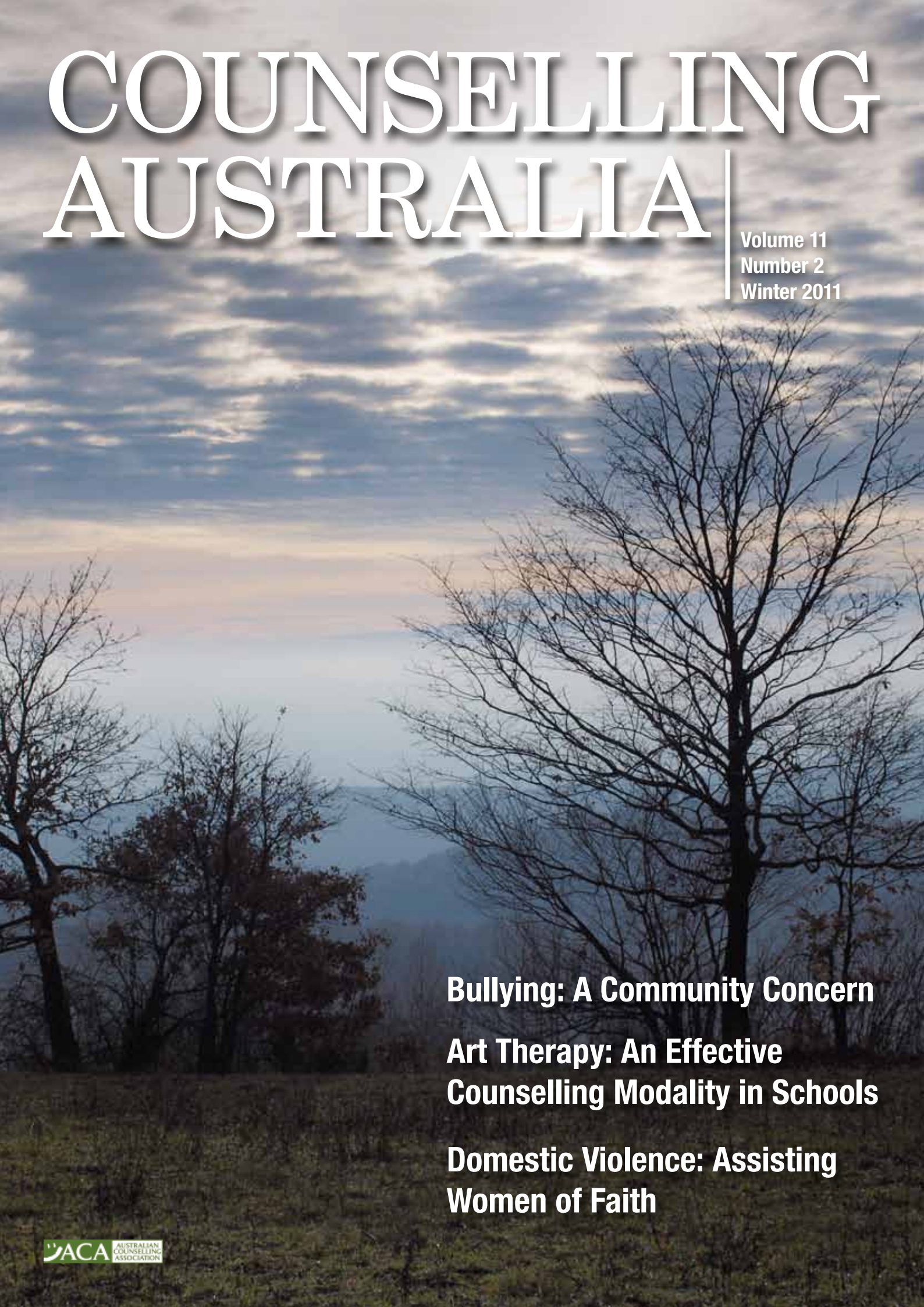

COUNSELLING AUSTRALIA

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Art Therapy: An Effective Counselling Modality in Schools

Domestic Violence: Assisting Women of Faith

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Contents

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Special Editorial Policy: Supervision

There are several policy changes that will come into effect on July 1st this year. The two most prominent are the changes to OPD and the introduction of specialist Professional Colleges. One area where there will not be any immediate changes is to Professional Supervision requirements. Professional Supervision, sometimes referred to as Clinical Supervision, requirements still confuse some members and in particular who can be your Supervisor. There are two aspects to who your Supervisor can be in relation to meeting ACA standards that need to be considered.

Members who receive Supervision in the workplace come under a different standard than Private Practitioners. Supervision within the workplace is generally supplied by the employer. ACA has no power over employers and by law cannot dictate who an employer nominates as a Supervisor in the work place. Therefore members who receive Supervision within the workplace still need to show their Supervision in their logbook and have it signed off however it is the employer who nominates who your Supervisor will be. Having said that, the employer has a duty of care to their consumers regardless of the standing of the organisation or who funds it. It is also a condition under the ACA code of conduct that all counsellors and supervisors only practice within their skill set. If an employer nominates an employee who does not have the necessary skills to effectively supervise counsellors then they have an ethical and moral responsibility to the counsellor and consumer to not accept the position or insist the employer arrange for them to complete the necessary training. ACA has advised employers that it is in theirs and the counsellors interest if Supervision is contracted out externally.

A counsellor who is misled or misguided by a Supervisor who is not appropriately qualified to undertake the position they are given may find themselves having a complaint made against them by a client. Unfortunately poor Supervision is no defence when it becomes obvious the Supervisor was not qualified to be undertaking this form of work whereas a counsellor led astray by a qualified Supervisor does have such a case. It is highly recommended due to dual position and conflict of interest issues that Supervision should be undertaken externally at the employers cost unless the employer actually employs Supervisors to specifically undertake this work and who are not directly involved in the counsellors performance reviews or promotion within the workforce. Counsellors who also work in private practice outside of their employed work hours cannot use their work supervisor for their out of hours practice. Counsellors in this position will need a separate qualified Supervisor who is independent from their place of work.

Private practitioner members of ACA are required to have Supervisors who do meet ACA supervision requirements. These requirements are:

1. A Supervisor must have completed a course of training of not less than 6 months in length in Professional/ Clinical Supervision that meets ACA Supervisor training standards; or
2. The Supervisor must have been assessed and approved for registration as a Supervisor by ACA; or
3. The Supervisor has been assessed by ACA has being appropriate on an individual basis to Supervise only certain members.

A Supervisor does not need to be registered at the same level of membership to ACA as the supervisee. All members however must abide by the Code of Conduct which as mentioned above does state a member must not practice beyond their skill level, this also applies to Supervisors. If a Supervisor is supervising a supervisee who is obviously more highly skilled and/or works with clients beyond the experience levels of the Supervisor then they have an ethical responsibility to advise the supervisee to seek out a more appropriate Supervisor. Although Supervision is delivered in many cases as a fee for service, Supervisors should not use delivering supervision as simply an extra income stream to the detriment of the supervisee. Supervisees should also not simply seek out the cheapest Supervisor they can find but more importantly they need to contract to a Supervisor who best meets their professional needs. For example a new Private Practitioner who is still developing their client base will not require much clinical supervision but will require a Supervisor who is experienced in marketing and business building and who can help them to build their practice. A well established counsellor on the other hand who does not need to build their business may require a Supervisor who is more clinically orientated. The type of Supervisor you require will change as you evolve which is why changing your Supervisor every few years is also recommended.

Philip Armstrong
Editor

(69795) VOCATIONAL GRADUATE DIPLOMA IN COUNSELLING SUPERVISION

Nationally Accredited Training - 2011

Will be delivered in partnership with a Registered Training Organisation (RTO)

Course Designer & Developer: Veronika Basa

Course Overview

Te course provides the graduate with advanced specialised technical and theoretical knowledge and skills for professional or highly skilled supervision work in a complex and specialised field of counselling supervision at AQF level 8, and further learning.

Graduates at this level have autonomy, judgement and responsibility in often complex and unpredictable counselling supervision context that require self directed work and learning and within broad parameters to provide professional advice and functions.

Course Structure

Core Unit 1- Individual counselling supervision (Nom hrs - 156),
Core Unit 2 - Live counselling supervision (Nom hrs – 136),
Core Unit 3 - Group counselling supervision (Nom hrs – 132),
Full Qualification: Total nominal hrs – 424 over a period of 36-weeks at 12hrs/week or part time equivalent.

Course Content

- Working Within a Counselling Supervision Framework
- Metaphors and Definitions,
- Goals of supervision,
- Processes and tasks of supervision,
- Dimensions of supervision,
- Supervision models: Orientation –Specific Models, Functions Model, Developmental Models, Social Role Supervision Models, Eclectic & Integrationist Models, Models for Supervisor Development,
- Supervision interventions,
- Ethical and legal issues and response frameworks,
- Supervision relationship issues and response frameworks,
- Supervision Tools/Instruments.

Modes of Delivery

Delivery includes on the job learning and off the job learning through:

- Classes (underpinning knowledge of theoretical component);
- Independent studies/self-directed learning via projects: research, reflective journal, formulating action plans relating to the provision of counselling supervision, which addresses the addition of greater currency to knowledge of skills and extends scope of prior/present learning to the specialised field of counselling supervision;
- Case studies and scenarios, which addresses the application of cognitive, analytical and problem solving skills, and ability to relate theoretical concepts to practical real life situations of ethical issues and dilemmas in particular workplaces; and
- Practicum - practical demonstrations of the practical component, (address and initiate skill development - involves conducting real supervision sessions - that addresses demonstration of knowledge, application of skills and capacity to transfer knowledge and skill to all aspects of application of counselling supervision (individual, live and group formats)

Students who can not attend classes/seminars or practicum are able to complete the course requirements via distance by demonstrating their skills on DVD/video.

Assessment

The assessment is competency based and complies with the assessment guidelines in the PSP04: Public Sector Training Package and the CHC08: Community Services Training Package, and conducted in accordance with the Australian Quality Training Framework (AQTF) Standards, and the industry requirements.

The assessment process will be an integrated assessment of underpinning knowledge and skill application over the duration of the learning program to ensure consistency, and includes:

- Projects (action plan, research, reflective journal, self critique of a counselling supervision session
- Case studies and scenarios
- Practicum - practical work experiences in counselling supervision in a workplace or simulated workplace in a range of 3 or more occasions over a period of time
- Authenticated evidence from workplace/ training courses
- Portfolio

Delivery

The course will be delivered in partnership with a Registered Training Organisation (RTO).

Certification

Graduates from the course are awarded the qualification (69795) Vocational Graduate Diploma in Counselling Supervision, and will be issued by BECS partner Registered Training Organisation (RTO).

Minimum Entry Requirements

Counsellors who wish to enrol in this course must meet the minimum entry requirements:

- Hold a current ACA/equivalent accredited qualification with a minimum 5 years post qualification experience,
- Are fully registered member of ACA/equivalent at minimum practicing level 2,
- Undertaken a minimum of 25 hours of professional development per year of practice,
- Have completed and documented proof of undertaken minimum of 100 hours of counselling supervision.

Study Materials

Study materials to complete the studies consist of BECS learning materials (as part of the course resource materials), and recommended text books.

Recognition

The Australian Counselling Association (ACA), peak body for counsellors in Australia with a membership in excess of 3000 Australia wide, has approved and accepted this course as an appropriate accredited level of training for their counselling supervisors.

Who Should Attend?

Experienced counselors interested in supervising other counselors or anyone who is working in the helping profession who satisfy the minimum entry requirements of this course.

Cancellations/Refunds

For Cancellations and Refunds, please read BECS Code of Practice at www.becsonline.com.au, to ensure you understand our policies and procedures.

BOOKINGS AND ENQUIRIES
Basa Education & Counselling Services
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GPO Box 359 Chelsea Vic 3196
Telephone: 03 9772 1940 - **Fax**: 9772 6030
Mobile: 0418 387 982
Email: info@becsonline.com.au
Web: www.becsonline.com.au

ACA Ongoing Professional Development (OPD) Policy Effective as of 1 July 2011

Ongoing Professional Development (OPD) is a mandatory annual requirement for all practicing members of ACA. ACA requires all members to demonstrate through documentary evidence with their membership renewal forms that they have accumulated a minimum of 25 points (or pro rata amount for new members) of OPD. The easiest and most efficient form of showing OPD points is through using the online log book that each member can access through the ACA home page. Each member is issued an online log book which keeps a running calculation of PD points for all submitted OPD activities. The online system enables you to upload OPD certificates which ensures we maintain a paperless environment and at the same time a verification system which ensures fewer hassles during renewal periods.

OPD can be accumulated in several ways:

1. Participate in an ACA approved OPD activity. This is the easiest way to accumulate OPD as it can be automatically uploaded on your member profile. This means you do not need to submit any paperwork with your membership renewal. All ACA approved activities should carry an ACA OPD logo and state how many points have been allocated for completing the activity. The following points are allocated for ACA activities that have sought prior approval:
   1. Mental Health Academy:
      i. Short Courses which include assessment
         a. 1 hour duration = 2 points
         b. 2 hours duration = 4 points
         c. More than 3 hours duration = 6 points
      ii. Video's
         a. Less than 2 hour duration = 3 points
         b. Between 2 and 4 hours duration = 4 points
         c. More than 4 hours duration = 5 points
   2. Annual Subscription to an ACA published journal = 4 points per annum (1 point per journal)
   3. Attendance at an ACA approved member association activity;

i. a presentation of between 1 and 4 hours = 4 points
ii. a presentation of 5 or more hours in duration (not including breaks) = 7 points

2. Participate in a non approved OPD event. Any activity that is relevant to your work as a counsellor such as workshops, conferences, further qualifications, research, published articles etc can be counted towards OPD. ACA reserves the right to determine what is deemed relevant. Prior to committing to an activity members can seek guidance on this by contacting ACA via phone or email with an outline of the activity. For activities to be allocated points members are required to submit original Certificate of Attendance, receipt/s or signed log book before these activities can be counted. All documentation needs to be submitted prior to your renewal being approved. Non ACA activities attract the following points:

1. Presentation/workshop, length 1 to 4 hours = 1point
2. Presentation/workshop longer than 4 hours per day = 2 points per day
3. Further training/education transcripts of training must be supplied= 6 point per semester
4. Published book review in an ACA publication = 3 points per review
5. Attendance at non ACA approved conference = 2 points per day
6. Published peer reviewed articles in non ACA journal = 2 points
7. Published peer reviewed articles in an ACA published journal = 5 points
8. Member association conference that has not sought approval points = 2.5 points per day
9. Member association workshop duration of more than 4 hours that has not sought approval = 3 points per day.

When Three is Not A Crowd: The Practice of Polyamory

Dr. Angela Lewis

I recently came into contact with an Australian relationships counsellor who specialises in kinky and poly relationships. While I was aware of what polyamory was, I had not included it in my recent book so I took some questions on non-monogamous relationships to my (now) extensive friend and acquaintance network in the kinky community. Three men and one woman graciously came forward and offered their insights and experiences on how they experienced polyamory.

The daring (for its time) sixties movie Bob and Carol and Ted and Alice, dealing with two swinging couples, was probably the first mainstream light to shine on consensual non-monogamous relationships—otherwise known as polyamory. The term polyamory (first coined in the 1990s) was included in both the Merriam-Webster and Oxford English dictionaries in 2006, but is still often confused with polygamy, which denotes having multiple spouses and is generally patriarchal in nature (the TV series Big Love, based on a Mormon man and his four wives, is a fairly traditional example). Polyamory means 'loving more than one' (poly, from the Greek meaning many or several and amor, the Latin meaning love). Depending on those involved, this love may be sexual, emotional, spiritual, or any combination thereof. While swinging, casual sexual contact and even cuckolding can be poly activities, for many polyamory is predicated on committed relationships between multiple people. However people choose to practice it, it is a lifestyle choice in which it is acceptable or even ideal to have more than one loving or sexual relationship; and while it excludes monogamy, it is done with the full consent and knowledge of all parties concerned. Statistically there is little conclusive data available on polyamorists, but anecdotally a large number are bisexual.

Monogamy is assumed to be the state of normality in virtually all cultures, but as polyamorist C.J. who is in his mid thirties and is in a relationship with two others, asks, "why exactly should sexual monogamy be valued as the only 'true' marker of a committed relationship?" It's an interesting point to consider for those involved in family and relationship therapy, because there is no denying that non-monogamy is generally assumed to be a symptom of something being wrong in a relationship. The problems C.J. and his partners face are always to do with the opinions and suppositions of others, and as a result none of their family members are aware of their relationship status. For the past five years C.J. has been in a primary relationship with his girlfriend and both of them have an intimate relationship with another female. He says he isn't always happy with the arrangement, as he sometimes feels left

out, or in his words "outnumbered", particularly when the girls shop, cook or bathe together; and he thinks the primary status of his original relationship is slowly blurring. However the value he places on his current domestic arrangement, particularly the companionship it provides, means he will not consider changing the status quo despite struggling to accept occasional feelings of jealousy and loneliness.

Ivan has the opposite problem: a self-described dominant male who enjoys the BDSM lifestyle, he has had numerous relationships with submissive women during the course of his twenty-year marriage, all with the full knowledge of his wife who has no interest in this dynamic. The relationships generally do not last long as, despite making it clear that his wife is and remains the primary partner, at some point the secondary partner demands equal billing and the women begin to compete and come into conflict. Ivan is quick to point out this is a fairly common scenario in the one male/two female combination, whereas he believes polyamory works far more equitably in a one woman/two men combination as one of the men is generally submissive and, in his words, "knows and understands his place in the relationship".

While the first thought of most people outside this lifestyle choice is that it must be all about free love, infidelity and sex for breakfast, lunch and dinner, most polyamorists (or polys as they are simply known) emphasise the value of their multiple interpersonal relationships rather than the availability of casual sex. In the ideal poly world, "polyamorists discuss potential lovers with current lovers, share feelings of jealousy with all involved, negotiate rules about time, place and acceptable sexual acts, decide what to tell the children and other family members, talk about whether to meet a partner's lover and many other details" (Melby, 2007). A common observation of those who have made this lifestyle choice is that it is very freeing. They maintain that instead of hiding and cheating, people can partake of their desire for others while still returning to their primary partner. Another common argument is that it is unrealistic to expect one person to successfully and continually fulfil another's needs, emotional, sexual, companionate, and intellectual, and that the search for the "one perfect person" who supposedly exists for each of us puts too much pressure on a one-to-one relationship, dooming it to failure or burnout. Ivan's need for BDSM activities and his wife's complete lack of interest in this lifestyle is a good example. His secondary partners are all selected for their matching "kinkiness", allowing him to explore and satisfy his "other self" with a complementary and willing partner, rather than insisting his wife join in activities that are distasteful to her, or choosing to leave a marriage that works on other levels in order to satisfy his need for BDSM play.

Polyamory means 'loving more than one' (poly, from the Greek meaning many or several and amor, the Latin meaning love).

Whatever our own value systems are, polyamory does question notions of love, loyalty and sexuality that many of us hold without questioning, and invites an examination of our assumptions about non-traditional partnering and relationships.

One of the many challenges polyamorists report facing is the scheduling of time for more than one relationship and then time for self. Jillian is in her forties and lived with her husband and their bisexual lover for a period of nearly ten years. She began a relationship with her lover after meeting him at a work function, and as her husband also got along with him and found him to be sexually attractive, they began a domestic living arrangement that worked for all of them for a decade before coming to an end. She remarked that given everyone in this type of living arrangement is having more than one relationship, it requires a tremendous amount of work to keep each person feeling happy and valued:

> think about the effort most people put in to make one relationship successful, then throw in multiple partners complete with their own expectations, wants and needs and you can see why I'm saying that the amount of work this implies should not be discounted; polyamory is probably not for the faint-hearted or emotionally lazy!

She says that during the time of her poly relationship they were all fairly young and more concerned with their personal than professional lives, so had the necessary time, energy and will to make their multiple relationships flourish. Now older, with a demanding career and children, she says she has her hands full maintaining her monogamous relationship, along with nurturing friendships, family and personal interests:

> looking back on my life, having an open relationship with all the effort it really takes is a bit like having two jobs—all very good when you are in your twenties, but who has the time or energy for that commitment as they get older!

R.A. is in his forties and divorced, and gravitates towards poly relationships with two women. He always actively encourages them to bring home lovers, saying he has never given jealousy a thought; however, it has also never been a topic of discussion with his poly partners (who tend to come and go), which is at odds with how most in the community tend to operate. While jealousy is not the exclusive domain of polyamorists, it is an important aspect of non-monogamous relationships that successful polys caution needs to be well understood, discussed and acknowledged as a possible issue in their relationships—Easton and Liszt's the Ethical Slut,

considered essential poly reading, devotes a chapter to its negotiation. Polyamorists do struggle with issues of jealousy and possessiveness based on insecurity, fear of loss, fear of abandonment, feeling one of the other partners is getting more attention, or with accepting they are not "the one and only"—and this is despite choosing the lifestyle voluntarily. In a recent article, Australian relationships coach Frances Amaroux (Cosmo 2008) predicts a spike in polyamory's popularity in the near future. She says the large number of young, long-term singles who have turned to 'friends with benefits' or so-called 'bonk buddies' to fulfil their sexual needs are leading this revolution, and maintains that "in these relationships, people get used to managing jealousy effectively". Weitzman, Davidson, et al (2009) write about what is termed 'compersion', described as the antonym of jealousy. It is a state that many poly relationships aspire to, and refers to feeling joy for the partners as they delight in their relationship/s, much as, say, a parent might feel joy in a child's new relationship. Striving to see their partners' partners in terms of the gain to their partners' life rather than the threat to their own is another active strategy of managing jealousy in poly relationships.

As in the rest of life, poly people come in all shapes and sizes, are attracted to the lifestyle for various reasons, and practise it in various permutations: a poly lifestyle can be chosen for some because they want to have more or 'different' sex, for others because they want to have less sex but more companionship. For some people it is about the joy of multi-partner living, or recognising that one person will never fulfil their emotional needs, while for others again it is simply about falling in love with another person and wanting to be with them as well as, instead of without the previous person—and mixtures of all the above. Whatever our own value systems are, polyamory does question notions of love, loyalty and sexuality that many of us hold without questioning, and invites an examination of our assumptions about non-traditional partnering and relationships.

Notable public figures in open marriages:

Warren Buffett (investor and industrialist), Tilda Swinton (actress), Jean-Paul Sartre and Simone de Beauvoir (philosophers), Dolly Parton, Will and Jada Smith (actors), Alfred Kinsey (sexologist).

Poly Terminology and Configurations

(See polyamory.org for more details)

Primary: used in a hierarchal multi-person relationship to denote the person with whom one is most strongly bonded, and may include the legal marriage partner.

***Secondary:** the person (or persons) in the relationship given less in terms of time, energy and priority in a person's life than the Primary, and who usually requires fewer ongoing commitments such as plans or financial/legal involvement.

Triad: three people involved with each other sexually and/or emotionally.

Vee: a relationship involving three people, in which one person is romantically or sexually involved with two partners who are not romantically or sexually involved with each other.

Polyfidelity: a poly relationship which does not permit members of the relationship to have additional external partners; at least without the approval and consent of all the existing members.

*However, as counsellor Frances Amaroux notes, some poly people don't like the terms primaries and secondaries, given the hierarchical implications of these words, and prefer to relate to all partners equally. In her practice she has seen this egalitarianism bring its own set of problems, when a long-term partner may struggle with an incoming new partner being given "equal billing".

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Dr. Angela Lewis has written extensively on alternate sexualities, and her book My Other Self: Sexual Fantasies, Fetishes and Kinks, as well as a regular blog, can be accessed at www.myotherself.com.au

Evidence Based Practice (EBP): Talking Points

Barry Duncan

Believe those who are seeking the truth; doubt those who find it.
Andre Gide

1. What exactly is an evidenced-based treatment?

It usually means an approach that has established itself better than placebo or treatment as usual in two clinical trials. Such demonstrations are nothing to write home about; intervention of nearly any kind has demonstrated its superiority over placebo for 50 years! This research tells us nothing that we already do not know: Treatment works. So, when Multisystemic Therapy (MST) says that it is an evidence based practice, it only means that it is better than no treatment or treatment as usual, not any other systematically-applied form of treatment. When Ontario implemented MST province-wide, they found that MST was no better than treatment as usual (probation officer visits in this case) as did an independent meta-analysis conducted by the Cochrane/Campbell foundation. Is MST worth the cost of implementation?

2. What does the "evidence" touted by proponents really tell us?

Treatment is on average four times more effective than no treatment and twice as effective as placebo. So when Functional Family Therapy (FFT), for example, reports in one study that the no treatment group had a 41% recidivism rate, while FFT achieved 9%, that's great but nothing more than would be expected. Any approach systematically applied by individuals believing in what they are doing will be similarly better than no treatment. FFT has never demonstrated that it is better than any other model of treatment. Is it worth the cost of implementation?

3. When you say "evidence-based treatment," whose evidence is it?

Most research regarding evidence-based practice is conducted by the very founders of the approach under study. In such circumstances, up to 40% of the results can be attributed to what is called "allegiance effects," or the researchers' bias toward their own models. This doesn't mean the researchers are dishonest, it just means that the results should be interpreted with this in mind. And how much allegiance are we talking about? MST founders, for example, have received over $55 million in grants and over $5 million in licensing and consultation fees.

4. When you say "evidence-based treatment," what kind of evidence is it?

A real look at the evidence or pulling the curtain back on the Wizard reveals not much to get excited about—a real humbug. Thousands of studies have found no difference among approaches. While a few studies have reported a favorable finding for one approach or another, the amount of studies finding differences are no more than one would expect from chance. For example, Cognitive Behavioral Therapy (CBT) proponents often point to 15 comparisons showing an advantage for CBT—however, there are 2985 comparisons that show no difference (Wampold, 2001). There is far more evidence for other factors contributing to change than what model the therapist practices: Over a thousand studies have demonstrated that the alliance between the clinician and the client is 7 times more important than the technique of the therapist. And the largest source of change (accounting for at least 40%), virtually ignored by EBP, is accounted for by what the client brings—their strengths, struggles, culture, and preferences. The approach accounts for so little of change, while the client and the practitioner—and their relationship—account for so much. Given this evidence, is implementation of a specific model of practice worth the cost?

Consider the above picture. While the cow may give it a good shot, a swimming contest between a cow and a porpoise is not really a fair comparison. Another side of the "what kind" of evidence question is whether the study is really a fair contest—is it actually a contrast between two approaches fully intended to be therapeutic? Or is it, in fact, the pet approach of the experimenters pitted against a treatment as usual or less than ideal opponent? Consider MST's claim that it is better than individual therapy. An inspection of one such comparison involving serious juvenile offenders (Borduin, Mann, Cone, et al., 1995) reveals MST conducted in the home, involving parents and other interacting systems, by therapists trained and regularly supervised by the founders of the approach. MST is compared with therapy of the adolescent only, with little to no outside input of parents or others, conducted in an outpatient clinic by therapists with no special supervision or allegiance. This type of comparison is an unfair comparison—a treatment as usual contrast rather that a bona fide treatment comparison. Consequently, this study, like many others claiming superiority, is set up with the winner already determined. Do such unfair comparisons justify the expense of implementation?

5. Because of the above points, and the fact that providing an EBP does not guarantee success at the individual client level, the American Psychological Association formed a task force to clarify the meaning of EBP and its implications:

Definition: Evidence-based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences (American Psychologist, May 2006).

Implications:

- Clinical decisions should be made in collaboration with the patient, based on the best clinically relevant evidence, and with consideration for the probable costs, benefits, and available resources and options
- Psychological services are most effective when responsive to the patient's specific problems, strengths, personality, sociocultural context, and preferences.
- The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential.

Bottom Line: While the way EBP is wielded (and often mandated) grossly misrepresents the actual data, the idea of it can make a lot of sense if it contains a little bit more common sense—and follows APA's definition and recommendations. Evidence then, also consists of:

- Evidence based on 40 years of outcome research supporting the common factors of change and the known predictors of success (the alliance and early change).
- Evidence of the progress and fit of services collaboratively collected with clients, which significantly improves effectiveness and efficiency in real clinical settings—or what we call "practice based evidence."

The only way to guarantee successful outcomes at the individual client level, as APA suggests, is to systematically monitor progress with clients and tailor treatment to the individual receiving it—to move from evidence-based practice to EBP (as defined by APA) PLUS practice-based evidence.

All approaches have valid explanations and solutions for the problems that clients bring us. As discussed in this book, it makes sense to expand our theoretical horizons and learn multiple ways to serve client goals. Similarly, it also makes good clinical sense to be "evidence based" in our work. In truth, no one says, "Evidence, smevidence! It means nothing to my work—I fly by the seat of my pants, meander Willy Nilly through sessions, and rely totally on the wisdom of the stars to show the way." Saying you don't believe in the almighty evidence in tantamount to not believing in Mom or apple pie, or whatever your sacrosanct cultural icons happen to be. So what is the controversy about?

Evidence Based Practice

(Excerpted from Duncan, B. (2010). On Becoming a Better Therapist. Washington, DC: American Psychological Association)

On the heels of the American Psychiatric Association's development of practice guidelines in 1993, to ensure their continued viability in the market, psychologists rushed to offer magic bullets to counter psychiatry's magic pills—to establish empirically supported treatments (EST). With all good intentions, the task force of Division 12 (Task Force on Promotion and Dissemination of Psychological Procedures, 1995) reviewed available research and catalogued treatments of choice for specific diagnoses based on their demonstrated efficacy in two RCTs. On one hand, the 12 Task Force effectively increased recognition of the efficacy of psychological intervention among the public, policymakers, and training programs; on the other hand, it simultaneously promulgated gross misinterpretations—that ESTs have proven superiority over other approaches, and therefore, should be mandated and exclusively reimbursed. Unfortunately, many now believe, to paraphrase Orwell, that some therapies are more equal than others.

The notion, however, that any approach is better than another is indefensible in light of the evidence summarized in chapter 1, and covered extensively throughout The Heart and Soul of Change that support the dodo verdict as well as the relative influence of other factors than model and technique. I encourage you to dig a little deeper and bolster your ability to respectfully counter statements that suggest mandates for practice. Littell's (2010) scathing commentary of ESTs in The Heart and Soul of Change is a good place to start. Littell provides a useful template for understanding the varied ways that findings can be distorted and evidence constructed from underwhelming results.

Like understanding anything else, there is a language involved here and it takes a bit of wading through tedious material. But it is worth it if you desire to counter mandates for specific approaches and promote the freedom for therapists to practice as they see fit according to clientpreferences and benefit. Our necessary pluralism, the theoretical breadth so important to resonating with clients and accentuating our development, is at stake, as well as our identity—ESTs suggest a therapist

identity based on technical acumen in administering manualized, cookie cutter interventions (Duncan & Miller, 2006).

Recall that efficacy over placebo, sham, or no treatment is not efficacy over other approaches, or what is called differential efficacy. Chapter 1 asserted that being better than nothing can lay no claim to differential efficacy. In the minority of studies that claim superiority over treatment as usual (TAU) or another approach, you need only to ask one question of the investigation (see Duncan et al., 2004 and Sparks & Duncan, 2010 for a full discussion and examples): Is it a fair contest? Is the study a comparison of two valid approaches intended to be therapeutic administered in equal amounts by therapists who equally believe in what they are doing and who are equally supported to do it—are the therapists from the same pool with equalcaseloads or is the experimental group specially selected, trained, and supervised by the researcher/founder of the approach, and have reduced caseloads?

I have never seen an advantage of any approach over another (or TAU) that wasn't a lopsided contest that had its winner predetermined. For example, in one study that found only minimal advantages (despite lofty conclusions) for the favored treatment (Ogden & Hagan, 2008), experimental therapists received 18 months of training and ongoing support/supervision during the study, while the TAU therapists received no additional training, support, or supervision; and the amount of treatment favored the experimental approach, 40 v. 21 hours (Sparks & Duncan, 2010). It is not hard to find the answers to the proposed question once you know what to look for.

And now, thankfully, there is a sanctioned argument to help efforts to rescind mandates for particular approaches. In the face of growing criticism, 2005 APA President Ronald Levant appointed the Presidential Task Force on Evidence-Based Practice (hereafter Task Force). The Task Force defined evidenced based practice (EBP) as "the integration of the best available research with clinical expertise in the context of patient (sic) characteristics, culture, and preferences (Task Force 2006, p. 273). This definition transcends the "demonstrated efficacy in two RCTs" mentality of ESTs and finally makes common clinical sense.

In fact, the Task Force's EBP definition emphasizes the major themes of this book: The first part, "the integration of the best available research" includes the consideration of ESTs without privileging them, as well as the wide range of indings regarding the alliance and other common factors. Next, "with clinical expertise," in contrast to the EST mentality of the therapist as an interchangeable part, brings you back into the equation—your interpersonal skill plus the competence attained through education, training, and experience—highlighting what therapists bring is consistent with emerging research about the importance of clinician variability to outcome. This part of the EBP definition supports attention to your development as well as your increased sense of Healing involvement. Moreover, the Task Force submitted:

Clinical expertise also entails the monitoring of patient progress (and of

I have never seen an advantage of any approach over another (or TAU) that wasn't a lopsided contest that had its winner predetermined.

changes in the patient's circumstances -- e.g., job loss, major illness) that may suggest the need to adjust the treatment (Lambert, Bergin, & Garfield, 2004a). If progress is not proceeding adequately, the psychologist alters or addresses problematic aspects of the treatment (e.g., problems in the therapeutic relationship or in the implementation of the goals of the treatment) as appropriate. (APA, 2006, p. 276-277)

So, attaining feedback as described in this book is an evidence based practice.

Next, "in the context of patient characteristics, culture, and preferences," rightfully emphasizes what the client brings to the therapeutic stage as well as the acceptability of any intervention to the client's expectations, how well any model or technique resonates. In short, EBP now accommodates the common factors detailed in this book, and reinforces the importance of your development of clinical expertise, and includes client feedback as a necessary component.

Finally, the Task Force said:

The application of research evidence to a given patient always involves probabilistic inferences. Therefore, ongoing monitoring of patient progress and adjustment of treatment as needed are essential (Task Force, 2006, p. 280).

Proponents from both sides of the common v. specific factors aisle recognized that outcome is not guaranteed regardless of evidentiary support of a given technique or the expertise of the therapist (Anker et al., 2009). Practice based evidence, again, as detailed in this book, must become routine. The new definition supports an identity of plurality, essential attention to client preferences, a focus on therapist expertise, and the importance of feedback. Bottom Line: There is nothing wrong with ESTs or evidence based practice. Challenge statements, however, that use evidence based practice to justify mandates, exclusive reimbursement, or dictates about "the" way to address client problems. Know about the dodo verdict and unfair contests in research. Educate others about APA's definition and the importance of measuring the client's response to any delivered treatment—advocate for practice based evidence as an evidence based practice.

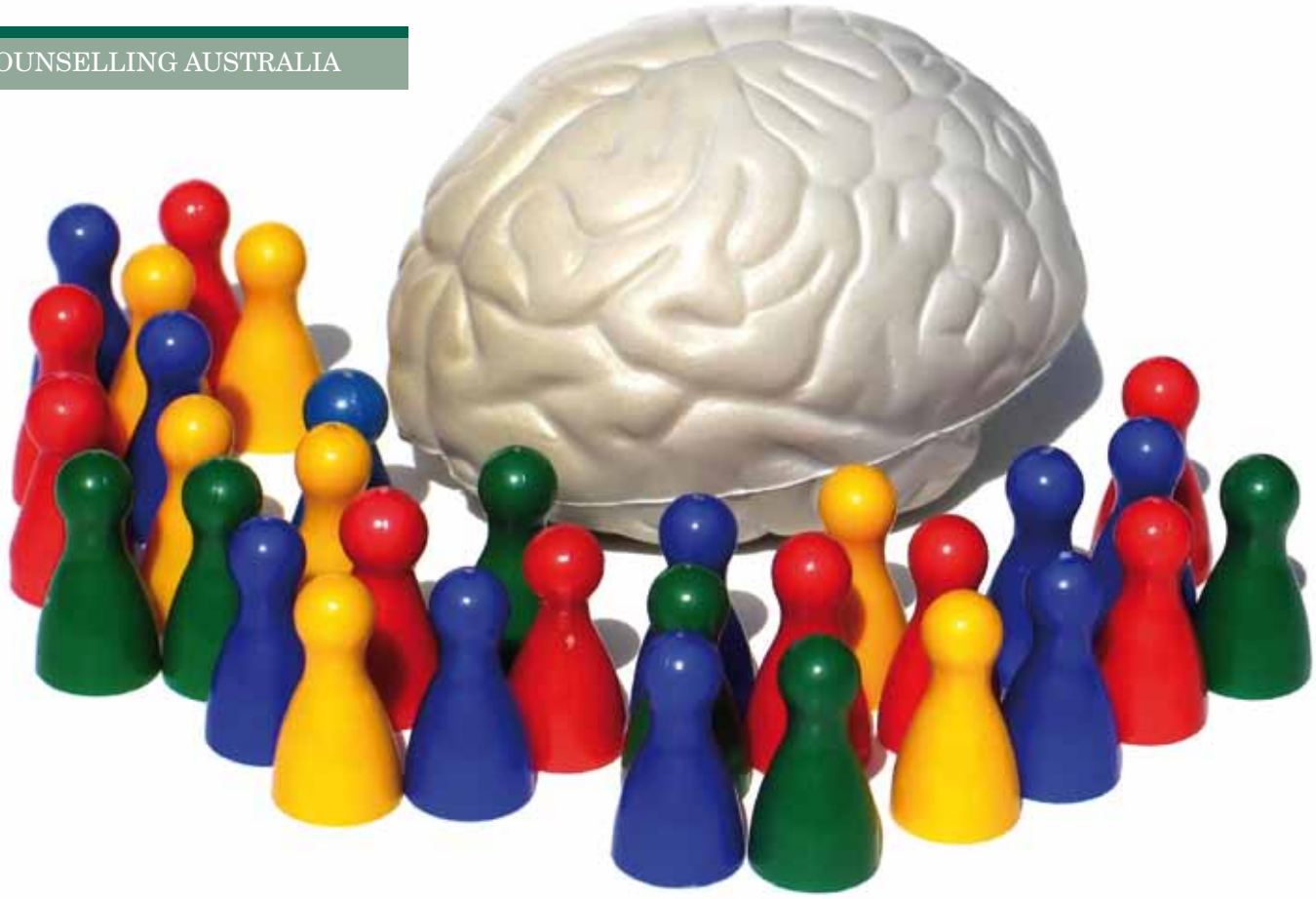
ACA National Conference
11th to 13th of November 2011
Hilton on the Park, Melbourne

2011	Event	Time	Presenter	Title
Fri 11th	Preconference Workshop APS Endorsed Activity 6.5 CPD Hours APS College Endorsed (CCOUN) Code: 11-07 Valid To: 24 November 2011	9am -5pm	Dr's Allen and Mary Ivey	New Dimensions in Assessment and Treatment: The Positive Wellness Approach from Developmental Counselling and Therapy (DCT)
	Preconference cocktail party	7pm – 9pm	All	Plaza Ballroom 191 Collins St Melb
Saturday 12th	Registration	8am – 8.30am	Jovana & Vicki	Registration desk
	MC welcome	8.45am – 8.50am	Philip Armstrong	Welcome, housekeeping, intro VIP
	VIP open conference	8.50am – 9.20am	Hon Mary Wooldridge, Minister for Mental Health (TBC)	Mental Health in Victoria
	Keynote	9.25am – 10.25am	Dr's Allen & Mary Ivey	Neuroscience: The Cutting Edge of Counselling's Future
	Morning tea	10.30am – 11am		
	Workshop 1	11.05am – 2.35pm	Dr Angela Lewis	Understanding Non-Mainstream Sexual Practices
	Workshop 2	11.05am – 2.35pm	Richard Hill	From Behaviour to Brain to Genes and back again.
	Workshop 3	11.05am – 2.35pm	Dave Goldsmith	Counselling children using the interaction of all five senses
	Workshop 4 (3 x 30 minute papers)	11.05am – 2.35pm	1. Lyndall Briggs & Anne Clarke 2. Carol McGowan 3. Aurelia Satcau	1. Results of a study into the Effects of Using Hypnotherapy and/or Homeopathic Remedies on Anxiety 2. Do Business Coaches Think they Need Counselling Skills (Results of Research Project) 3. The 'trivialization' of cultural-context: multicultural counselling revisited
	Lunch	12.35 pm – 1.25pm	Book signing Allen & Mary	
	Workshop 5	1.30pm – 3pm	Richard Cook	Interweaving Narrative and Cognitive Approaches to Therapy: Problems and Possibilities
	Workshop 6	1.30pm – 3pm	Steve Thaxton	Counselling Traumatized Children: E.M.D.R. and Play Therapy
	Workshop 7	1.30pm – 3pm	1. Prof Richard Hicks & Clive M Jones. 2. Stan Korosi 3. Dr Randolph Bowers.	1. Counsellor burnout, occupational stress and coping resources: A study of Australian counsellors, using the OSI-R and the CBI 2. When parents rupture their children's loving bond with the other parent 3. Exploring Competencies for Counselling Practice
	Afternoon tea	3.05pm – 3.25pm		
	Workshop 9	3.30pm – 5pm	Dr Mary Ivey	Coaching and Microcounselling
	Workshop 10	3.30pm – 5pm	Dr Randolph Bowers	Exploring Competencies for Counselling Practice
	Workshop 11	3.30pm – 5pm	George Thompson	The Purpose of The Recovery Foundation

2011	Event	Time	Presenter	Title
	Workshop 12 (4 x 30 minute papers)	3.30pm – 5.30pm	1. Tra-ill Dowie & Adam Rock 2. Dr Clive Jones 3. Aurelia Satcau 4. Dr Nadine Pelling & Ian Richards	1. Re-conceptualising Transpersonal Counseling: An Extended Vision of the Humanistic Counselling Project 2. What makes counselling work? An investigation into factors that contribute to the effectiveness of psychotherapeutic treatment processes in Australia 3. On psychoneuroimmunology, 'molecules of emotion', and counselling 4. Family Conflict from a Child's Perspective
	Pre-dinner drinks	6.30pm – 7pm		
	Conference dinner	7pm – 11pm	All	
Sunday 13th	Day registrations	8.30am – 8.50 am		
	Workshop 13	9am – 10.30	Zohar Berchik & Adam Rock	The Phenomenology of the Voice Dialogue Process
	Workshop 14	9am – 10.30	Dr Linda Hanson	What's your style? If counselling was a television show, who or what would you be?
	Workshop 15	9am – 10.30	Dr Jeffrey Po	Counselling the elderly within a multi-cultural environment using Psychosynthetic-Buddhist technique
	Workshop 16 (3 x 30 minute papers)	9am – 10.30	1. Mary Pekin 2. Dr Richard Cook 3. Dr Ann Moir-Bussy	1. GULANGA (Ngunnawal for) "We too include you" 2. Interweaving Narrative and Cognitive Approaches to Therapy: Problems and Possibilities 3. Yin/Yang and Beyond: The Tao of psychological transformation
	Morning tea	10.30am – 10.55am		
	Workshop 17	11am – 12.30pm	Judith Morgan	A Failure to Correct Weaknesses – When psychotherapy collides with goals and outcomes in medicine and education
	Workshop 18	11am – 12.30pm	Nathan Beel	What can we learn from what works across therapies?
	Workshop 19	11am – 12.30pm	Gwenda Logan	Same, same but different
	Workshop 20	11am – 12.30pm	Heather McClelland	Managing anxiety using accessible body strategies
	Lunch	12.35 pm – 1.25pm		
	Workshop 21	1.30pm – 3.00pm	Monica Hadges & Flora Pearce	Sharing the Load: Helping Young People and Families Move Toward Independence in Managing Chronic Illness
	Workshop 22	1.30pm – 3.00pm	Stan Korosi & Gabby Skelsey	A differentiated view of sexuality, intimacy and the fragility of life, and how practitioners respond to working with couples regardless of gender
	Workshop 23	1.30pm – 3.00pm	Veronika Basa	The Importance of Counselling Supervision
	Workshop 24	1.30pm – 3.00pm	Marg Garvan	Experience the Power of Sandplay Therapy
	Afternoon tea	3.05pm – 3.25pm		
	Closing keynote	3.30pm – 4.30pm	Dr Cathy Kezelman CEO ASCA	The process of integration, from a consumer perspective

Conference web site - Registration and further information: http://conferences.ozaccom.com.au/2011/aca11/index.html

Payment plan: ACA will be introducing a monthly payment plan starting 1st of April for those who wish to pay off their registration over a 6 month period . For further information and registration forms go to the ACA website, ring 1300 784 333 or email jovana@theaca.net.u



Developmental Counselling and Therapy: A Brain-Based Approach to Counselling and Therapy

Allen E. Ivey, EdD, ABPP
Mary Bradford Ivey, EdD, NCC, LMHC
Sandra Rigazio-DiGilio, Ph.D.[1]

Our interaction with clients changes their brain (and ours). In a not too distant future, psychotherapy will finally be regarded as an ideal way for nurturing nature.
- Oscar Gonçalves

Developmental Counselling and Therapy (DCT) originated in the 1980's as an exploration into what Piagetian thought had to say to the counselling and therapy field. It turned out that Piaget, indeed, has a good deal of relevance (Ivey, 1986/2000).

In the early phases of DCT, the following points soon became obvious:

1. Adolescents and adults again and again recycle through the Piagetian stages of sensorimotor, concrete, formal, and post-formal consciousness. DCT uses the term cognitive/emotional style to explore the different ways our evolving consciousness shapes our view of the world
2. Counselling is about promoting the evolution of consciousness. Adapting Piaget to our field enables us to map the development of our clients in the here and now of the interview and over time.
3. Human consciousness grows when the client actively processes the difficulties they are dealing with. When professionals process the client's issues, it is the counsellor's answer, not the client's. DCT stresses the importance of collaborative therapeutic environments.
4. Mapping levels/styles of cognitive/emotional development enables us to match our language and our treatment interventions to each client, his or her unique family constellation, and salient members and groups within the wider community.
5. DCT, then, makes it possible to integrate all forms of counselling and psychotherapy within a unified theoretical framework, which has been researched and tested over the years.

The four cognitive/emotional styles, as adapted by DCT are sensorimotor, concrete/situational, formal/reflective and dialectic/systemic. More complete descriptions of each follow later in this article. Flowing from a practice of counselling based on these five theoretical points, DCT theory turned

Ivey & Ivey

Allan and Mary's farewell workshop for Australia

Melbourne Hilton, 11 November 2011

This is Allen Ivey's 8th visit to Australia and Mary Ivey's 4th. The couple has worked extensively with Australian counsellors/psychologists and also with Aboriginal people since 1979. Both are internationally known authors and lecturers, who specialize in counselling skills, developmental counselling and therapy, neuroscience, and multicultural issues.

Allen E. Ivey, EdD, ABPP

Distinguished University Professor (Emeritus) at the University of Massachusetts, Amherst. He is also a Courtesy Professor at the University of South Florida, Tampa. A Diplomate of the American Board of Professional Psychology, Dr. Ivey is a past-president and Fellow of the Society of Counseling Psychology of the American Psychological Association and is been a life member of American Counseling Association.

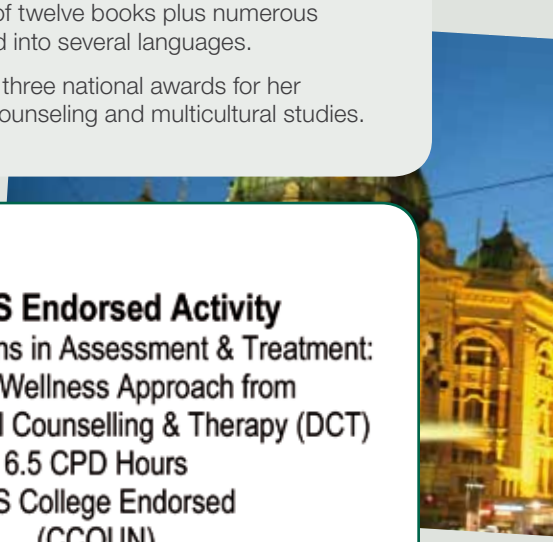
Author or co-author of over 40 books and 200 articles and chapters, his works have been translated into 20 languages. Neuroscience, spirituality and multicultural counselling are central in his work.

Mary Bradford Ivey, EdD., NBCC, LMHC

Courtesy Professor of Counseling, University of Florida, Tampa. Mary has three areas of expertise and experience—writing, independent consulting and school guidance.

Recognized by and listed in Who's Who in America, she is co-author of twelve books plus numerous articles, translated into several languages.

She has received three national awards for her contributions to counseling and multicultural studies.



1 Day Workshop

New Dimensions in Assessment and Treatment: The Positive Wellness Approach from Developmental Counselling and Therapy (DCT)

Allen and Mary will share their central approach to child, adolescent, and adult counselling and therapy. Their goal is to provide a basic introduction to DCT with enough specifics so that participants will be able to use the concepts in their practice in the coming weeks.

The first focus will be on assessment of client cognitive/emotional style and potentially useful treatments for each style. Working with positive approach to child, adolescent, and adult depression will be the second topic. The afternoon will provide practical experience with the community genogram, a tested strategy that enables clients to see their issues in broad social and multicultural context. The session will close--as time permits--with an examination of Axis II, personality "disorder, " which the Ivey's regard as personal style rather than disorder.

APS Endorsed Activity

New Dimensions in Assessment & Treatment:
Positive Wellness Approach from
Developmental Counselling & Therapy (DCT)
6.5 CPD Hours
APS College Endorsed
(CCOUN)
Code: 11-07
Valid To: 24 November 2011

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to an emphasis on pragmatics, which refers to the specific intrapersonal and interpersonal language and behaviors that individuals and groups use to navigate their environments. These four styles (or levels/stages) have been empirically supported, not only in the counselling domain, but also in the fields of education, human development, and human resource management.

The pragmatics of DCT are fairly straight forward and have specific implications for counseling action.

1. *Assessment of client cognitive/emotional style.* Client word usage and natural language in the here and now of the session enable a counsellor to appraise the client's way of making meaning and worldview.
2. *Style matching and mismatching.* With awareness of how clients make sense of their world, the counsellor joins the language and narrative style of the client, thus facilitating relationship and a working alliance. At a later point, the counsellor can mismatch client style and thus encourage new and additional perspectives on issues.
3. *Questions to encourage exploration at each style level.* DCT has identified specific questions that facilitate client expansion of the narrative within each style. For example: 1) What are you seeing/hearing/feeling? 2) Can you tell me specifically what happened? 3) What are your reflections/thoughts about that? 4) What other ways could you talk about this story? There is solid evidence for predictability and reliability of client response style to the varying questions (Rigazio-DiGilio and Ivey, 1990.
4. *Matching treatments with cognitive/emotional style.* Example sensorimotor treatments are prescribing exercise or meditation, here and now Gestalt exercises, and Gendlin's focusing, areas on the periphery of counselling training and practice. The concrete and formal styles have an immense array of theories and strategies associated with them, ranging from Ellis' REBT, Rogers person-centered counselling, narrative methods, to interpersonal and psychodynamic approaches. Less common is emphasis on systems via the dialectic/systemic style. Examples here are multicultural counseling and therapy (MCT), feminist approaches, and much of family systems work.
5. *Encouraging multiperspectival thought, feeling, and action.* DCT is integrative and seeks to enable clients to examine their issues from as many cognitive/emotional styles as possible. DCT offers the field both an alternative, researched-based approach to contemporary culturally-responsive counselling and a meta-theory, which can be used to organize strategies and techniques from multiple counselling models to form a cohesive and unified treatment framework.

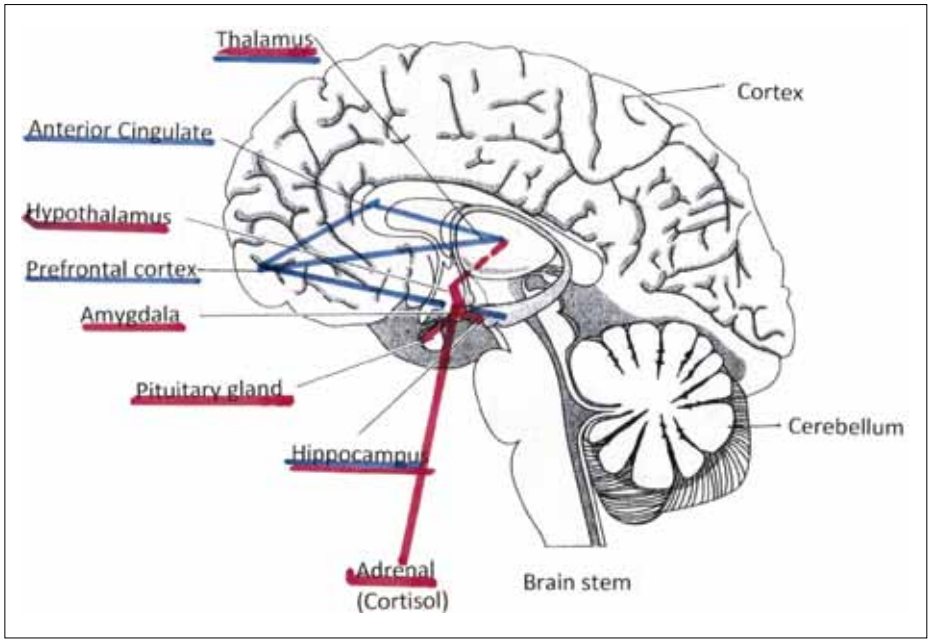

Figure 1: The Brain Reacts to Stress

Over the years, ways to use the DCT framework were validated in treating counselling issues as varied as spirituality, multicultural issues, family therapy, Adlerian and psychodynamic therapy, and a broad range of so-called "disorders" within the Diagnostic and Statistical Manual of Disorders (DSM III, IV, and now the forthcoming V). It was found that the system worked effectively with children as well as adults and that it has relevance for the treatment of clients dealing with issues such as substance abuse, phobias, anxiety, depression, eating disorders, child and partner abuse, and trauma.

Piaget's many books have resulted in a plethora of both clinical and research studies. The concept of a hierarchical progression of cognition from sensorimotor thought concrete, formal, and post-formal is well established. This hierarchical progression was deemed to be linear and sequential. In other words, the general view of developmental psychology was that one evolves from sensorimotor through concrete, to formal and maybe post-formal ways of knowing the world. DCT rejects this one-way progression point of view and assumes a holistic viewpoint, which states that the four styles of cognitive/emotional consciousness are dynamic. In this way the styles are constantly being recycled as humans attempt to understand and operate in their world, and therefore shape the worldviews of individuals and groups. This holistic versus hierarchical nature of cognitive/emotional styles is consistent with evidence that humans rely on a wide variety of intellectual and emotional skills to survive and thrive in their world. Neuro-psychological findings suggest that the brain is holistic (Jensen, 2005). DCT's relationship with neuropsychology goes beyond its holistic perspective and connects counselling theory to actual regions of the brain.

The Brain Base of Developmental Theory

No cognition without emotion; no emotion without cognition.
- Jeanne Piaget

Allen and Mary Ivey are perhaps best known for their writing and workshops on microcounselling, the original and most researched approach to counsellor education and training (e.g. Ivey & Ivey, 2008; Ivey, Ivey, & Zalaquett, 2010). Basic to the microskills model since 1971 is what they term the **positive asset search** in which strengths and resources of the client are brought in to help clients deal more effectively with their concerns, issues, and problems. This is similar to what Carl Rogers (1961) termed **unconditional positive regard** and to what the movement toward wellness and positive psychology posits about the importance of a more positive approach to the counselling process (Ivey, Ivey,

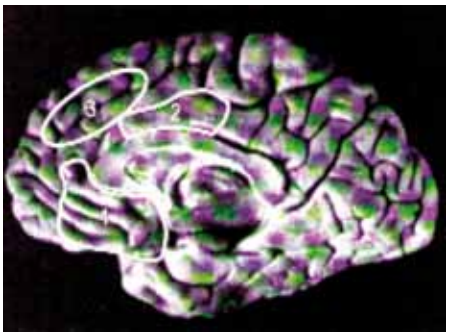

Figure 2: Structures on the medial surface of the prefrontal cortex.[2]

Piaget	Ivey	Lane	Neuroanatomical Emotional Structures
Sensorimotor	Sensorimotor	Visceral Activation	Brainstem
Preoperational	Late Sensorimotor	Action Tendencies	Diencephalon (Thalamus, hypothalamus)
Concrete Operations	Concrete/ Situational	Discrete Emotions	Limbic system (Above, plus amgydala, hippocampus, anterior cingulate cortex)
Formal Operations	Formal/ Reflective	Blends of Emotion	Paralimbic cortex (Three levels: cingulate cortex, connector, and striatum)
Post-formal Operations	Dialectic/ Systemic	Blends of Blends	Prefrontal cortex

Table 1: Three Views of Cognitive/Emotional Development With Lane and Schwartz's Outline of Anatomical Structures.

Myers, & Sweeney, 2005). In effect, we spend much too much time on "problems" while giving insufficient attention to the existing strengths and resources within and outside client and client systems for resolving these issues. The strength-based, positive asset search is, not surprisingly, basic to the DCT framework and is now supported by evidence in brain-based processes.

When we are stressed, challenging things happen in our brains. The amygdala is sometimes called the "energizer bunny" of the emotional system. When a person is stressed sufficiently, the amygdala sends messages about the problem to the hypothalamus, pituitary, and adrenal glands. This is often called the HAT axis (or the "short circuit" of the emotional system) and hormones are activated throughout the body. In particular the adrenal gland produce cortisol, which in overabundance can destroy brain cells and erase memories in the hippocampus.

Simultaneously, the "long cognitive circuit" of the thalamus, anterior cingulate cortex, and prefrontal cortex (TAP) receives the same message. The executive area of the prefrontal cortex decides what to do and again sends messages throughout the brain and body on how to deal with the stress. But, if the stressors are too much (or if drugs such as cocaine are involved), the individual may be at the mercy of the HAT axis with little help from TAP.

DCT considers stress the underlying factor of many, perhaps most, issues that we face in counseling. So, given the power of stress to destroy us both mentally and physically, what can we do about it? This is where the **positive asset search** and positive psychology come in. Negative emotions (e.g., anger, fear, sadness) tend to be located primarily in the amygdala and the lower brain HAT axis. This is logical as fear, in particular, is adaptive for survival in the evolutionary process. The prefrontal cortex and the higher brain is the primary location of positive emotions. Thus strengthening the TAP axis is obviously important for counsellors to consider.

DCT and the importance of relationship. It is sometimes said that it takes ten positive comments to counteract a negative one. If that negative comment is elevated to a serious life narrative or a stressful traumatic event, a good deal more positive work will be required to combat the negative energy of the HAT axis. Stress management is clearly one important way to help clients manage theses narratives and events, and we need to think of stress management both as prevention and treatment.

Norcross (undated) has summarized his extensive research on the effectiveness of counseling and therapy in a set of PowerPoints. He finds that 12% is related to relationship, 8% to treatment method, and 7% to the individual helper. The client contribution is 30%, leaving 43% unexplained variance or other factors. Another way to view these data is that we can explain the 49% of the success of counseling to interpersonal factors, thus suggesting all the more that we need to give attention to client worldview and our place in this process. Our treatment methods remain important, but perhaps are not as central as we think. With a solid and egalitarian relationship, clients are more likely to participate and cooperate with treatment alternatives.

DCT stresses relationship and assessing client's style of perceiving the world. As we move to treatment for stress, sensorimotor aspects of stress management include meditation, exercise, and positive imagining, all of which can be highly beneficial for both treatment and prevention. Developing increased gray matter in the brain (Hölzel, 2010) and a healthy body are excellent ways to help clients deal with stress.

Stress management includes looking at client stories and the irrational, automatic thoughts that go with these stories. Thus cognitive-behavioral strategies are useful for managing and preparing for stressful narratives and events. Cognitive Behavioral Therapy includes reflecting on the stories and changing the meaning of narratives.

Seeing the big picture and putting stressors within a wider context are also effective ways to manage stress. Helping clients examine their experiences and narratives within a formal/reflective processing style is very useful in developing alternative understandings of stressful events and narratives.

However, stress management gives insufficient attention to systemic issues such as racism, sexism, and the way social systems negatively affect the individual and the family. As noted in psychotherapy as liberation and in Rigazio-DiGilio's work with inpatients diagnosed with recurrent major depression, understanding how systems affect individuals and families is an important result of effective counselling.

In all of the above strategies, we are seeking to help clients find strengths and positives in self and system. DCT and SCDT are committed to facilitating human and systemic development over the lifespan by enlarging the possibilities and competencies of clients and client systems.

The complementary brain studies of Richard Lane. In 1987, Lane and Schwartz published a cognitive developmental view of the psychotherapeutic process very similar to that of DCT. Also based on Piagetian thought, it organized treatment plans for various cognitive/emotional levels in a framework almost exactly parallel to that used in DCT. The two frameworks were developed independently and continued for several years without awareness of the other. The authors have since met, compared approaches, and are in frequent communication.

Table 1 shows Piaget's well known levels of cognitive/emotional development, followed by the Ivey and Lane approaches. Lane focuses on implicit and explicit emotional processes, while Ivey emphasizes the holistic idea of cognitive/ emotional development. The fourth column outlines specific brain structures

However, stress management gives insufficient attention to systemic issues such as racism, sexism, and the way social systems negatively affect the individual and the family.

Lane and Schwartz associated with each type of experience.

Lane's neuroanatomic emotional structures form a hierarchy of cognitive/emotional areas. But, remember, the brain is holistic and all these structures operate together, almost instantaneously to external stimulation (i.e., what we see, hear, feel, touch, taste). Evidence supporting this **holistic** perspective is found in a careful examination of the child's (or adult's) sensorimotor emotional or cognitive experience which demonstrates that aspects of the other styles are being used to produce and maintain sensorimotor worldviews.

Each of the DCT cognitive/emotional styles has been connected to specific areas and processes within the brain. Brain research summarized in Lane's 2008 presidential address presents specific areas of the prefrontal lobe associated with each style of experience (Figure 1). PET scans show that different areas fire or light up. The numbers on the circled areas of the prefrontal cortex refer to: 1) Background feelings (sensorimotor); 2) Attention to feelings (concrete); and, 3) Reflective awareness (formal and dialectic/systemic).

Thus, we can say with some certainty that different areas of the brain relate to different cognitive/emotional styles, but what meaning does this have for the counselling process?

Empathic Matching of Language and Interventions With Client Cognitive/Emotional Styles

Whereas the typical approach to intervention in counselling is to select a theory and a set of strategies with which to approach a client, the DCT and Lane models suggest that we start with the client and match our language and intervention to their way of experiencing the world. Rigazio-DiGilio has adapted DCT methods to work with families and wider human systems in the Systemic Cognitive Development Therapy (SCDT) model (Rigazio-DiGilio, 2000).

Our first task in the interview, whether working with individuals or families,

of course, is to establish an empathic working alliance. The two developmental models stress the importance of assessing client cognitive/emotional style and then providing culturally-sensitive treatment interventions.

Sensorimotor style. The client is able to experience cognitions and emotion in the here and now and to be in the moment. Lane speaks of neural substrates of emotion where feelings are experienced rather than named. Crying and laughing are very much here and now experiences. At the late sensorimotor level, magical preoperational thinking may occur. The advantages of this style are the ability to experience the moment, but constraints of this style occur and clients may tend to have random thoughts and difficulty telling a linear story. Many formal reflective clients will have lost touch with the sensorimotor style and the ability to be in the here and now.

Sensorimotor interventions. Adults who engage in exercise, meditation, prayer, and "being-in-the-moment" are enjoying the benefits of the sensorimotor style and there is evidence that these activities increase the effectiveness of the brain. For example, meditation has been shown to produce increases in gray matter, while simultaneously the amygdala (i.e., negative emotion energizer) is reduced in size (Hölzel, et al, 2010). Here and now interventions such as Gestalt exercises, experiential treatment methods, and bodily anchored treatment methods such as those outlined in the Gendlin Focusing Model need more attention. In general, the majority of counselling theories and strategies tend to be limited in this area. Traditional theories tend to focus on the concrete and formal aspects of human development. DCT is unique in that it gives special attention to the body, including nutrition and exercise. In addition, special attention is given to strategies such as meditation, guided imagery, and other strategies designed to bring clients to the here and now.

Concrete/situational style. This is where we find linear narratives and stories of events and experiences. As therapists we get the client's perspective on what he or she thinks happened. With a little help, the client can see cause and effect; "if this happens(ed) . . ., then the result is/was . . . ". Obviously, this cognitive/emotional style again has constraints. Clients who are primarily concrete in thought and emotion may have difficulty reflecting and thinking about their experience. They also may be partially out of touch with the here and now sensorimotor world.

Concrete/situational interventions. Our field has many ways to reach clients who are primarily concrete. Strategies include the multitude of behavioral interventions, narrative storytelling, and the "if . . ., then" aspects of rational emotive behavioral therapy and cognitive work. In family therapy interventions within structural, strategic, narrative, and behavioral approaches are typical of those used with families and wider groups.

Forma/reflective style. Abstract thought brings with it the ability to reflect on experience and to see patterns in life, certainly critical components of effective counselling. Counsellors themselves tend to operate primarily in the formal reflective area. We are often impatient with clients who tell us long concrete stories and then have difficulty seeing how their behaviors and thinking tie together in patterns. So, while formal abstract thought is essential to our being in the helping professions, sole reliance on this cognitive/emotional style brings with it several potential problems, such as: 1) Clients and counsellors having difficulty being in touch with here and now sensorimotor experience; 2) Clients and counsellors being so thoroughly imbued with "thinking about things" that they ignore concrete reality; and, 3) Clients and counsellors having difficulty moving beyond a few new and useful reflections, toward multi-perspective thought and systems thinking. The counselling field is replete with individualistic and family theories and methods that fail to see social context and multicultural issues.

Formal/reflective interventions. Again, our field has an almost endless number of ways to enable clients to reflect on their lives. These include our most popular theories such as client-centered, cognitive-behavioral, and psychodynamic interpersonal approaches. Interventions from psychoanalytic, intergenerational, and developmental systemic approaches represent formal/reflective treatment options in family therapy.

Dialectic/systemic style. Along with sensorimotor, this style receives insufficient attention from our field. Multiple perspectival thought and awareness of the ways in which exchanges across individuals, families, groups, communities, and wider systems are characteristic of the dialectic/systemic style. With awareness of multiple possibilities, thoughts, and feelings, individuals, families, and wider systems can be well prepared to make intelligent and positive decisions. But, on

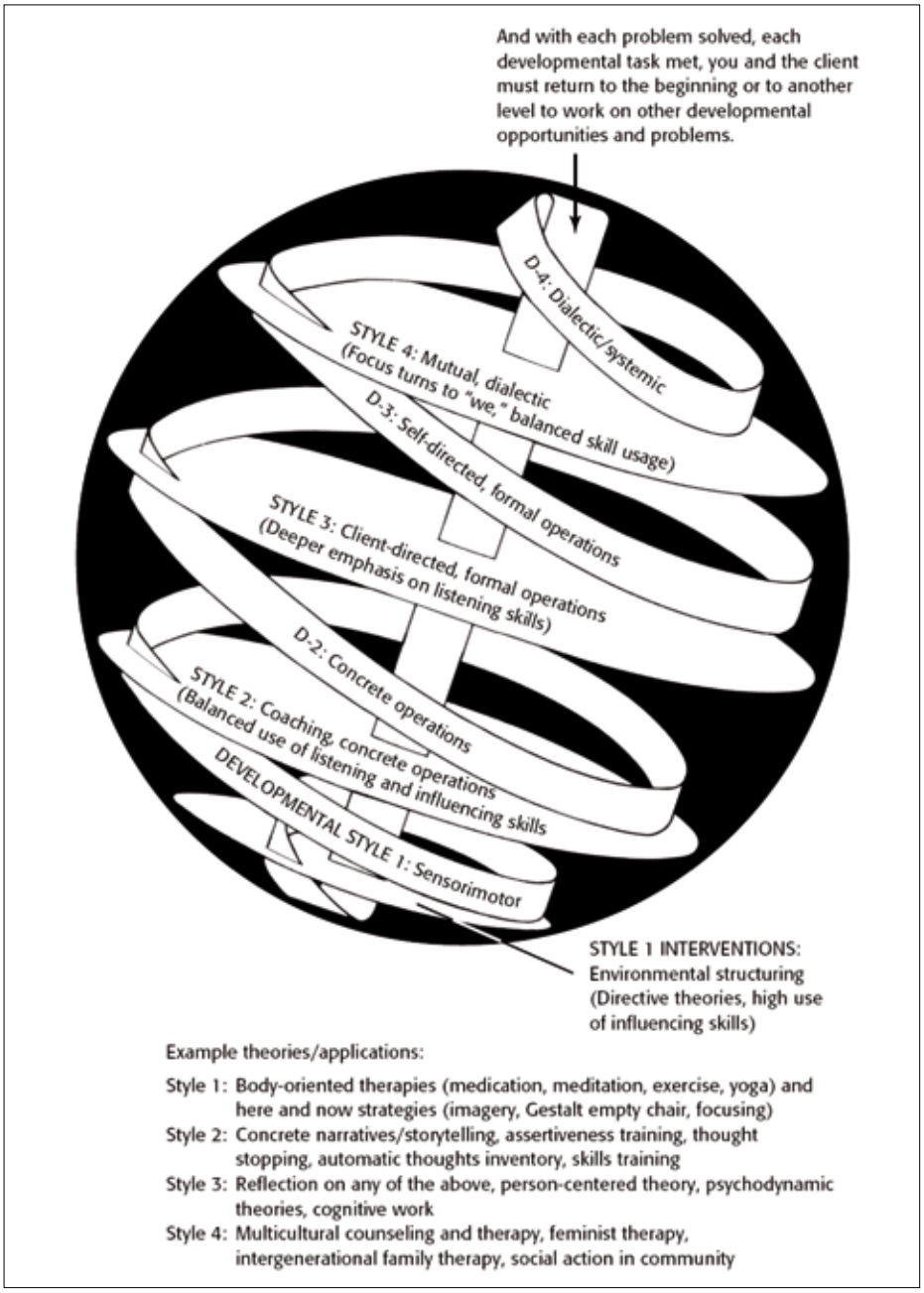

Figure 3: Developmental Sphere. (Reprinted by permission of Lois Grady.

the other hand, it is not unusual for those who tend to mainly rely on this style of consciousness to be out of touch with their feelings and less able to concretely carry out their decisions.

While attending to client issues, DCT includes a social action dimension as well. According to Albert Ellis (2000):

> To be sure, REBT has not emphasized dialectic/ systemic counseling as much as it is heavily encouraged in DCT and SCDT. Quite possibly, it - and most other popular therapies - are relatively lax in this respect. The unique element of both DCT and SCDT is the way Ivey and Rigazio-DiGilio stress this fourth process; and REBT had better seriously consider emphasizing it more than it sometimes has done in the past, and thereby learn from DCT and SCDT. But, as also noted above, much can be said on the hazards as well as the advantages of stressing this aspect of therapy. It is nonetheless accurate, as Rigazio-DiGilio, Ivey, and Locke (1997, p. 241) note, 'Theories of counseling and practice that perpetuate the notion of individual and family dysfunction without giving equal attention to societal dysfunction and to the dysfunctional interactions that can occur between individuals, families, and societies (e.g., intentional and unintentional power differentials) may unwittingly reinforce the oppressive paradigm.' All systems of counseling had better give serious thought to this hypothesis as, in fact, few of them have to date done. (pp. 101-102)

Dialectic/systemic interventions. Multicultural counselling and therapy, feminist therapy, and much of family and community therapy focus on how the individual is impacted by systems. Assisting clients to understand how individual issues are part of a larger systemic context is not something we always see in counselling and psychotherapy. Ivey has written on "psychotherapy as liberation" in which the client learns that in many cases, the problem is not in the client, but in the system.

The Developmental Sphere: An Integration

Developmental Counselling and Therapy is holistic and believes that clients benefit most fully when they can experience their issues, tell concrete stories about these issues, reflect on what occurred in relation to these issues, and also see these same issues in a broader systemic context. Thus, as was noted previously, one cognitive/emotional style is not better than another, but further and deeper development within each style is what is desired. Figure 3 summarizes the DCT assessment and treatment model in visual form. Keep in mind, that higher is not better; rather more awareness within and across the four cognitive/emotional styles is what is to be sought.

The Developmental Sphere illustrated in Figure 3 provides a summary overview of the model. The sphere provides a visual understanding of the complexity of human consciousness development. Clients have the capacity to operate within all domains of the sphere. Looking at it holistically, the sphere provides the therapeutic underpinning for making decisions about how and when to use strategies from the various counselling approaches to match and then extend the client's use of multiple cognitive/emotional styles. It also helps identify the primary styles of consciousness a client is using at the moment. Consider a client whose primarily operating from a formal/ reflective cognitive/emotional processing style. This client may demonstrate little interest in or ability to consider aspects of other styles of consciousness. Imagine a "bulge" across the formal operational domain that can be mapped over time to assess movement in therapy.

Some clients need to work within their primary cognitive/emotional style before moving to an adjacent one (i.e., either "up" or "down"). Other clients are ready for explorations within less familiar

Counsellors use DCT questioning strategies framed within various cognitive/emotional styles to engage clients in therapeutic dialogues that generate broader perspectives of the issues and the options for change.

styles of consciousness and will need support maximizing their learning from these under-utilized perspectives. As clients progress through their current style of consciousness and onto others, the therapeutic environment needs to shift. The sphere helps counsellors determine the types of conversation and exploration methods that might best be used to maximize explorations within each of the four styles of consciousness at any given time in treatment.

In sum, brain-based activity supports the construct of different styles of consciousness. DCT **assessment methods** are based on the premise that clients rely on a primary cognitive/emotional style to understand and approach particular problems they are working through. Counsellors use specific DCT questioning strategies to ascertain the primary style clients rely on to understand and express the thoughts and feelings associated with the issues that brought them to therapy and to determine their capacity to access resources from other styles. DCT treatment methods are based on the premise that clients do have the capacity to access resources from less familiar or not yet realized cognitive/emotional styles. Counsellors use DCT questioning strategies framed within various cognitive/emotional styles to engage clients in therapeutic dialogues that generate broader perspectives of the issues and the options for change. For example, a client might rely on a formal/reflective processing style to understand his marital relationship and, at the same time, rely on a concrete/situational processing style when it comes to issues of parenting. The holistic nature of DCT permits these and other less familiar processing styles to be explored and reinforced during the treatment phase.

Clinical Applications of DCT to Practice

At the **individual** level, clients are concerned with the tensions that may be generated about their sense of self-identity: That is, "Who am I as an individual person"? Such tension can be generated when they recognize inconsistencies between and among the many self-narrative scripts they are relying on to guide their current and future behaviors. Tensions also may arise from inconsistencies in intrapersonal and/or interpersonal narratives: That is, "How do others perceive me as an individual person"? At this level, DCT questioning strategies can be used to assist clients in defining the contours of their major narratives and in identifying the intersections among these narratives such that clients can focus on major life themes embedded in their predominant narratives.

As noted before, DCT aims to design therapeutic environments that promote active client exploration of the treatment objectives. DCT counsellors use their understanding of the individual's styles of consciousness to tailor conversations that focus on strengthening the predominant styles and extending access to other styles. This is the empowerment goal of DCT. When individuals realize the many resources they have readily available to understand their difficulties, they can activate pathways to resolve these issues in an adaptive, productive fashion. Their sense of agency, confidence, and competence increases, thus reinforcing their resiliency and personal sense of power. In individual counselling, the use of DCT empowers counsellors to make informed treatment decisions that maximize these types of processing opportunities for their clients.

The ability for DCT to promote empowerment was first realized in the original clinical trials of the model. In 1990, Rigazio-DiGilio and Ivey reported that all subjects participating in a study of the model's reliability and predictive validity were able to consider their issues from all cognitive/emotional perspectives. "The evidence found in this study suggests that DT can help depressed patients achieve a greater sense of self-awareness, in that all subjects demonstrated the ability to progress from simplistic, unidimensional perspectives of their situations to more complex, multidimensional cognitive frames during the treatment phase of this study" (p. 474).

At the **family** level, Systemic Cognitive Development Therapy (SCDT) provides similar questioning strategies to first assess a family's collective cognitive/emotional processing style and predominant narratives. Here the number of narratives available to the family and within the therapeutic encounter geometrically expands as multiple individuals forge various alliances within and outside the family system.

SCDT posits that as members of a family or wider group, like a network, interact with the environment they create and share collective cognitive/emotional styles by participating in resonating experiences. Those resonating experiences generate intrapersonal and interpersonal narratives that may relieve or exacerbate tensions. As with DCT, research confirms that these collective information processing styles can be reliably identified and elicited through specific questioning strategies (Speirs, 2006).

Families whose tensions are debilitating may seek counselling. When they do, SCDT assessment and treatment strategies can be used to first match and then challenge families to use the strengths of their current processing styles and to shift to less familiar or less utilized styles in order to promote growth for all family members. Ho, Rasheed, and Rasheed (2004) comment that the questioning strategies associated with DCT and SCDT are helpful when working with ethnic minority families. Both provide specific, language-based methods so that families and counsellors can coinvestigate personal, social, and ethnocultural realities in the multiple life spaces families reside within to identify meaningful themes related to sociopolitical and relational constraints.

For example, the Serranti family came to treatment because of the distress members were experiencing due to the father's terminal cancer prognosis, the daughter's increasing oppositional behavior at school, and the mother's anxiety about her new role as the family's primary breadwinner and caregiver. Problem-solving at the parental level had ceased and the family was in a reactive mode, responding to the expectations (viewed as demands) of medical and school officials. The family lost a collective narrative that members had come to rely on, and external agencies (i.e., hospital, school) were not talking with the family or one another. The core themes of loss, decreasing competence and confidence, and withdrawal became dominant in shaping the family's collective narratives.

Using SCDT assessment methods, the counsellor and family identified three goals for treatment: 1) To help the family

replace the negative, disempowering image of the family with a positive, proactive identity; 2) To align efforts of the medical team, the school, and the family to attend to the issues of anticipating the father's decline and death, the daughter's school behaviors, and the mother's new role; 3) To improve the communication patterns within the parental subsystem.

SCDT's contextual approach requires counsellors to consider internal and external dynamics affecting the family. Treatment concentrated on using matching and mismatching strategies to help family members extend and alter their image of themselves as competent members of a competent family. The outcomes of this holistic approach were to empower the Serranti family to improve internal communication and problem-solving strategies and to guide the work of medical and school personnel while living through the father's dying process and creating memories and legacies.

The Australian Counselling Association Experience

Mary and Allen Ivey will be presenting a one-day workshop on Developmental Counselling and Therapy on November 7, 2011. The session will highlight DCT as an integrative brain-based approach to counselling. Participants will encounter the basics of the framework, learn more specifics on how to assess cognitive/emotional styles, and work through a basic DCT interview and treatment plan.

The day-long workshop will present an update of the current revision of the Diagnostic and Statistic Manual of Mental Disorders (DSM-V), as well as the National Institu`te of Mental Health's action initiative to move from DSM to a brain-based model. In this light, DCT's views on the treatment of depression will be presented followed, later in the day, by an update on the new DSM V approach to personality "disorder," which DCT prefers to think of as personality style.

Throughout the presentation, current issues related to neuroscience will be included. Special attention will be given to the often neglected sensorimotor and dialectic/systemic styles. The Community Genogram will be introduced as an effective way to help clients see their issues in social/cultural context. Participants will learn how to guide their clients to an increased sense of themselves as people-in-systems and persons-in-context.

The Iveys will keynote the ACA Conference the following day with an overview of neuroscience and counselling. Part of this presentation will focus on substance abuse and on how an understanding of neuroscience can be beneficial both to counsellors and clients. And, on November 9, 2011, Allen Ivey will repeat the workshop on personality style/disorder from the one-day workshop. Mary Ivey will take a different tack and present specifics on how microskills and the structure of the interview can help us understand the increasingly popular coaching movement. Her objective is not to make counsellors into coaches, but to show how coaching really is part of effective counselling and interviewing.

All that sounds well and good, but what can DCT do for you today and tomorrow? Come to these sessions and find out for yourself.

When individuals realize the many resources they have readily available to understand their difficulties, they can activate pathways to resolve these issues in an adaptive, productive fashion. Their sense of agency, confidence, and competence increases, thus reinforcing their resiliency and personal sense of power.

Notes

1. Allen Ivey is Distinguished University Professor (Emeritus), University of Massachusetts, Amherst and Courtesy Professor, University of South Florida, Tampa. Mary Bradford Ivey is Courtesy Professor, University of South Florida, Tampa and Award Winning School Counsellor in the Amherst, Massachusetts Schools (Retired). Sandra Rigazio-DiGilio is Professor, Department of Human Development and Family Studies, University of Connecticut, Storrs. Contact information allenivey@gmail.com. (© 2011 Allen E. Ivey, allenivey@gmail.com)
2. © 2011 Richard D. Lane, M.D., Ph.D. Presented here by permission.

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Mapping Competencies for Entry to the Counselling Psychotherapy Profession in Australia

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Abstract

In the Australian and Asia Pacific contexts, counselling is a fairly new discipline with a decidedly fresh and foundational opportunity to explore the nature of the discipline in generative ways arising from local and multicultural contexts. This paper proposes to the profession a timely, practical, and integrative model for core competencies. The model arises from a reflection on contemporary Australian and Asian Pacific contexts in clinical practice. In a rich cultural, linguistic, multi-national, collegial, and post-colonial context, the model proposed carries forward contemporary notions of competence from wholistic perspectives.

Introduction

The purpose of this paper is not to convey even a briefly adequate survey of the literature in the area of competencies in practice. Nor is the purpose to convey a comprehensive description of the content areas under discussion. To really grapple with this paper, the most challenging aspect for readers is that all of this prior knowledge is assumed. This reminds me that I have written this paper assuming my undergraduate, graduate and doctoral studies in fields related to western therapeutic practice along with well over a decade of teaching and leadership in the field. The literature is extensive, long-standing, and can take a practitioner a decade to gain a basic comprehensive perspective warranting a senior level analysis. In one sense, this paper is written for those in positions of leadership who may appreciate a discourse opened up around central issues of defining fields of competence related to design and evaluation of curriculum in training programs. But at the same time, every practitioner at the coal face knows what they need to do in order to practice in effective ways. We understand the notion of core theoretical and skills based awareness – and we know that our perspectives are always growing and changing if we wish to stay current, and to remain vital as a therapist. With a sense of humility, we ought to come to this discussion realising that we must in some ways put our personal bias aside to engage with a vision for the discipline that can provide a well-rounded, culturally-grounded, and practical model that can support the field regardless of areas of specialisation, focus, or application.

Contemporary Contexts

From contemporary examples of national efforts towards articulating standards for practice and education as competencies, such as those of the Task Group for Counsellor Regulation in British Columbia, Canada (2007), a comprehensive package endorsed by at least three other Canadian provinces to date and which forms the basis for accreditation and regulation in those provinces, to the seminal work of pioneers in the field during the 1970s in America (Fuller 1975) which formed the basis and foundation for counsellor education in the decades that followed, we acknowledge a longstanding interest in defining fields of practice and competencies. More so, we understand that the profession has continually made efforts towards greater appreciation and measurement of competencies.

During the past decade, the field overall has undergone extensive change and development. Much of the development was brought about due to great advances in social technologies, as well as greater appreciation for diversity, culture, and higher expectations around practitioners being prepared for comprehensive and integrated approaches to practice. The profession has been asked from within and from outside to demonstrate greater comprehension and measurement of core competencies as a baseline for entry into the profession (Arrendondo et al 1996).

This movement has been viewed as important for establishing baselines for ethical and professional conduct. Likewise, having baselines is important for the protection of the public, for clear expectations around the social and professional content and boundaries of practice, and for guidelines that assist counsellor educators to develop programs that meet the needs of the public, of practitioners, and of professional governing bodies.

In recent years one expression of this shared disciplinary passion comes through considerable efforts to study and articulate multicultural counselling competencies (Arrendondo et al 1996, Cole 2008). On the international level, as mentioned above, one of the best examples of a comprehensive framework for competencies as baseline for entry to the profession comes from the Task Group for Counsellor Regulation in British Columbia, Canada (2007). From a wider international perspective the British Colombia model is heavily influenced by existing models deployed in the North American context, lending itself to forms of cultural and professional bias. Those of us working at the national and international levels in Australia have already begun to articulate a comprehensive view of counselling and psychotherapeutic practice that is unique from the North American model (Pelling et al 2007). In part, the Asia Pacific perspective has been formed over the past decade from local, national, and regional experience plus through a process of critical analysis of regional views verses our unique perceptions on North American views. In so doing, the profession in Australia and neighbouring countries has come to celebrate both the strengths and weaknesses of the North American conception of the field, and to suggest that there are many other views globally which need to be expressed, articulated, and considered which rest outside of the Northern hemisphere perspective on the discipline.

Depending on people's perspectives, the basic need to articulate a model for comprehensive competencies may seem mute if not downright unnecessary. Certain practitioners may argue that the western canon of practice is very well defined – who are we to suggest otherwise? However, with a sociological and historical view of the field, it becomes clear that definitions of practice and what the domains or boundaries of practice are, is in fact an ongoing and lively debate within and outside of counselling and psychotherapy.

By raising the debate, and asking questions, and proposing a model for comprehensive competencies as a baseline for entry into the profession, there is great potential for mutual discourse, learning and change. There are also greater potentials for a wider understanding between professional associations, bodies, and regulatory authorities in Australia and in the Asia Pacific region. We might, for instance, ask ourselves: what is in fact unique about our perspectives within the global profession? How do we within our Associations wish to define the field? While much of the evolution of the profession, from a sociological stance, may reside with Association and/or Federation politics as various groups gather and debate the nature of the field of practice – by laying out on the table a map of competencies we have at least somewhere concrete and tangible to begin a more logical and scholarly analysis of the domains of practice as compared to what tends to remain a politically driven discussion based in personalities vying for authority.

In contrast, this paper lays out a model focused on the core content and skills areas required by the profession for students to gain entry as certified practitioners. The model proposed brings together in one integrated package international sources and our Asia Pacific experiences to articulate an integrative model for counsellor practice and education. This model only constitutes "a first major draft" that can feed further study, reflection, debate, and practical development. The model can be used as a starting point for accreditation bodies within various sectors within Australia and the Asia Pacific – towards a hopeful and necessary development of actual accreditation models that make more sense, that lend themselves to accountability and public-transparent analysis, and that are responsive to ongoing change and challenge.

Regional and National Contexts for an Emerging Profession

We recall at this time that when the first Australian programs in counsellor education were launched during the late

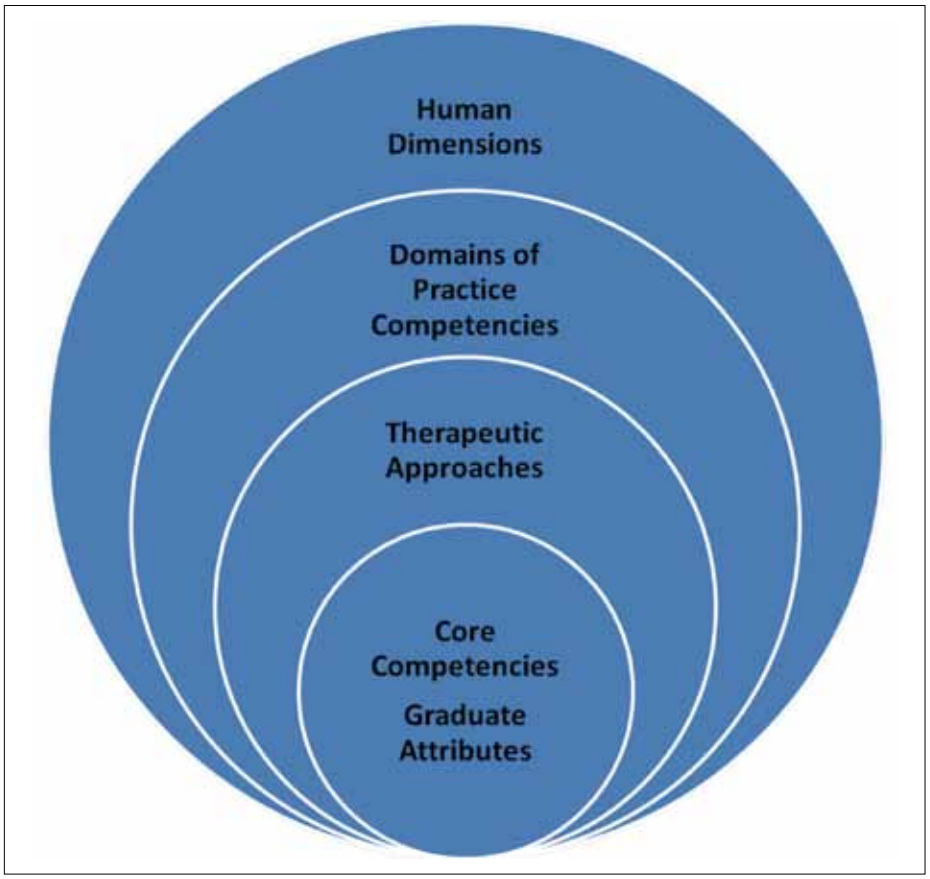

Table One

1990s, counselling as a discipline did not exist in the Australian tertiary sector. Key infrastructure, professional bodies, literature, textbooks, and teaching resources have been developed and instituted over the past six to ten years, with much room for growth in future (Pelling et all 2007). In teaching we still heavily rely on overseas resources, but with greater attention to multi-national sources that decentre American approaches. It appears that contemporary approaches tend to move further in regards to integrating inter-cultural studies, Indigenous approaches, post-colonial analysis, feminist and gender studies, gay and lesbian discourses, narrative approaches, and critical sociological analysis. Counselling as a field of practice is quite unique and distinct from allied fields through the use of current integrative models of counselling and psychotherapy that include aspects of human, social, and environmental ecology such as complex-systemic analysis, among a wide diversity of other approaches and modalities.

With a wider view of counselling we also acknowledge that current philosophy emphasises postmodernism, poststructuralism, post-colonialism, and narrative analysis. All of these new conceptions reflect an inadequacy in previous theories and practices and offer challenges to liberal humanist, existential, and narrowly understood empirical approaches upon which much existing counselling curriculum is constructed. For these reasons, there seems to be a collective albeit somewhat unspoken agreement among practitioners and instructors that the field of counselling has transformed in many ways over the past ten years. There is also a sense that these changes need to be reflected in fresh and new curricula that can speak to widely endorsed competency standards.

Likewise, key leadership changes on the national scene contributed to major developments during 2008, with the historic convergence of opinion that encouraged the Australian Counselling Association (ACA) and the Psychotherapy and Counselling Federation of Australia (PACFA) to collaborate together for the first time in creating one independent national regulatory authority for the field. This became the Australian Register of Counsellors and Psychotherapists (ARCAP). As well, during the same year colleagues in Hong Kong hosted the inaugural Asia Pacific conference at which a new multi-national Asia Pacific Confederation of Counselling was founded.

Since 2008, the field has continued to grow and change following national governmental developments in funding of private psychologists under Medicare. Counselling has moved into many agency based forms of practice during this time while still maintaining a small but important foothold in private practice services. A greater emphasis on comprehensive care has seen the growth in mental health education as a concern within counsellor education. Advances in the practice of supervision suggest future integration of at least introductory supervision theory and skills within counselling psychotherapy as a whole.

Within the field there have been and will continue to be different levels of 'accreditation' of practitioners. Within PACFA at this time, for example, there are entry level standards and the highest level leading to being listed on a national register within the Federation. Within ACA, there is now a four level system which defines competency. The latter will be discussed below.

When taken together, widespread social technologies along with extensive disciplinary changes plus moving forward with key infrastructure developments in the profession have all set the stage for major Australian advances as well as major Pacific regional advances over the coming years. All these changes increase the need for an integrated and distinct model of counselling psychotherapy competencies so that pioneers in many countries can turn to such a model for guidance and inspiration.

The work at hand

The following model reflects upon current requirements and the author's sense of what may be included (or ought to be considered) in upcoming aspirations for the level of entry to clinical membership in the two peak national bodies in Australia (ACA and PACFA). It must be noted that both body's requirements do not yet articulate core competencies. In concert with international directions across many professions and within the clinical counselling sectors in many countries, we suggest that core competencies are viewed as essential criteria for entry to the profession.

Ultimately the profession as a whole and Associations in particular will need to consider the baseline for entry to the profession and how this may be translated into the diverse expressions which support what emerges as core competencies for practice. In this process, aspects of current diversity may be sacrificed toward the clarity of core training requirements which become accepted within the field. Personally, my belief is that diversity can be accommodated within a universal and flexible model of core dimensions for education, training and practice.

Table One

Faculty in various programs will need to reflect on the models that are proposed by the profession, and part of this reflection needs to consider how we express this "core work" of counsellor education and clinical practice within our program(s). Practitioners at the coal face will need to examine their practice in light of this ongoing professional evolution and the changes that are occurring at the national and international levels. This ongoing disciplinary evolutionary process will take at least another ten years of further discussion, debate, and hard-won experience and hindsight, before a profession-wide consensus may emerge. Within this debate the push for governmental regulation among certain sectors of the profession may continue to provide immediacy to these concerns, making our profession all the more aware of the need to self-define our field of practice.

Allowing for all of these permutations, this paper focuses on laying out a "cosmology of practice" or a map for core competencies for entry to the profession. Thus, like good and faithful practitioners we begin with a big-picture and theoretical view of what our profession looks like in its simple-though-elegant form.

The model

Beginning with a big-picture emphasis, 'Table One' presents a nested model that we propose as a unifying and universal symbol of counselling and psychotherapy practice and education across the sector. In many respects, the diversity and wealth of the discipline collectively can be expressed by these inter-related spheres of knowledge, theory, and practice. Again, the purpose of this paper is not to engage in extensive discussion of these models. Rather our purpose is to lay out the models for ongoing discussion, debate and consideration.

Core competencies: The minimum standard required for entry level to the profession of counselling psychotherapy, and for graduation from a four year Bachelor of Counselling or equivalent.

Graduate attributes: Qualities of graduates built into curriculum and complementary to and integrated within the minimum standards required for entry to the profession of counselling psychotherapy, and for graduation from a Bachelor of Counselling or equivalent – as determined by each program following from their unique philosophies of teaching and learning.

Therapeutic approaches: The necessary therapeutic approaches as determined by each program following from their unique philosophies of practice, teaching and learning, and expertise available.

Domains of practice competencies: The necessary domains of practice competencies as determined by each program that build upon their unique approaches, and that further define the fields of competency which their programs embody.

Human dimensions: The dimensions and definitions of meaning and purpose that arise from each program's core values, beliefs, and philosophies which convey their approach to therapeutic practice.

'Table Two' is the 'heart' of the model proposed in this paper. The model articulates the 14 core competencies for counselling psychotherapy as defined by a collective sense of the field unique to Australia and to the Asia Pacific environment.

What does this model mean?

Basically, the model proposed in Table Two suggests that there are 14 core competency fields from which a range of specific competencies can be measured or assessed toward completion of a Bachelor equivalency. This means that counsellors who wish to gain entry to professional accreditation must successfully complete these competencies, or be deemed to have completed them, by an accredited counsellor education provider.

As of 2008, the competency domains defined by many overseas national regulatory bodies include various expressions of core competencies in:

1. counselling process;
2. professional ethics;
3. collegial relationships;
4. diversity and culture, as well as
5. individual, couple, family, and
6. group – as areas deemed necessary for entry to the profession.

The proposed model is more comprehensive and includes:

1. self care;
2. supervision;
3. management and marketing;
4. clinical assessment;
5. mental health,
6. distance technology as well as
7. loss, grief and trauma.

While certain people may argue that the proposed model covers too many areas, a more logical analysis suggests that these areas are already required in Australian and Asia Pacific contexts, and are indeed a core part of practice within most international contexts. The main challenge this model presents rests with

The profession of counselling psychotherapy provides one important example of the importance of civic support of higher education, its standards and its integrity.

educational providers who must grapple with ways to apply a comprehensive body of theory, knowledge, and skill within a foundational competency leading to graduation from a Bachelor award or qualifying Master degree or equivalent.

The other insight to offer at this stage is that the model as proposed does reflect directly on a comprehensive knowledge of the disciplinary literature, and the so-called "new" domains represented by areas such as clinical supervision, mental health, or marketing and management of clinical practice are already well established within the literature, as well as being practiced at the coal face and within many existing counsellor education programs – and yet these core dimensions have never before been an overt and transparent part of what constitutes professional accredited education and training for entry to the profession. By remaining outside of our core competency models, these areas also lie outside of accountability structures. They may or may not become part of counsellor education programs, and in so doing, we may leave the training of counsellors and psychotherapists up to chance depending on the knowledge, awareness and skill of various education programs. At the same time we must acknowledge that over regulation of the field is not productive. Yet we must agree that forming a basic map, vision or cosmology of what counselling practice is all about will always leave a great deal of latitude for creativity and diversity in application and interpretation. Both the spectrums of freedom and regulation must be maintained to some degree for a sustainable and healthy disciplinary context.

Three Primary Levels of Competency

Each area within the 14 core competency areas relates to three specific measures that can be addressed in different ways within any given training program. These are entry level competency; advanced competency; and expert competency. These three levels allow accreditation bodies and training providers to set realistic goals for outcomes in learning and attainment. Below is a working description of each level.

1. Entry Level Competency

The Counsellor Psychotherapist at this level is able to handle all routine situations by applying the relevant competency to the situation in a way that is consistent with standards in the profession. They can function without supervision or direction, and within reasonable timeframes. The Counsellor can select and apply competencies in an informed manner. The Counsellor can anticipate outcomes in a given situation, and responds appropriately. The Counsellor is competent in demonstrating the range of measures and can be adequately rated on each major field of competency. They are able to assess and recognise unusual or difficult to resolve or complex situations. The Counsellor is able to take appropriate steps to address these situations based on ethical standards of practice. They are capable and prepared to seek consultation and/or supervision. The have capacity to review the research literature relating to difficult or complex cases and as a matter of standard practice. The Counsellor is also highly skilled in regards to appropriate issues and processes around referring the client on to other services.

2. Advanced Competency

The Counsellor Psychotherapist working at this level has extensive experience and can demonstrate a nuanced comprehension and acknowledgement of interpersonal and clinical environments. Based on a long term commitment to practice resulting in seasoned perceptions that are able to quickly assess the dynamics of a case, the advanced clinician is able to make efficient decisions and to facilitate effective and timely treatment plans. They are able to discern the many aspects of a presenting situation while focusing in on important areas for client outcomes. The advanced clinician is competent in proceeding toward treatment outcomes and can work effectively with most unusual, difficult to resolve and/or complex situations. With appropriate training and preparation, these practitioners are able to engage in clinical supervision and in the education and training of counsellors.

3. Expert Competency

Counselling Psychotherapists with expert competency are recognized as leaders in the field. The expert clinician is able to demonstrate excellent client outcomes and have normally developed one or several clinical specialisations. The expert clinician is recognised for contributing regularly to the advancement of the profession. They are often senior practitioners who engage in clinical supervision, and/or counsellor education and training, and/or to public and professional speaking engagements, conferences, and to original written contributions to the literature of the field.

Taking this notion of levels of practice competency further, and applying it to current needs within the profession as a more transparent model for the public, government and regulatory bodies, ACA has developed a four level model, reporting that they did this based on pressures from employer groups.

ACA have indicated that "several employer groups including WorkCover (NSW) and the Federal government have indicated that ACA needs to introduce a system that is more transparent for employer groups. Categories need to be formed to reflect the real experience and qualification level of members, terms such as Clinical and Professional do not do this and the term Clinical tends to lend itself more to a medical leaning. The term Clinical in counselling associations is also so overused with no consistent criterion it no longer reflects experience and seniority it once had" (ACA 2011). ACA also suggest that introducing a transparent system will allow employer groups to identify rates of pay appropriate for each level, following the Australian system of levels within award systems, perhaps making the newly instituted system a first step toward a National Award for Counselling Psychotherapy.

Australian Counselling Association Award Levels

Counsellor Level 1

- Has graduated from an ACA Accredited Course of study.
- Completes 25 Points of ACA approved Ongoing Professional Development per annum.
- Completes 10 hours Professional Supervision per annum.

Counsellor Level 2

- Has graduated from an ACA Accredited Course of study at minimum Diploma Level and has a minimum of 2 years post-Diploma professional experience; or 1 year post-Diploma experience plus hold a Graduate (vocational or higher education) qualification; and has completed a minimum of 50-hours Professional/Clinical Supervision.
- OR,
- Has graduated from an ACA

Accredited Course of study at minimum Degree Level.
- AND,
- Completes 25 Points of ACA approved Ongoing Professional Development per annum.
- Completes 10 hours Professional Supervision per annum.

Counsellor Level 3
- Has graduated from an ACA Accredited Course of study at minimum Degree Level.
- Has 3-years post qualification counselling experience, including minimum 750 client contact hours.
- Has completed a minimum of 75 hours Professional/Clinical Supervision and completes 10 hours Professional/Clinical Supervision per annum.
- Completes 25 Points of ACA approved Ongoing Professional Development per annum.
- Requires a statutory declaration declaring client contact hours

Counsellor Level 4
- Has graduated from an ACA Accredited Course of study at minimum Degree Level.
- Has 6-years post qualification counselling experience, including minimum 1,000 client contact hours.
- Requires a statutory declaration declaring client contact hours
- Has completed a minimum of 100 hours of Professional/Clinical Supervision and completes 10 hours Professional/Clinical Supervision per annum.
- Completes 25 Points of ACA approved Ongoing Professional Development per annum.

The ACA Levels of Award status provide a much clearer framework for placing the majority of the members of the profession into relevant award categories. The categories can be more easily associated with education and training as well as counselling practice and supervision experience. In future, we imagine the levels may extend to include a more advanced practitioner and senior level, particularly when this model is used to bid for associated levels of salary. At the same time, it is conceivable that at some stage both PACFA and ACA may increase entry to profession expectations, however, the transparency of the model proposed by ACA suggests that Diploma qualified practitioners will have a place in the industry for the foreseeable future.

This paper proceeds from the point of focusing on Level Two of the ACA framework noted above, where the assumption is that practitioners are degree qualified or equivalent. The "or equivalent" is used quite often in the higher education sector to allow for flexible entry into programs based on a combination of prior education and professional or employment experience. In this sense, the ACA model is not far off from the needs of the education sector to more clearly define the needs of the profession in the context of designing programs that meet entry and exit requirements.

What we really wish to map here is the main content areas of a Bachelor of Counselling for entry into the profession, as we are assuming that regardless what happens in future with "lower" level qualifications the standard is now set at this minimum of a degree qualification, and that this will become even more clear over the coming years.

Conclusion

This paper then proceeds to map the 14 Core Competencies for Counselling Psychotherapy. The best way to map this complex set of measures seems to be in a 'grid' into which the various parts of each competency area can be placed. By documenting these areas in a way that describes the required content or focus and application of the competency, we have provided a valuable baseline from which to construct counsellor education programs – as well as to lay claim to a process of possible accountability through a documented practice of education and training.

We also not that to this time, the responsibility to map curriculum has largely been the sole domain of higher education providers. This proposed model does not negate the traditional independence of the education sector to self-define curriculum content focus and pedagogy standards. However, in Australia the mass scale erosion of the higher education sector has resulted in the corporatization of the sector, to some degree, which has influenced a move during the past decade to grab market share in while providing a less than adequate disciplinary content and standard for counsellor education, often housing counselling courses under a social sciences umbrella without adequate provision for professional disciplinary standards.

Clearly if the higher education sector cannot manage its own affairs and provide the highest quality of education and professional standing, other sectors of the Australian society must step up to the plate and contribute to the establishment of accreditation standards. In many respects, this is the role of groups like PACFA and ACA, which even though they have been in some ways too closely aligned with educational providers, must also realise their civic duty as professional members of such a group in society to articulate an independent membership-driven stance on defining standards for practice and for education to practice.

Having stated these things it is important to note that in my case, this paper has been in a process of development since 2007 when I was working within the counselling program of the University of New England. This paper reflects the evaluative emphasis of these years where, truth be told, many of the programs in which I found myself working were felt

to be less adequate and less contemporary than they could have been. This is no news as my prior work has suggested many ways that counsellor education can be improved, especially in regards to minority populations. When finishing this paper I had only just taken on the role of Program Leader in Counselling with the University of the Sunshine Coast. Therefore, it needs to be clear that this paper does not represent a reflection on any specific program from the past or present. Indeed, this paper reflects on a rather ideal model of what we ought to consider as important to include in a comprehensive but realistic and manageable program that may run between three to four full time years.

My role within programs and in the profession over the years has been as a voice of conscience and contention, for example, raising debates and issues that needed to be considered during the rush of the Howard Government era when we were forced to rationalise and dismantle much that we had prior created. Without a doubt, the wider corrosive politics of education and the internalised processes that academics engage in during the development of educational programming reflect the fundamental critical issues of this era in which we live, underscored by the stress and anxiety that occurs when changing or developing programs. It is no wonder that many express how stressful the higher education sector can be as a place to work. Most essentially, when academics feel their jobs may be on the line under economic rationalist agendas or simply due to what appears to be a pervasive social loathing by members of government toward independent scholarship that would dare to speak to the issues of the day and to provide a necessary social and scientific conscience to the decisions of government, corporate and business concerns, we have a situation when most academics just stop contributing to the social debate for fear of their job security. In this context, the corporate management of education can lead to the compromise of academic standards. Corporate dominance in higher education can reduce scholarship to a product.

These are powerful statements that reflect back on the Australian Government agenda which needs to be confronted by all sectors of society, and that have their own unique impact on counselling education programs. The profession of counselling psychotherapy provides one important example of the importance of civic support of higher education, its standards and its integrity. The independence of scholarly and academic affairs are factors essential for the development of the professions, as our task is to not only help define the field of practice but to speak to the real and most difficult issues of society with a pragmatic concern for public health and safety.

Therefore, it is important to realise that the model proposed here does not agree with first admitting limitations. Academics today are big on foregrounding limitations, because they know how hard it is to effect change. They also know how defeating it can be to invest enormous personal energy into their passion only to realise that the system will crush them one way or the other. In spite of these contexts, which I have great empathy for, this model proposed reflects on what is possible and what ought to be considered regardless the particular contexts of any given school or institution. My approach is still to move forward with dreams and visions for my profession as my primary commitment, otherwise I would have given up several years ago and this work would not see the light of day.

The 14 Core Competencies for Counselling Psychotherapy is designed for any program across the field to fill in their own measures relevant to each category. Some information or examples are provided.

The Grid may assist program faculty and teams in determining how their own program can address the standards in their own unique ways. Likewise, the Grid could assist professional bodies in requesting information about how programs address criteria in a more transparent and comprehensive manner.

Additional columns or additional categories can be added to further define specific competency criteria for each component of curriculum. So this draft is only a draft and ought to be developed and debated as necessary. For example, certain fields of competency may take on less significance, and others will be fore-grounded. We see this as a natural and necessary expression of the diversity our discipline supports. Depending on the program emphasis, each field will be toned down or expanded accordingly.

The Grid can be used for many purposes. Some of these purposes may be to:

1. express curriculum that currently exists,
2. evaluate and develop course content,
3. rate or assess candidates, and
4. form a basis for accreditation of programs.

For example, within a learning context, a 'Student Assessment Grid' can be generated from the information provided here that can be integrated throughout a curriculum, making setting assessment tasks and outcomes easier, while giving students a map through which to navigate during their program.

As the nature of this paper is about tabling the model for discussion, this paper will end with an open invitation to members of the profession to consider what you wish to see as the future of our field, and how you would want the future education of counsellors to evolve.

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Appendix One: 14 Core Competencies for Counselling Psychotherapy

Core Competency Field	Core Competency Criteria	Core Competency Measure
	Upon entry to the field of Counselling Psychotherapy, and/or upon graduation from a Bachelor of Counselling or equivalent, the candidate will be able to:	Note: While this column would normally be filled out by the training program or provider, we provide examples as reference points only.
1. Counselling process	1.1 Demonstrate comprehension of counselling theory and skills	1.1.1 Programs specify theoretical approach
	1.2 Demonstrate adequate practical skills relevant to the approach under study	1.2.1 Core-micro-skills, which may include clear and concise communication; speaking in a way the listener can understand; conveying information; offering instruction or guidance when appropriate; demonstrating empathy; feedback meaning and feeling; open and closed questions; appropriate use of silence; appropriate use of confrontation; appropriate use of self-disclosure; using effective listening skills; differentiating fact from opinion; evaluating the meaning and significance of non-verbal communication; responding appropriately to non-verbal communication; attending to voice qualities during communication; responding appropriately to voice qualities during communication; showing and conveying respect and unconditional positive regard; exploring the full range of emotions; engaging client strengths; maintaining appropriate boundaries; identifying potential or implied conflicts whether overt or covert, verbal or non-verbal; identifying potential ruptures in the therapeutic relationship and taking appropriate steps to re-establish therapeutic alliance; using appropriate conflict resolution skills; following through on commitments to clients in a timely and efficient manner; monitoring the impact of self on others; maintaining congruence and authenticity between what is said and what is done; ensuring interventions are timely within the context of therapy; identify significance of action and non-action; attend to pre-therapy, in-therapy, between therapy changes; attend to contexts and influences; monitoring progress toward client goals or objectives; summarising in-session; offering a review of progress with the client periodically; changing the direction of therapy as necessary; identifying when to conclude therapy; engaging closure skills. 1.2.2 Contingency skills may include responding appropriately to: litigation, client emergencies, hospitalisation, suicide ideation, third party indifference, premature closure, lack of funds to pay for therapy, conflict and expressions of violence toward therapist. Identifying circumstances where referral is necessary may result from adequate planning for contingencies. 1.2.3 Evaluative skills may include gaining client feedback verbally, through written forms; engaging a therapist/client dual evaluation; developing a format and SASE for encouraging client post-therapy evaluation two weeks, one month, and three months after therapy ends; asking the client key questions such as 'on a scale of one to ten, how likely are you to suggest my services to a friend?' 1.2.3 Evaluative skills may include gaining client feedback verbally, through written forms; engaging a therapist/client dual evaluation; developing a format and SASE for encouraging client post-therapy evaluation two weeks, one month, and three months after therapy ends; asking the client key questions such as 'on a scale of one to ten, how likely are you to suggest my services to a friend?'
	1.3 Demonstrate adequate interpersonal skills in facilitating the counselling process	1.3.1 Introduction and orienting of client to therapist's practice, therapist's education, qualifications and background; explain the scope of practice; describe expertise and limits of expertise; obtain consent and agreement; explain client's right to stop, pause, and/or refuse therapy at any time; documenting intake information; and providing client with adequate information on their rights and responsibilities as well as the rights and responsibilities of the therapist relevant to the model of therapy you employ; explain the limits of confidentiality; provide a copy of key procedural or administrative information or policies; respond to client questions 1.3.2. Establishing and maintaining core conditions, consistent with relevant theory and practice; troubleshoot difficulties as they arise in each case; engage in assessment, obtaining of information, and integration of multiple levels of information during therapeutic process; conduct an appropriate risk assessment 1.3.3 Explore client's issues or concerns; establishing a therapeutic focus; move through the therapeutic focus; maintain therapeutic relationship; structure and facilitating the therapeutic process; manage interruptions to the therapeutic process 1.3.4 Conduct appropriate referrals; conduct appropriate closure process; evaluate clinical practice; seek supervision; seek feedback on practice
	1.4 Demonstrate ability to self-reflect, analyse, and critique performance and the place of self within the therapeutic process	1.4.1 Self reflection; analysis; critique of performance; balanced articulation of self awareness; document ability to learn, develop, change direction during learning processes; document ability to maintain flexibility and openness to critique and critical feedback; articulate learning goals; show developmental plan
	1.5 Demonstrate ability to identify contexts where therapeutic strategies are contraindicated	
	1.6 Demonstrate ability to integrate knowledge of historical, philosophical, socio-cultural, and scientific foundations for theory and practice	
2. Relationship	2.1 Demonstrate adequate knowledge of theory related to couple counselling	2.1.1 Theory 1 2.1.2 Theory 2
	2.2 Demonstrate adequate ability to work within an established theoretical framework	2.2.1 Theory 1 2..2.2 Theory 2
	2.3 Demonstrate adequate practical skills relevant to the approach under study	
	2.4 Demonstrate adequate interpersonal skills in facilitating couple counselling	

Core Competency Field	Core Competency Criteria	Core Competency Measure
	2.5 Demonstrate adequate knowledge of theory related to family counselling	
	2.6 Demonstrate adequate ability to work within an established theoretical framework	
	2.7 Demonstrate adequate practical skills relevant to the approach under study	
3. Group	3.1 Demonstrate adequate knowledge of theory related to group work and group counselling	
	3.2 Demonstrate adequate ability to work within an established theoretical framework	
	3.3 Demonstrate adequate interpersonal skills in facilitating group work and group counselling	
	3.4 Demonstrate ability to apply appropriate leadership skills to group practice	
	3.5 Demonstrate ability to evaluate group therapy outcomes	
4. Diversity and culture	4.1 Demonstrate adequate comprehension of diversity issues and contexts in therapy	4.1.1 Across a range of areas including ability, age, class, education, ethnicity, gender, giftedness, health, immigrant status, indigenous status, language, personal identity, race, religious beliefs, sexuality, socio-economic status, and spirituality. 4.1.2 Recognise how differences may impact and/or interact with therapeutic approaches. 4.2.3 Adapt and adjust approach as necessary when working with diverse clients – and indeed, all clients 4.2.4 Recognise how subtle or blatant, chronic or acute, experiences and/or perceptions of discrimination, prejudice, bias, and oppression negatively impact on people's functioning 4.2.5 Acknowledge help seeking behaviours, and the barriers to accessing counselling services 4.2.6 Acknowledge how the therapist's beliefs, values, and bias can negatively impact on clients, particularly diverse clients 4.2.7 Identify, collect, and utilise resources for and with culturally diverse clients
	4.2 Demonstrate adequate use of socio-critical, historical, and political tools of analysis	4.2.1 Post-colonial; Feminist; Post-modern; Critical theory
	4.3 Demonstrate adequate comprehension of cultural issues and contexts in therapy	4.3.1 Multicultural or inter-cultural; Indigenous and traditional cultures; Ethnic and immigrant; Racism, prejudice, violence; Integration of self-culture and familial background in practice; Openness to inter-cultural dialogue, discourse, and challenging existing methods by new insights gained; Openness to working within linguistic and cultural references of clients, to learning their language, and to gaining cultural knowledge outside the confines of therapy; Facilitating appropriate co-therapy, interpretative services, support, and/or referral where the above is beyond the capacity of the therapist
	4.4 Demonstrate integration of knowledge regarding spirituality, religion, and meaning	
	4.5 Demonstrate integration of moral development, reasoning, rationality, and consciousness	
	4.6 Demonstrate personal and professional ability to acknowledge beliefs and values related to issues in therapy	
5. Professional ethics	5.1 Demonstrate adequate knowledge of relevant ethical codes within the profession, and the codes of allied professions	5.1.1 Specify codes 5.1.2 Demonstrate ability to apply step-wise and complex ethical decision making processes within the context of therapy
	5.2 Demonstrate adequate knowledge of legal requirements nationally and in each state, particularly where the practitioner is residing	5.2.1 Specify National, My state, Surrounding states 5.2.2 Demonstrate ability to apply legal frameworks to informed decision making processes within the context of therapy
	5.3 Demonstrate adequate knowledge of ethical and legal issues in distance therapy and supervision that cross political and national boundaries	5.3.1 Ethical guidelines for distance counselling 5.3.2 Legal issues in distance counselling 5.3.3 Ethical guidelines for distance supervision 5.3.3 Ethical guidelines for distance supervision 5.3.4 Legal issues in distance supervision

Core Competency Field	Core Competency Criteria	Core Competency Measure
	5.4 Demonstrate compliance with all relevant legal requirements of training and service provision	5.4.1 Forms 5.4.2 Protocols 5.4.3 Maintain client records 5.4.4 Mandatory reporting 5.4.5 Documentation and case notes 5.4.6 Document clear boundaries between training practice verses other types of practice undertaken 5.4.7 Ensure security of information when using email, internet, video, or other distance technology for counselling or supervision purposes, or for transmission of client data
	5.5 Demonstrate current knowledge of regulatory requirements and professional associations	5.5.1 Maintain evidence of current student-membership in a professional association 5.5.2 Maintain evidence of personal indemnity insurance and public liability insurance as appropriate for the training context verses the student's other practice
	5.6 Demonstrate participation in continuing education and ongoing professional development	5.6.1 Demonstrate record of professional supervision 5.6.2 Demonstrate record of lecturer supervision 5.6.3 Demonstrate record of peer-supervision 5.6.4 Demonstrate ability to identify circumstances where the therapist's own life experiences may compromise therapeutic effectiveness 5.6.5 Demonstrate ability to identify circumstances where the therapist's own life experiences may enhance therapeutic effectiveness
	5.7 Practice in a way consistent with the role of the Clinical Counsellor and Psychotherapist within the health care and social welfare sectors	5.7.1 Define the limits of competence and consult within these limits 5.7.2 Define the limits of competence as an educator or trainer and practice within these limits 5.7.3 Engage in group process, education, and therapy within the limits of defined competence 5.7.4 Demonstrate capacity to advocate for clients 5.7.5 Demonstrate capacity to speak and write to critical social and political issues on behalf of clients and the profession 5.7.6 Demonstrate capacity to write clear, concise, and accurate reports, presentations, and paper drafts for submission to disciplinary journals
6. Management & marketing	6.1 Demonstrate adequate comprehension of management theory	
	6.2 Demonstrate ability to work within an established theoretical framework in management and workplace supervision (as differentiated from clinical)	
	6.3 Demonstrate adequate practical skills relevant to the management approach under study	6.3.1 Employ sound financial management skills 6.3.2 Employ ethical advertising 6.3.3 Establish a fee schedule 6.3.4 Establish policy related to third-party payment 6.3.5 Establish policy related to client attendance 6.3.6 Establish effective business strategy to respond to client crisis 6.3.7 Establish procedure to deal with workload while away from practice, on vacation, or in the case of illness or personal crisis 6.3.8 Demonstrate adequate comprehension of marketing guidelines for the profession 6.3.9 Demonstrate capacity to develop a management and marketing five year plan to support clinical practice provision 6.3.10 Demonstrate planning and time management skills
7. Clinical supervision	7.1 Demonstrate adequate comprehension of clinical supervision theory	7.1.1 Specify theory, and/or create and develop theory
	7.2 Demonstrate adequate comprehension of clinical supervision standards for practice	7.2.1 Specify standards, and/or create and develop standards
	7.3 Demonstrate capacity to engage in collegial and mutually supportive peer-supervision through one-on-one arrangements and through small groups	
	7.4 Demonstrate comprehension of the importance of supervision for competent practice	
	7.5 Identify sources for appropriate supervision	7.5.1 Articulate purpose, focus, and outcomes for supervision 7.5.2 Agree on a contract for supervision 7.5.3 Apply feedback from supervision to practice 7.5.4 Identify when supervision is urgent 7.5.5. Protect client confidentiality and rights while undertaking supervision
8. Self care	8.1 Demonstrate capacity for growth in self-awareness throughout clinical training and commitment to ongoing life-long learning	8.1.1 Keep a personal clinical learning journal 8.1.2 Chart and/or document learning process for evaluative purposes
	8.2 Demonstrate ability to negotiate high-pressure schedules during the course of study and/or practice while maintaining self-care and personal health necessary for responsible therapeutic practice	8.2.1 Document monthly schedule 8.2.2 Note times and activities undertaken for self-care 8.2.3 Demonstrate capacity for self-care and self-growth by documenting related personal goals relevant to practice and life-long learning 8.2.4 Demonstrate capacity to seek personal support when needed 8.2.5 Build and regularly use and manage a personal and professional support network 8.2.6 Maintain personal hygiene and appropriate apparel 8.2.7 Respond to signs of burnout before this occurs, and recognise burnout as an occupational hazard

Core Competency Field	Core Competency Criteria	Core Competency Measure
	8.3 Demonstrate capacity for self-evaluation and improving profession performance	8.3.1 Show how feedback from lecturers and/or supervisors is taken on board 8.3.2 Initiate and seek out personal counselling and/or supervision 8.3.3 Chart development of performance by making a 'mind map' of key moments of learning and how these were later incorporated in practice
	8.4 Keep a professional portfolio of practice and related information for career advancement, lifelong learning, and for quality assurance	8.4.1 As specified in training handbook or manual, and as required for evidence for professional membership and maintaining membership from time to time
9. Collegial relationships	9.1 Maintain professional relationships with peer trainees, co-workers, colleagues and appropriately disclose and/or document any conflicts of interest as they arise	9.1.1 Inform program coordinator of issues, gain advice, and possibly document issues as necessary 9.1.2 Maintain professional relationships within the health and social welfare sector relevant to your work, location, and context
	9.2 Take responsibility for your representing the training institution and/or professional body and/or employer in your clinical practices, and maintain high standards for professional behaviour and ethical conduct	9.2.1 Take responsibility for understanding and complying with complaints protocols, disciplinary, and suspension procedures
	9.3 Show by your identity and conduct as a clinical counsellor and psychotherapist an informed social and environmental conscience, demonstrating wider professional and collegial commitments to improving the human condition	9.3.1 Demonstrate capacity to take on collegial roles of social advocate and to engage in political debate and processes to improve client circumstances and social conditions for society and for the environment 9.3.2 Be willing to undertake an educative collegial role in your community of practice, and to engage in proactive leadership through collegial interactions that facilitate greater understanding and appreciation for the complex and vital role of clinical counselling within the allied health sector and within society
10. Applied research	10.1 Demonstrate ability to search, find, utilise, apply, and critique high quality research findings in clinical practice	
	10.2 Demonstrate ability to engage in and understand the connection between informal clinical research skills and formal research outcomes and their central role in all clinical practice	10.2.1 Apply ethical standards in informal inquiry as well as formal 10.2.2 Engage the scientist practitioner model by considering exploratory based qualitative and hypothesis based quantitative and/or empirical approaches that enhance clinical expertise, investigation, assessment, and treatment outcomes 10.2.3 Share theory or hypothesis with client when appropriate, using the investigative method as a means to monitor progress, keep and open mind, and to never assume the corner of truth on any client issue or circumstance
	10.3 Demonstrate adequate standards for clear, concise and professional writing of case notes, paper drafts, and presentations for workplace, seminars, and conferences	
	10.4 Demonstrate capacity to write from clinical practice and to contribute to the professional literature through various forums which may include published journals	
	10.5 Demonstrate capacity to integrate knowledge of research into practice	10.5.1 Decide the effectiveness of research findings in practice, as related to each case 10.5.2 Engage in critical analysis of research findings 10.5.3 Ensure ongoing access to on-line professional databases through universities for updated literature searches while in-practice, and access a wide range of sources including the internet 10.5.4 Use research findings to increase therapist's effectiveness and to disseminate findings into the therapeutic community
11 Clinical assessment	11.1 Demonstrate comprehension of theories of assessment and assessment approaches	11.1.1 Specify a range of theories and assessment approaches
	11.2 Demonstrate capacity to analyse, critique, apply through informed evidence based principles different theories of assessment in clinical practice	11.2.1 Demonstrate assessment skills across a range of measures 11.2.1 Demonstrate adequate and critical knowledge of assessment tools, tests, and models 11.2.1 Demonstrate capacity for clinical assessment and diagnosis of mental illness and other disorders as appropriate for a clinical counselling role 11.2.1 Demonstrate capacity for developing a treatment plan and treatment regime appropriate for a clinical counselling role 11.2.1 Demonstrate ability to engage in consultation with other professionals including clinical psychologists, medical doctors, mental health nurses, and community care workers for the benefit of the client 11.2.1 Demonstrate ability to clearly define, negotiate, maintain, monitor, and manage the clinical counselling role and case treatment outcomes with complex and co-morbid variables 11.3 Demonstrate ability to critique and further analyse clinical assessment skills in case analysis during clinical supervision
12 Mental health	12.1 Demonstrate comprehension of national and state based frameworks for mental health provision	12.1.1 Specify
	11.2 Demonstrate ability to work within a rights based framework to ensure safety, consumer and carer participation, health promotion and prevention, and privacy and confidentiality	

Core Competency Field	Core Competency Criteria	Core Competency Measure
	11.3 Demonstrate comprehension of cultural issues as they relate to provision of mental health services, including showing capacity to critique dominant views and to take into consideration alternative cultural beliefs and practices throughout the assessment and treatment process	
	11.4 Demonstrate capacity to work within an integrated health care system, and to engage in systemic development to improve conditions of care for consumers	
	12.5 Demonstrate a comprehensive awareness of working within the delivery of care, including access, entry, assessment and review, treatment and support, community living, supported accommodation, medication and other medical technologies, therapies, inpatient care, planning for exit, and exit and re-entry	
13 Distance Technology	13.1 Demonstrate integrated use of distance technology during training	13.1.1 Demonstrate use of many standard current technologies and/or hardware and/or software platforms necessary for integrated participation in the training context and/or in clinical practice, including intranet, internet, world wide web, public search engines, professional literature and professional journal search engines, electronic mail, blog, wiki, bulletin board, web CT, Sakai, videoconferencing, teleconferencing, chat rooms, and any other technologies as they come of age and that may be used as part of a training package from time to time
	13.2 Ensure that confidential data is protected during storage, and ensure that during transfer via regular mail or via electronic mail that data is secure	13.2.1 Edit case notes and mask identifying information to ensure all measures are taken to protect client's confidentiality 13.2.2 Ensure adequate security of backup systems for data storage
		13.2.3 Ensure policy and procedure for deletion and destruction of data in a timely manner under relevant legal guidelines 13.2.4 Ensure all participant's consent is recorded on paper and verbally during the first five minutes of the recording wherever and whenever audio and/or videoconferencing or video storage in any media is used (i.e. videotape, digital CD, webcam, portable devices, audio cassette, digital audio, etc...)
	13.3 Where distance clinical counselling and related services are delivered to the public during the course of training, ensure that ethical standards are adequately addressed and that trainees are required to comply with standards	13.3.1 Where applicable, incorporate distance provisions into ethical and legal student agreements, agreements for consent with clients, agreements with agencies and/or supervisors, and ensure adequate indemnity coverage is maintained by relevant parties
	13.4 Demonstrate any necessary modification of core clinical skills for delivery via distance technologies, ensuring client ease and comfort	13.4.1 Demonstrate distance therapeutic skills through peer-practice and simulations to ensure familiarity with the perimeters of the technology 13.4.2 Demonstrate understanding of the limitations of the technology being used in relation to the objectives of the therapeutic relationship 13.4.3 Demonstrate modifications to the analysis of the therapeutic relationship within the contexts of distance provision of services
	13.5 Demonstrate relevant core clinical applied research skills essential during the uptake and implementation of new technologies in therapy	13.5.1 Report back to the training authority and/or agency and/or workplace in regular and timely fashion regarding troubleshooting and ensure regular and consistent documentation of analysis of the use of technologies and therapeutic approaches employed 13.5.2 Seek out new information and keep up to date on developments in new technologies relevant to the therapeutic services provided 13.5.3 Join any relevant associations and/or access relevant journals that provide services to counsellors and psychotherapists who practice via distance
14 Loss, grief and trauma	14.1 Demonstrate adequate knowledge of relevant theory and treatment approaches in loss and grief therapy	14.1.1 Specify
	14.2 Demonstrate adequate knowledge of relevant theory and treatment approaches in crisis intervention and trauma therapy	14.2.1 Specify
	14.3 Demonstrate integration of theory and practice in loss, grief, crisis, and trauma therapies across a wide range of cases	
	14.4 Demonstrate adequate knowledge and clinical practice in suicide assessment and intervention	
	14.5 Demonstrate adequate knowledge of issues of access and equity in relation to rural and regional crisis and trauma services, and longer term services for chronic issues of post-trauma recovery, loss, grief, and co-morbid factors like depression	

Register of ACA Approved Supervisors

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
NSW					
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
Thomas Kempley	Central Coast	0402 265 535	MA Counselling, Supervisor Training	$55 ind, $75 Grp	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	$75	Face to Face, Phone, Group, Skype(Web)
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
Brigitte Madeiski	Penrith	0418 190 750	Dip Prof, Couns. Dip Womens Dev, Dip PSC, Superv. Trg (AIPC)	(Nego)	Face to Face, Phone, Group
Patriciah Catley	NSWv	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 McClure	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
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	Bach (Social Health Counselling MACQ Uni), Psychotherapist	$100	Face to Face, Phone, Group
Susan Rosevear	Invergowrie	02 6772 9973 or 0428 752 347	347 Diploma of Counselling; Supervision training,	$50	Phone, Group, Face to Face
Gwenyth Lavis	ALBURY	0428 440 677 or 02 6026 6141	Professional Supervisor training(July, 2007); Graduate Diploma of Counselling (May, 2005), Advanced Dip of Counselling and Family Therapy	$85	Phone, Group, Face to Face

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
QLD					
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
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, Phone
Philip Armstrong	Grange	07 3356 4937	B. Couns., Dip Psych, SOA Supervison (Rel Aust)	$88 Ind $25 Grp	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
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
Yildiz Sethi	Hamilton	07 3268 6016	Master Soc Sci (counselling), B.Ed. (Sci) Dip. Clin Hypno. NLP Practitioner. Cert Ego State Therapy. Family Constellations. Educator ACAP. Super Trng.	$90 Ind; $45 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
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/ West End/Eumundi	0410 457 208	Masters Gestalt Therapy	100 Indiv $70 grp	Face to Face, Phone, Group
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 Mackison	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	Redland Bay	07 3206 7855 or 0415 959 267	Dip. Prof. Couns., Dip Clin Hypnosis, Dip Multi Addiction	$70	Face to Face & Phone
Heidi Edwards	Gympie	07 5483 7688 or 0466 267 509	B.Bsc; CMACA; MCCA; Prof.Supv.(AIPC); Fac MHFA	$99	Face to Face & Phone
Stacey Lloyd	Aspley	0417 644 650 or 07 3420 4127	MA (Couns), BA (Psych), Dip.Bus (Mgnt), Cert IV Trng & Asst	$100	Face to Face. Phone, Group
Virginia Roesner	Kawungan	07 4128 2202	M.Edu;B.Sci (Psychology); CMACA; Prof Supr (AIPC)	$88	Face to Face
Valerie Holden	Peregian Springs	0403 292 885	M Couns, B Couns, Prof Supervisor Trg	$80	Face to Face, Group
Brenda Purse	Shelly Beach	07 5493 2333 or 0402 069 827	M Couns, B. Couns Prof Supervisor Trg	$90	Face to Face, Group
Linda Hanson	East Ipswich	07 3281 2747 or 0407 640 229	Master of Counselling (Supervision)	$100	Face to Face, Group, Phone

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
QLD					
Maartje (Boyo) Barter	Coorparoo/ Wynnum	0421 575 446	MA Mental Health, Post Grad Soc Wk, BA Soc Wk, Counsellor & Gestalt Therapist	$80 to $95	Face to Face, Group, Phone
VIC					
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 or 0417 447 374	MA Prelim (Ling) BA, Dip Ed, Dip. Prof Counselling, Cert IV in C.Supervision, Cert IV in TAA, MACA, MSCAPE	$90 Ind $35 Group	Face to Face, Phone, Group
Miguel Barreiro	Croydon	03 9723 1441	BBSc (Hon) Psychologist	$90	Face to Face, Phone, Group
Geoffrey Groube	Heathmont	03 99729 3652 or 0425 786 953	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
Sandra Bowden	Rowville	0428 291 874	Dip. Prof. Couns., Prof. Supervisor Trg (ACCS)	$60	Face to Face & Phone
Barbara Matheson	Narrewareen	03 9703 2920 or 0400 032 920	Dip. Appl Sc (Couns.) AAl, Prof. Sup (ACCS)	$70 Grp $20 Discnt for FVC membs	Face to Face, Phone, Group
Rosemary Carace-do-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
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
Rosslyn Wilson	Knoxfield	03 9763 0033 or 0422 120 114	Supervisor Training; Dip. Prof. Couns, Dip of Holistic Counselling, Dip of Expressive Therapies	$70	Phone, Group. Face to Face
Jenni Harris	South Yarra	03 9490 7599 or 0406 943 526	MA(MIECAT)Supervision; Adv. Supersion traning Nada Miocevic; Grad Dip in Experi-mental & Creative Arts Therapy	$80 indi $90 Grp	Phone, Group, Face to Face
Cheryl Taylor	Port Melbourne	03 8610 0400 or 0421 281 050	Certificate IV in Counselling Supervision-RTA &BECS; Dip of Teaching, Cert in Counselling an Psychotherapy, Accredited Telephone Counselling, Grad Dip in Christian Counselling,Neuro-Linguistic Programming	$88	Group, Face to Face
Michael Woolsey	Seaford	03 9786 8006 or 0419 545 260	Registered ACA Supervisor, Bach Social Welfare, Dip Prof Couns, Cert IV Assessment & Training	$70	Phone, Face to Face
Suzanne Vidler	Braybrook	0411 576 573	Clinical Supervision training (LA Trobe Uni), Grad Dip, Psy, MA Cous., BA B.Sc;	$100	Phone, Face to Face, Group
Patricia Dawson-Davis	Mooroolbark	0424 515 124	Master of Counselling and Human Services	$70	Face to Face, Phone, Group

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
SA					
Adrienne Jeffries	Stonyfell	0414 390 169	BA Social Work, Dip Psychosynthesis	$120	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
Moira Joyce	West Croydon	0432 764 151 or 08 7225 4319	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
Dr. Chris White	Gilberton	08 8344 3837 or 0414 884 637	M.B.; B.S.; F.R.A.N.Z.C.P. (Ret); DSc. (Psych); C.M.A.C.A.; M.A.I.P.C.; A.M.I.T.A.A.; M.R.E.A.A.	$100	Phone, Group, Small Group, Face to Face, Long distance
WA					
Dr. Patricia Sherwood	Brunswick	08 9726 1505 or 0417 977 085	B. Soc. Wor, Adv. Dip in Buddhist Psy & Coun, Adv Dip in Holistic Coun, Grad Dip in Arts, Dr. of Philosophy, M. of Arts preliminary	$50 - $90	Face to Face, Phone, Group
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
Deidre Nye	Canning Vale	08 6253 8190 or 0409 901 351	Supervisor Training; Trainer in NLP; TLT®; Hypnosis NLP Supervision, Dip Prof Couns	$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
TAS					
David Hayden	Howrah	0417 581 699	Dip Prof Counselling, Supervisor Trg (AIPC)	$80	Face to Face, Phone, Group
Michael Beaumont-Connop	Newstead	0429 905 386	Master of Social Work, Gra.Dip. Social. Sci. Bachelor of Arts MNZAC	$100	Face to Face, Phone
NT					
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
Rian Rombouts	Parap	08 8981 8030	Dip Mental Health, Dip Clin Hypno, Supervisor Trg	$88	Face to Face, Phone
ACT					
Brenda Searle	Canberra/Region	02 6241 2765 or 0406 376 302	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
Ingrid Wallace	Chisholm	02 6247 0655 or 0417 447 374	MA (Counselling), Grad Dip of Community Counselling, Adv. Practitioners' Cert in Clinical Hypnotherapy	$100	Face to Face, Phone, Group
HONG KONG					
Ann Moir-Bussy	Hong Kong	852 2806 4144		$500HK	Face to Face, Group
SINGAPORE					
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

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- **Dr Travis Gee,** BA (Hons), MA, PhD
- **Professor Michael Lambert,** BA (Psych), MA (CounsPsych), PhD
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PROFESSIONAL INDEMNITY & PUBLIC / PRODUCTS LIABILITY INSURANCE

Rowland House, in partnership with the Australian Counselling Association announced a new insurance program mid last year.

This policy is designed to cover all ACA recognised activities including counselling, psychotherapy, hypnotherapy, psychology, supervision and teaching.

We encourage you to visit our website and obtain a quote online - **http://www.rowlandhouse.com/aca.asp**

Policy features include:

- Discounted premiums
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ACA AUSTRALIAN COUNSELLING ASSOCIATION

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