COUNSELLING AUSTRALIA

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When the mermaid finds her pathway

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Special editorial

ACA will be releasing its long awaited for Healthy Weight program for members to deliver in the next few months. This program has been put together by a private group of interdisciplinary professionals who were asked by ACA to design a healthy weight management program, based on the latest science and literature on weight issues, which counsellors could deliver. It has taken over 2 years to finally complete the program which was privately funded. For full disclosure purposes I must put up my hand and declare that I was heavily involved in this program independently from ACA, something I am sure most ACA members who I have spoken to about the program are aware of. My passion on this subject is well known and I have been invited to do a presentation on this subject by the Canadian Counselling and Psychotherapy Association at their annual conference in Halifax this May.

The program will be initially exclusively licensed to ACA to be made available to members to deliver to the general public. This is a clinical program and has no quick and easy fixes however our field tests have shown it works and works well for those who are intent on losing weight. What makes this program special, well unlike most commercial programs the core to the program is working through the emotional elements of eating and eating habits. This requires the program to involve a mental health professional not a salesperson selling so called low fat healthy food replacement programs or counting calories. Unless the emotional triggers are dealt with no amount of calorie counting or meal replacements are going to work long term. I personally believe that any weight program that does not include personal counselling is bound to fail, which is why most dieters end up on the yo-yo merry go round finally giving in and not addressing poor eating habits.

The other motivation for pursuing this issue is to blunt the potential future cost we as tax payers will be paying through health insurance and Medicare for the treatment of weight related illnesses as they become the leading cause of death and illness in Australia. As grandma used to say "a penny of prevention is better than a pound of cure". For the younger readers this saying uses the old imperial currency where a penny is a cent and a pound a dollar. I am sure you get the meaning. The problem as I see it is that emotional and mental health issues are ignored by most weight programs that are designed to make a quick dollar through superficial weight loss measures. Weight management is a complex issue that requires programs to be flexible enough to be moulded to meet the individual's needs, few programs do this, most work on a production line mentality. This is reflected in the lack of use of counsellors by most commercial programs.

Australia is now ranked number two in the world for life expectancy (Switzerland number one) with heart disease being the number one killer of Australians, stroke number three, Colorectal cancer being number four and diabetes being number ten, all of these killers are heavily impacted on by eating habits and weight issues. For interest self-harm is the number five biggest killer of Australians with lung cancer being number two.

The following short articles demonstrate that weight and obesity issues are not restricted to Australia, the last article also demonstrates that advertising can be misleading so the consumer cannot rely on health messages through the media being accurate. This in itself is a major issue as many Australians rely on the media for nutritional advice.

EU Health Ministries

One European child in four is obese. Here are the data delivered by EU Health Ministries during the Dublin Conference held on March 4th and 5th. Statistics show that today an obese 12 year-old has an 82% chance of becoming obese in adulthood. As a consequence, obesity-related illnesses, such as diabetes, cancer and some mental disorders, hit the population five times more than road accidents and suicides.

Household chores are key for burning calories

by Letizia Orlandi - 03.03.2013

'If you do the laundry and pick up your post, you may lose weight.' What was once a simple sexist comment could be actually the key to reduce wide-spread obesity among women. To such an extent that, according to the study published in PLoS One, one of the reasons behind the increase in obesity among American women is the change of house work models over the last decades. From 1965 to 2010, time spent in housework decreased from 33,1 to 16,5 hours per week. In terms of energy, compared with about 666 calories burned by women every day in 1968, today calories burned are only 400. At the same time, hours spent before a computer have increased (from 8,3 to 16,5 hours per week). Want some advice? Turn off the TV and switch on the hoover.

Obesity, a plague for British men

by Annalisa Lista

Only a third of British men have a healthy weight. Precisely, 37%. These are the figures presented in the annual report released by the NHS Health and Social Care Information Centre (HSCIC). They show a worrying increase in obesity over the last 20 years, with 65% of men, 58% of women and 10% of children now classed obese or overweight. The report also reveals that obesity has led to a consequent stark rise both in hospital admissions and in surgical treatments. In fact, between 2011 and 2012, 11, 740 people were hospitalized, while 8,790 underwent a stomach stapling or gastric bypass. Respectively, a threefold and a fourfold rise over the last 5 years.

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> ACA will be releasing its long awaited for Healthy Weight program for members to deliver in the next few months. This program has been put together by a private group of interdisciplinary professionals who were asked by ACA to design a healthy weight management program, based on the latest science and literature on weight issues, which counsellors could deliver.

Are diet soft drinks a healthy alternative to regular soft drinks?

ABC Health and Wellbeing

It's the kilojoules in regular soft drink that promote weight gain and therefore increase your risk of diabetes type 2, cardiovascular disease and some cancers. Diet soft drinks contain artificial sweeteners rather than sugar, slashing the kilojoule load (often to zero). So you might think this would side-step any health issues. But that doesn't seem to be the case. For starters, research has not shown regularly drinking artificially sweetened drinks helps prevent weight gain (some studies suggest it does, others not and some suggest it actually promotes weight gain – possibly by triggering cravings for more sweet food generally). What's more, both regular and diet soft drink are acidic and damage tooth enamel, leading to increased decay. They also contain preservatives, colourings, flavourings and "other things you basically don't need," says nutritionist Dr Rosemary Stanton. And some recent research suggested diet drinks might increase your risk of type 2 diabetes. Experts suggest drinking soft drinks of any kind only occasionally and sticking to water to quench your thirst the rest of the time.

Fears Rockhampton facing diabetes epidemic

By William Rollo

Diabetes Queensland says more than 10 per cent of the population in Rockhampton in the state's central region has type 2 diabetes. Diabetes Queensland is hosting a series of forums aiming to tackle the high rate of diabetes in Rockhampton. It is forecasting up to 20,000 Rockhampton residents could have type 2 diabetes by 2025. At that rate of growth, the organisation says it is an epidemic. It says the sharp rise in diabetes cases is linked to the high rate of obesity.

The issue of weight and eating habits cannot be separated from mental health therefore it stands to reason counsellors not only should be but are integral to the issue of weight management programs. It is about time that Australian counsellors became the heavy hitters of the weight management industry.

Philip Armstrong
Editor

RESEARCH FROM AROUND THE WORLD

Revisiting Kirsch's groundbreaking study about the effectiveness of antidepressants

They are among the biggest-selling drugs of all time. Antidepressants supposedly lift the moods of those who suffer depression and are taken by millions of people in the UK every year. The authors of this study conducted a meta-analysis of 47 published and unpublished clinical trials submitted to the Food and Drug Administration in the US as part of licensing applications for six antidepressant drugs, including Prozac, Seroxat and Efexor. The results showed the drugs were effective only in a very small group of the severely depressed.

The findings were that they have no clinically significant effect. In other words, they don't work. The findings challenge standard medical practice of depression management and raise serious questions about the regulation of the multinational pharmaceutical industry.

The popularity of the new generation of antidepressants, which include the best known brands Prozac and Seroxat, soared after they were launched in the late 1980s, promoted heavily by drug companies as safer and leading to fewer side-effects than the older tricyclic antidepressants. In the UK, an estimated 3.5 million people take the drugs, collectively known as selective serotonin reuptake inhibitors (SSRIs), in any one year, and 29 million prescriptions were issued in 2004. Prozac, the best known of the SSRIs made by Eli Lilly, was the world's fastest-selling drug until it was overtaken by Viagra.

The study authors point out that given these results, there seems to be little reason to prescribe antidepressant medication to any but the most severely depressed patients, unless alternative treatments have failed to provide a benefit. This study raises serious issues to be addressed surrounding drug licensing and how drug trial data is reported.

In response, GlaxoSmithKline the makers of Seroxat, said the authors of the study had 'failed to acknowledge' the very positive benefits of SSRIs and their conclusions were 'at odds with the very positive benefits seen in actual clinical practice …This one study should not be used to cause unnecessary alarm for patients.' Eli Lilly said in a statement: 'Extensive scientific and medical experience has demonstrated that flouxetine [Prozac] is an effective antidepressant.' Wyeth said: 'We recognise the need for pharmacological and non-pharmacological treatments for depression.'

However, it appears the UK Health Department read this study. Alan Johnson, the UK Health Secretary, has announced that 3,600 therapists are to be trained over the next three years to provide nationwide access through the GP service to 'talking treatments' for depression instead of drugs in a 170m scheme. Perhaps there will come a day when antidepressants will be a second line treatment if psychological therapy does not work?

(Source: Kirsch, I., Deacon, B. J., Huedo-Medina, T.B., Scoboria, A., Moore, T.J., & Johnson, B.T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. PLoS Med 5 (2):e45)

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Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration

Irving Kirsch mail, Brett J Deacon, Tania B Huedo-Medina, Alan Scoboria, Thomas J Moore, Blair T Johnson.

www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0050045

ABSTRACT

Background

Meta-analyses of antidepressant medications have reported only modest benefits over placebo treatment, and when unpublished trial data are included, the benefit falls below accepted criteria for clinical significance. Yet, the efficacy of the antidepressants may also depend on the severity of initial depression scores. The purpose of this analysis is to establish the relation of baseline severity and antidepressant efficacy using a relevant dataset of published and unpublished clinical trials.

Methods and Findings

We obtained data on all clinical trials submitted to the US Food and Drug Administration (FDA) for the licensing of the four new-generation antidepressants for which full datasets were available. We then used meta-analytic techniques to assess linear and quadratic effects of initial severity on improvement scores for drug and placebo groups and on drug–placebo difference scores. Drug–placebo differences increased as a function of initial severity, rising from virtually no difference at moderate levels of initial depression to a relatively small difference for patients with very severe depression, reaching conventional criteria for clinical significance only for patients at the upper end of the very severely depressed category. Meta-regression analyses indicated that the relation of baseline severity and improvement was curvilinear in drug groups and showed a strong, negative linear component in placebo groups.

Conclusions

Drug–placebo differences in antidepressant efficacy increase as a function of baseline severity, but are relatively small even for severely depressed patients. The relationship between initial severity and antidepressant efficacy is attributable to decreased responsiveness to placebo among very severely depressed patients, rather than to increased responsiveness to medication.

Citation: Kirsch I, Deacon BJ, Huedo-Medina TB, Scoboria A, Moore TJ, et al. (2008) Initial Severity and Antidepressant Benefits: A Meta-Analysis of Data Submitted to the Food and Drug Administration. PLoS Med 5(2): e45. doi:10.1371/journal.pmed.0050045

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Abbreviations: d , standardized mean difference; FDA, US Food and Drug Administration; HRSD, Hamilton Rating Scale of Depression; LOCF, last observation carried forward; NICE, National Institute for Clinical Excellence; SD c , standard deviation of the change score.

> "Drug–placebo differences in antidepressant efficacy increase as a function of baseline severity, but are relatively small even for severely depressed patients.

RESEARCH FROM AROUND THE WORLD [cont'd]

Editor's Summary

Background

Everyone feels miserable occasionally. But for some people—those with depression—these sad feelings last for months or years and interfere with daily life. Depression is a serious medical illness caused by imbalances in the brain chemicals that regulate mood. It affects one in six people at some time during their life, making them feel hopeless, worthless, unmotivated, even suicidal. Doctors measure the severity of depression using the "Hamilton Rating Scale of Depression" (HRSD), a 17–21 item questionnaire. The answers to each question are given a score and a total score for the questionnaire of more than 18 indicates severe depression. Mild depression is often treated with psychotherapy or talk therapy (for example, cognitive–behavioral therapy helps people to change negative ways of thinking and behaving). For more severe depression, current treatment is usually a combination of psychotherapy and an antidepressant drug, which is hypothesized to normalize the brain chemicals that affect mood. Antidepressants include "tricyclics," "monoamine oxidases," and "selective serotonin reuptake inhibitors" (SSRIs). SSRIs are the newest antidepressants and include fluoxetine, venlafaxine, nefazodone, and paroxetine.

Why Was This Study Done?

Although the US Food and Drug Administration (FDA), the UK National Institute for Health and Clinical Excellence (NICE), and other licensing authorities have approved SSRIs for the treatment of depression, some doubts remain about their clinical efficacy. Before an antidepressant is approved for use in patients, it must undergo clinical trials that compare its ability to improve the HRSD scores of patients with that of a placebo, a dummy tablet that contains no drug. Each individual trial provides some information about the new drug's effectiveness but additional information can be gained by combining the results of all the trials in a "meta-analysis," a statistical method for combining the results of many studies. A previously published meta-analysis of the published and unpublished trials on SSRIs submitted to the FDA during licensing has indicated that these drugs have only a marginal clinical benefit. On average, the SSRIs improved the HRSD score of patients by 1.8 points more than the placebo, whereas NICE has defined a significant clinical benefit for antidepressants as a drug–placebo difference in the improvement of the HRSD score of 3 points. However, average improvement scores may obscure beneficial effects between different groups of patient, so in the meta-analysis in this paper, the researchers investigated whether the baseline severity of depression affects antidepressant efficacy.

What Did the Researchers Do and Find?

The researchers obtained data on all the clinical trials submitted to the FDA for the licensing of fluoxetine, venlafaxine, nefazodone, and paroxetine. They then used meta-analytic techniques to investigate whether the initial severity of depression affected the HRSD improvement scores for the drug and placebo groups in these trials. They confirmed first that the overall effect of these new generation of antidepressants was below the recommended criteria for clinical significance. Then they showed that there was virtually no difference in the improvement scores for drug and placebo in patients with moderate depression and only a small and clinically insignificant difference among patients with very severe depression. The difference in improvement between the antidepressant and placebo reached clinical significance, however, in patients with initial HRSD scores of more than 28—that is, in the most severely depressed patients. Additional analyses indicated that the apparent clinical effectiveness of the antidepressants among these most severely depressed patients reflected a decreased responsiveness to placebo rather than an increased responsiveness to antidepressants.

What Do These Findings Mean?

These findings suggest that, compared with placebo, the new-generation antidepressants do not produce clinically significant improvements in depression in patients who initially have moderate or even very severe depression, but show significant effects only in the most severely depressed patients. The findings also show that the effect for these patients seems to be due to decreased responsiveness to placebo, rather than increased responsiveness to medication. Given these results, the researchers conclude that there is little reason to prescribe new-generation antidepressant medications to any but the most severely depressed patients unless alternative treatments have been ineffective. In addition, the finding that extremely depressed patients are less responsive to placebo than less severely depressed patients but have similar responses to antidepressants is a potentially important insight into how patients with depression respond to antidepressants and placebos that should be investigated further.

Additional Information

Please access these Web sites via the online version of this summary at http://dx.doi.org/10.1371/journal.pmed.0050045.

The MedlinePlus encyclopedia contains a page on depression (in English and Spanish)

Detailed information for patients and caregivers is available on all aspects of depression (including symptoms and treatment) from the US National Institute of Medical Health and from the UK National Health Service Direct Health Encyclopedia

MedlinePlus provides a list of links to further information on depression

Clinical Guidance for professionals, patients, caregivers and the public is provided by the UK National Institute for Health and Clinical Excellence.

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RESEARCH FROM AROUND THE WORLD

The New Criteria for Mental Disorders

Maria Konnikova | New Yorker 8 May 2013

In 1959, Dr. Julian Lasky decided to conduct an experiment: How well could psychiatrists and hospital staff at a V.A. general-medicine and surgical hospital use individual patient interviews to predict post-hospital adjustments among their psychiatric patients? Once a month over a period of six months, Lasky gathered predictions on factors such as rehospitalization, work, family, and health adjustment. He then correlated those predictions, along with a number of other possible predictive factors, with actual readjustment success. He discovered something striking: the single strongest predictor of a patient's adjustment success was the weight of his case file. The heftier the file, the less likely a patient was to successfully readjust to life outside of the hospital. File weight significantly predicted every single outcome criterion—from the patient's ability to hold a job to his capacity for carrying on a successful, long-term romantic relationship—more accurately than monthly interviews, as well as other behavioral and self-report measures. And in the case of some factors, such as the chances of rehospitalization, the correlation was remarkably high. The natural conclusion was that the best predictor of future behavior is past behavior.

In some ways, not much has changed since those early days of clinical diagnosis. The director of the National Institute of Mental Health, Thomas Insel, announced last week that the institute would be officially reorienting its research agenda away from the categories in the soon-to-be-published fifth edition of the Diagnostic and Statistical Manual of Mental Disorders and toward a new set, the Research Domain Criteria (R.D.O.C.): "Unlike our definitions of ischemic heart disease, lymphoma, or AIDS, the DSM diagnoses are based on a consensus about clusters of clinical symptoms, not any objective laboratory measure. In the rest of medicine, this would be equivalent to creating diagnostic systems based on the nature of chest pain or the quality of fever." In other words, we are still relying on the subjective assessments that lost out to the weight of the case file over half a century ago.

Insel's point echoes a growing disconnect between the D.S.M. and the current state of psychological research and knowledge. When the D.S.M. was originally published, in 1952, its aim was largely statistical: How could we collect information about mental health? While the manual attempted to provide a clinically useful approach, it was hampered to a large extent by the dearth of accurate measures; as Walter Mischel points out in his 1968 book "Personality and Assessment," almost every known tool offered a pitifully small correlation to actual behavior. In 1980, the D.S.M.-III began to incorporate a more methodical approach. For the first time, it included explicit diagnostic criteria coupled with an approach that strove toward descriptive neutrality. Diagnoses were based to a large extent on clinical observations and patients' self-reported symptoms (gathered through structured, standardized interviews). To date, these remain the main points of diagnosis and assessment. (Gary Greenberg also charts the evolution of the D.S.M. and its impact on the nature of mental disease.)

In the intervening decades, however, we've developed psychological, biological, physiological, and neuroscientific techniques that have given psychologists unprecedented insight into the mind—advances that the D.S.M.-5 largely ignores. With the R.D.O.C., the N.I.M.H. is now trying to address the growing disconnect between reality—what we now know about mental disorders—and theory. The psychologist Kevin Ochsner, who served on one of the groups convened to advise on the new schema, said, "What was remarkable about this work group … was that the core N.I.M.H. staff explicitly guided us not to use current ways of defining clinical disorders when defining core constructs."

As a result, the R.D.O.C. looks strikingly different from the D.S.M. For the most part, the D.S.M. presents discrete categories, and the R.D.O.C. offers a continuum that ranges from the normal to the abnormal. These constructs, which the N.I.M.H. defines as concepts that "summariz[e] data about a specified functional dimension of behavior," are grouped into domains, such as motivation, cognition, and social behavior, and are explored through a range of tools, beginning at the genetic level and including observed behavior. It's not that the methods of the D.S.M. are thrown out entirely—self-reports and clinical assessments are still considered—but that they are incorporated into a larger frame that relies far more heavily on empirically derived methodology. Where the D.S.M.-5 uses only clinical observations and self-reports, we now have inputs from genetics and from molecular, cellular, and systems neuroscience. We are, as Insel says, moving past the nature of the chest pain and toward the underlying causes.

Perhaps most important is the fluidity of this new conception of mental health: it is meant as a starting point of classification that will evolve along with the methodology and the findings. For instance, in a study of emotion regulation, the experimenter could categorize

> "When the D.S.M.'s approach was conceived, we had to base categorizations on broad observations and one level of data: behavioral. That's demonstrably no longer the case. In fact, we now know that behavioral data is often at odds with other inputs.

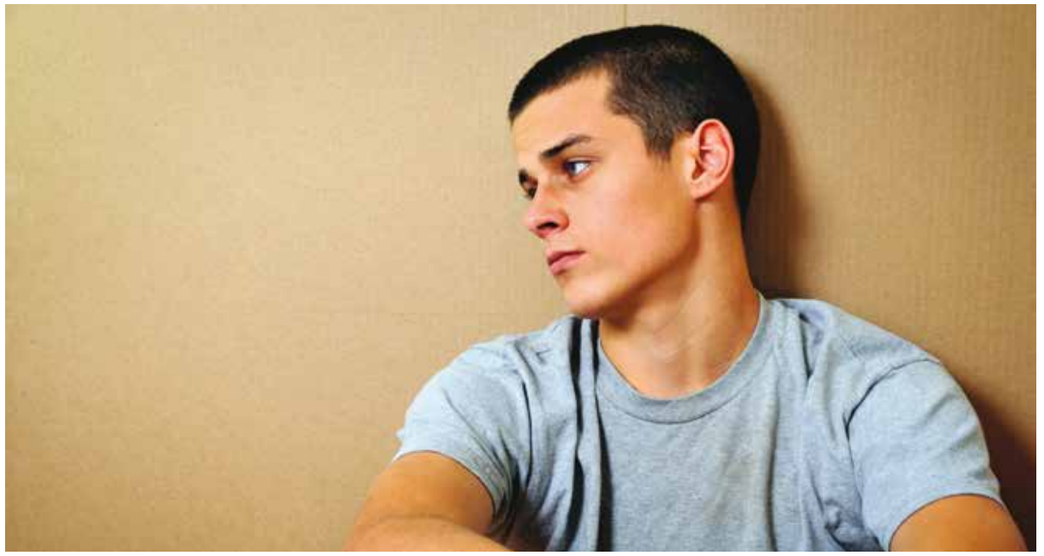
his work as belonging to both the positive and negative valence constructs, along with any of the cognitive-systems domains, such as attention or cognitive (effortful) control. She doesn't need to confine herself to a single disease or diagnostic category—and can even choose to add new dimensions as the work evolves. She could also choose one or many of the units of analysis to explore her work: genes, molecules, cells, circuits, physiology, behavior, self-reports, or the broad category "paradigms" for other methods of behavioral evaluation that may not fit neatly anywhere else. And should new methodology become available? It can simply be added to the matrix.

The classification can thus cut across categories and be used to study underlying constructs that may apply to multiple disorders. They, along with units of analysis (or the methods used) can be mixed and matched depending on what the study finds and how the understanding of the research and results develops. Researchers are not constrained by a monolithic entity, such as depression, that they must then explicitly address in their research agenda, regardless of what the data is telling them. As the N.I.M.H. explicitly states, "We expect these [domains and constructs] to change dynamically with input from the field, and as future research is conducted."

That sort of dynamism is almost entirely absent from the D.S.M.: not only was the last overhaul almost twenty years ago, in 1994, but the changes between that 1994 version and its 2013 counterpart, however controversial they may have been, are minimal at best. At a time when our understanding of the brain evolves on a nearly constant basis, can we still afford to be tied to a book that changes once every few decades—and refuses to reconceptualize itself in any meaningful fashion?

When the D.S.M.'s approach was conceived, we had to base categorizations on broad observations and one level of data: behavioral. That's demonstrably no longer the case. In fact, we now know that behavioral data is often at odds with other inputs. Just as a reported pain in the arm can be a radiating effect of a heart condition, a reported psychological problem, like difficultly concentrating, actually be a symptom of an underlying biological or physiological condition. The science has now outgrown the original approach to the point where following such a symptom-based path may undermine the D.S.M.'s original intent. With the introduction of the R.D.O.C., Insel and the N.I.M.H. are trying to ensure that the D.S.M.'s accomplishments evolve with the times, instead of being left behind in a clinical vacuum that hurts research as much as it hurts patients.

Maria Konnikova is the author of the New York Times best-seller "Mastermind: How to Think Like Sherlock Holmes" and received her PhD in Psychology from Columbia University.



RESEARCH FROM AROUND THE WORLD

Bipolar confusion worries medical experts

10 May 2013 | 9 News

Millions of people are being let down by a lack of knowledge about how to diagnose and treat bipolar disorder, according to Australian and international experts.

Bipolar disorder is one of the main causes of suicide in Australia.

The mood swings, impaired concentration and impatience in many patients can lead to incorrect diagnoses, including ADHD and clinical depression.

There are also several sub-types that exist along a spectrum. These include bipolar one (previously manic depression) and bipolar two.

All these conditions need different treatments, and the incorrect treatment can do a lot more harm than good.

Now new diagnostic guidelines are about to cause more confusion, says Professor Gin Malhi of the University of Sydney.

Writing in one of a series of papers published by The Lancet on Friday, Prof Malhi says the new DSM-5 diagnostic guidelines to be introduced in May will further obscure the boundary between major depression and bipolar disorder.

"DSM-5 has moved the goalposts. My concern is diagnosis is going to become more complicated, so that people who don't have the illness get labelled as having it."

Asked to comment, Professor Gordon Parker, from the school of psychiatry at the University of New South Wales, says bipolar two affects around five per cent of Australians during their lifetime.

"Unfortunately, most professionals have not received training in its detection and diagnosis. The majority of people probably never get diagnosed."

His policy is to screen all mood-disorder patients. "I continue to be struck by the high rate of bipolar."

Prof Parker says a tendency by most practitioners to treat bipolar one and two disorders in a similar way appears inappropriate, with evidence favouring different mood stabilisers for the separate conditions.

One of the Lancet papers says there is a five to 10-year delay between onset and diagnosis of bipolar disorder.

The US authors call for urgent effort to find an objective biomarker to differentiate bipolar disorder from clinical depression.

This could lead to new, personalised, treatments.

A biomarker is a measurable characteristic that indicates if a person has a disease.

Another paper in the series says there have been no fundamental treatment advances in the past 20 years.

The main problem, say the UK authors, is scarce knowledge of basic disease mechanisms.

Lithium, developed in Australia in the 1940s, remains the favoured long-term treatment, but its benefits are restricted by adverse effects and alternatives are often needed for long-term treatment, say the authors.

PEER REVIEWED ARTICLE

Wool, wonderful wool

by Dr. Angela Lewis

What comes to mind when you think of hand knitted sweaters (jumpers, to Australians), ponchos, gloves or scarves? Perhaps an older aunt or grandmother sitting comfortably on the couch with her balls of wool and knitting needles, or unhappy memories of being a kid in a scratchy and unfashionable hand-knit?

Well, probably neither of those images if you happen belong to a small and little known section of the community who are erotically attracted to woollen fibres—because to them woollen items are alluring and sexy. People who experience erotic pleasure from looking at, wearing or touching woollen items, or observing others doing this, identify themselves as wool lovers, wool freaks or wool fetishists. If they are only interested in a specific type of woollen article—sweaters, for example—then they might identify as sweater lovers.

Wool is used as a generic term in this community to cover a gamut of fibres, so while an individual might have a preference for merino wool or mohair, the term wool lover or wool fetishist is still applied. The majority of adult websites dedicated to this interest (for example MelodyOhair, Lovewool.forum and Woolspace) also use the generic label 'wool', although they cater for those drawn to various knitted fibres.[1]

Personal preferences range across mohair, angora, wool, merino wool, cashmere, alpaca, cotton, acrylic and mixed blends. According to the wool lovers who were kind enough to provide expertise for this article, mohair and pure wool are the two most popular yarns in the wool community, followed by angora. However

1 Nobody I spoke with were aware of crocheted items being sought after in this fashion, the interest is specifically for knitted items.
2 Issues of wool ply and colour are not as important, with no particular colour standing out as most popular—unlike other fetish groups such as the foot lovers who overwhelmingly favour red toenails.

individual tastes vary in terms of whether the garment is a hand knit (which is more prized than a machine knit), and what form the garment takes—ranging from leggings, catsuits, socks, legwarmers, mittens, balaclavas, scarves and dresses to the most popular item: the turtleneck woman's sweater.[2]

While men will wear a man's sweater and enjoy the experience, the wool lover (whether he identifies as heterosexual, bisexual, transgender or cross dressing) who loves wearing turtleneck sweaters will generally always choose a woman's sweater. Some of the reasons men offer for choosing this particular garment is that women's sweaters are generally of a softer yarn and the cut of the garment is nicer; for some, boyhood memories of a fetching turtleneck on a woman have left a lasting impression. There is some confusion around the association of males wearing female woollen sweaters and cross dressing: yes, some cross dressers and transgender men will wear female sweaters, but purely as a fashion item; but for the wool-loving cross dressers and transgender men the choice of a female sweater is part of dressing as a woman—as well as a way of expressing their love of wool. For the majority of male wool lovers (regardless of how they identify sexually), their erotic attraction is only to the woollen item, not in using it to look female. Some wool lovers do not even wear woollen garments and simply get enjoyment from seeing others (most commonly women), in them, and swapping images of women in wool is highly popular on all the wool lovers' websites. On Woolfreaks.de for example, there are literally hundreds and thousands of images of celebrities and models wearing woollen items on the wool lover's websites; and I was surprised to find my favourite celebrity chef Nigella Lawson has a huge following—thanks to her preference for always appearing on camera in little button cardigans that cinch at the waist.

To an outsider the question is, of course, 'why wool?' As is the case with every other erotic attraction, wool lovers don't have a ready answer, knowing simply that they are deeply drawn to specific woollen items that they find sexually arousing to wear or look at, as well as for some, comforting. This is how wool lover James describes wearing a fluffy, hand-knitted mohair: "for me it's like being wrapped up and hugged in a big, warm, soft fuzzy cloud—as well as that added sex appeal". The personal stories of both James and Katie follow, and offer some insights into the personal life of a wool lover.

Katie in one of his favourite sweaters.

> "Some wool lovers do not even wear woollen garments and simply get enjoyment from seeing others (most commonly women), in them, and swapping images of women in wool is highly popular on all the wool lovers' websites.

James is a heterosexual man in his twenties and is the reason this research began, after he wrote to say he was disappointed that I had not included the wool fetish in my book. James lives in a large town in North America with his parents and works in the construction industry. He enjoys most things young men his age do: playing video games, music, surfing the web, eating, getting out and about in nature and time with his steady girlfriend. The only thing that's different is that these activities are even more pleasurable for him when he is wearing a soft woman's sweater. He remembers being 12 or 14 years old when he first tried on one of his mother's sweaters, liked it, and then did it whenever he had the opportunity. He stopped briefly for a few years, and then when he was around 16 he saw a woman in a fuzzy turtleneck sweater and it brought back some strong erotic feelings. He went online and joined some wool communities, which helped him to recognise that he had a wool fetish. Still in school and without much money, he bought his first female sweater at the local thrift shop as this was all he could afford. Nowadays he has a large collection, which he adds to regularly, and his interest in wool remains a large part of his life.

James is private about his love of wool and hasn't shared it with anyone aside from his girlfriend although his mother is aware of his interest, having coming across his burgeoning female sweater collection. However it has not been openly discussed, so she is not sure about his reason for amassing articles of female clothing. He is in a long-term relationship with his girlfriend, and while she has no interest in wool herself she is open to sharing this interest with him, and James considers himself a very lucky man:

She loves me for me and accepts me for me and knows that my fetishes and kinks are part of who I am. This goes both ways of course. My girlfriend really wasn't into sweaters that much herself being she doesn't wear them much as part of her regular wardrobe and because she has sensitive skin, so I found some soft and cuddly ones she can handle. She does like them quite a bit more now since she first found out about my fetish and at times will include them in our activities without me bringing it up. It's an amazing feeling being able to share this with someone you love and who loves you back. It took her a little while also to get used to the fact that I wore them myself but she has been more open to it recently.

Katie, as he has chosen to be known, is a biological man. By day a devoted husband employed in the military, in his personal time a lover of wool for the past 28 years—particularly women's sweaters. While he has enjoyed wool since he was a pre-adolescent, it wasn't until 2000 that (like James), he used the Internet to do some research and was able to identify himself as a wool fetishist. Like so many others with an interest deemed socially unusual, he experienced a great sense of relief and belonging from discovering he was not alone. Katie acknowledges that he loves to cross dress, but he is a cross dresser with a penchant for woollen items, particularly sweaters; his love of wool just happens to be intertwined with his cross dressing. His wife was told of his interest before they were married, but it is not acknowledged in their relationship and he continues to privately wear and collect women's sweaters, keeping them in his attic or in boxes in his garage. In our conversations he theorised that the reason he came up with the persona of Katie was to fulfil the need for a 'sweater girl' (the slang used for women who love wearing sweaters for erotic reasons), as he wasn't able to meet her himself, as he explains:

I really feel that in my situation, seeing that in all my life I have never found that one sweatergirl to fulfill my desire, I in turn became that sweatergirl, but I have limited my online activities to Facebook, Fetlife, and Twitter.

Research by Ray Blanchard (still considered controversial in the field of sexology), would define this type of activity as Autogynephilia, love of oneself as a woman,[3] in which the erotic interest is centred on the man's thoughts or images of himself as a female.

Katie lost his mother to illness in his early teens and later discovered her sweaters packaged up in the attic while rummaging for a bag of old comics:

Being a child of the 60's and in her 20's during the 70's, my mother was not a stranger to wool or turtlenecks. These bags had long been abandoned, so I knew no one would realize them missing. Those clothes became my solace, my sanity, my safe place, and my playground. My first orgasm was in a white angora turtleneck. It was a strange time for me, I did not know what to think of my new hobby.

This was compounded by having a crush on his fifth grade school teacher, who looked more like a favourite heroine from the Batman comics than a suburban school teacher:

She wore black spandex pants and knee high hi-heeled boots. She was the spitting image of the Catwoman I had encountered in my youth, absolutely purrfect in every way. She looked just like a burglar. During the winter she would teach class wearing her long black fuzzy gloves. She had so many turtlenecks it was unreal. One of my favorites was a blue turtleneck sweater dress and to this day I can't look at a woman in a turtleneck without getting aroused.

The teacher was kind to him, and when he was staying back one afternoon for extra tutoring, offered him one of her sweaters because the school furnace was faulty and the classroom was cold. It was pink and fuzzy, but he didn't mind because it was hers. Over the years he has maintained his interest in sweaters, although as is the case with most cross dressers, he has periodically tried to give it up. He admitted to seeing two different psychiatrists in the last 10 years, which

3 This Wikipedia link points to multiple references with regard to Autogynephilia: http://en.wikipedia.org/wiki/Blanchard's_transsexualism_typology.

to quote him, "just tangled me further into a web of wool". In his ideal world he would be married to a woman who also loves turtlenecks, and encourages him to cross dress in private whenever he feels the need.

The wool loving community is made up of more men than women, although there are some couples in the community. Katie, who has been in the wool community since the early days of the Internet, notes that Woolspace, (the woolfreaks.de website) in particular has a high number of gay members, but in terms of age there does not appear to be a specific age group who find themselves attracted to wool. This interest appears to be most popular in Europe and North America, which makes sense given their climate and the opportunity to wear these types of warm, knitted garments.

Most wool lovers agree that the wool community is very friendly, welcoming and open to newcomers. James says that in his experience everyone he speaks with is "pretty laid back and easy going". He believes the wool community is friendly because it is still small compared to other alternative communities. As a result members appreciate the sites, forums, groups and fellow members that exist because they are dedicated solely to their interests and give them a space to socialise and share content with like-minded people. In terms of what they chat about, well, according to James it is definitely sweaters and sweater related:

Overall sweaters are the center-piece for most of us when it comes to our interests in knitted items and that is usually what our discussion is about when it comes to our fetish—our personal preferences and what gets us going—down to the very detail. How thick is the sweater, what is it made of, how long is the collar, how chunky the collar is, whether the cuffs and hem are ribbed and can you fold up the cuffs or not, how long the sleeves are, the type of knit. Also how soft it is, how fluffy/fuzzy it is, whether it is itchy, the type of sweater (turtleneck, cardigan, cowl neck, zip up, button up, crew neck, etc.) We also discuss if we like to layer our sweaters or not, if we like a turtleneck and cardigan for example or a couple of turtlenecks and a cardigan. For us, it's all about the detail.

> "Most wool lovers agree that the wool community is very friendly, welcoming and open to newcomers. James says that in his experience everyone he speaks with is "pretty laid back and easy going". He believes the wool community is friendly because it is still small.

I asked both James and Katie about why they thought the turtle neck was so popular, and while neither was really sure, they agreed it would have something to do with the sensual experience of having the wool so close to their faces.

While some wool lovers' websites and forums expressly forbid nudity, there is a section of this community that likes to mix pornography, nudity and even bondage with their love of woollen items. James says that for him, his girlfriend naked but for a sweater is far more arousing than seeing her in lingerie. James is also open to admitting he has an interest in wool bondage, which centres on enjoying videos, pictures and activities related to bondage as we know it, but using woollen items such as a scarf to bind a person, or having the person in bondage wearing woollen items such as a sweater. For this segment of the community the wool bondage hood is a popular item.

This does not seem to be a fetishistic interest that has found its way into professional BDSM establishments. Mistress Electra Amore is a well respected, professional Dominatrix and qualified Somatic Sexologist who owns The Fetish Palace in Adelaide, South Australia. In the 18 years she has been in the BDSM lifestyle, she recalls only ever coming across one person with a wool fetish. She fondly remembers him as a middle-aged client who regularly paid her to slap his palms, and then he would rub them on her grey wool skirt (a specific item she wore just for him).

And what about the notion of grandmothers knitting mittens and cardigans for the grandkids or the local school fête? While they might still do that, the smart ones also produce goods for the lucrative and highly successful wool lovers market. Thanks to Ebay, knitters have found a novel and eager consumer sector for their hand-knitted garments, which they produce mostly in mohair, given its popularity in this sector. Mohair items are not cheap (unless they are smaller, such as gloves) ranging in price from a few hundred dollars to $500 to $700 for articles such as a knitted dress. As well as selling the more usual items as such as sweaters, scarves, mittens, ponchos and cardigans, most knitters are well aware that their clientele are overwhelmingly from the wool community; so they also advertise knitted legwarmers, catsuits/body suits, balaclavas, full head hoods and, knitted penis/scrotum covers (one of Katie's most treasured items is a knitted mohair penis hood), as well as knitting items to order.

References

Autogynephilia and the work of Ray Blanchard: http://en.wikipedia.org/wiki/Blanchard's_transsexualism_typology.

Wool Websites: no nudity

www.woolfreaks.de (Woolspace)
www.MelodyOhair.net
http://lovewool.forumup.us

Wool Websites: nudity/BDSM

http://www.woolbondage.com
http://mohairsluts.com
http://www.sweatered.com

A sincere thanks to all those who were kind enough to spend the last few months in dialogue with me for this article. In particular my heartfelt thanks go to both James and Katie for their wonderful contributions; as well as Katie for being kind enough to share the photo of himself in one of his favourite sweaters.

Dr. Angela Lewis is the author of My Other Self: sexual fantasies, fetishes and kinks and more of her work is available at **www.myotherself.com.au**

Google trends suggest seasons affect all mental health disorders

by Liat Clark | 9 April 2013

A study has shown that Google searches for mental health disorders ranging from anorexia to bipolar depression peak in winter, suggesting seasons have a greater role to play in causation than previously thought.

The study, carried out by a team at San Diego State University, relied on Google Trends to compile its historical search listings.

Taking into account search results related to timely news and events, the trend remained clear -- between 2006 and 2010 in the US and in Australia, searches for all kinds of mental health disorders surged in the wintry months. Taking pools of data from both sides of the equator helps corroborate the theory that it's the sunshine that's the linking factor.

Those suffering from seasonal affective disorder (SAD) are reliant on sunlight, with studies suggesting a lack of it can reduce the release of mood- and sleep-controlling serotonin and spike the sleep-inducing hormone melatonin. Some sufferers can control symptoms with light therapy. The find by the San Diego team suggests there could be a whole host of other approaches for treating mental illness not already considered -- and that the gathering of public data could be key in uncovering these trends going forward.

"We have the potential to rapidly assess population health by passively gathering data from search queries," San Diego professor and coauthor John W Ayers told the San Diego Union Tribune. "We're able to see, what no other data elicited, that there is potential for seasonality in a host of mental health problems... Here is a way that we can actually look inside the heads of people searching online, and we can use that to infer how there's population fluctuation in illness across the season."

The stats revealed that searches for eating disorders were on average down 37 percent in summers in the US, and 42 percent during Australia summers. Schizophrenia searches were down 37 percent in the US and 36 percent in Australia; bipolar searches 16 percent in the US and 17 percent in Australia; ADHD searches down 28 percent in the US, 31 percent in Australia; OCD down 18 percent in the US and 15 percent in Australia; suicide down 24 percent and 29 percent respectively and anxiety down seven and 15 percent.

Although there is an argument for more sufferers using the internet to ask the questions they are too embarrassed, unsure or scared to ask a friend, family member or medical professional, there are plenty of issues relating to the method that call into question any broad conclusions.

Some individuals suffering from SAD might actually be searching online to diagnose their symptoms and feelings, for instance -- various country studies have shown that around 70 percent of the population gets health information from the internet, and self-diagnosis is rarely a great or accurate path to take.

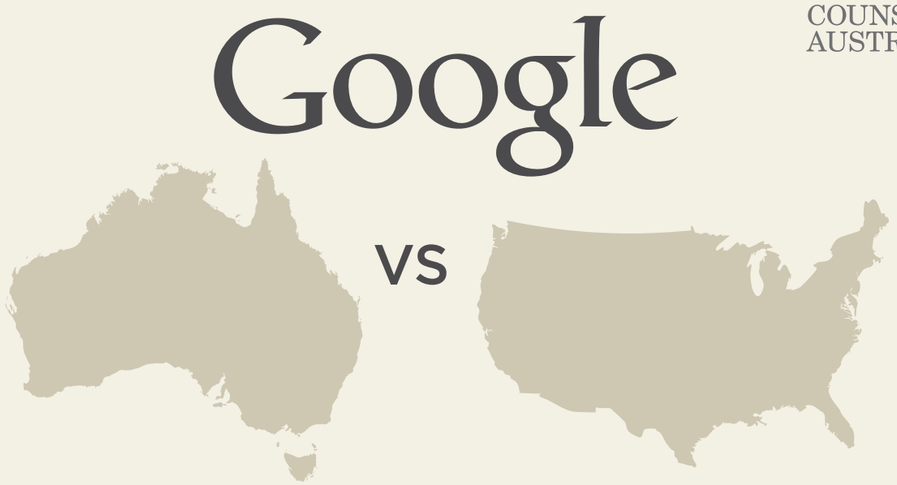
Furthermore, none of the search terms in Google Trends come with a context, for the sake of privacy. The team collected words relating to all types of mental illness questions, then sorted them out according to the specific disorder. Without context, however, it's unclear how the researchers could be sure of the intent behind the search -- it might be for academic research purposes, for instance, or perhaps by a concerned friend.

On the other hand, individuals might be more honest when typing into a one-way communication system like Google -- they may not hold back on what it is they want to ask, unlike in face-to-face interactions.

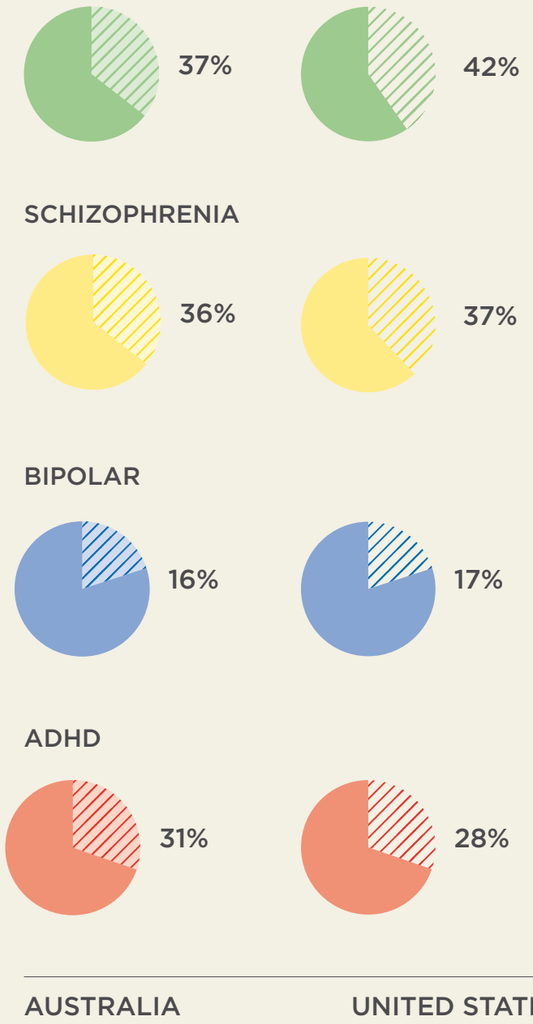
Either way it's opening up a whole new perspective for the field, and Ayers and his team hope to next break down the pattern by cities -- that way, they'd be able to monitor search terms correlating to weather at more incremental levels. Data is being used to predict outbreaks of epidemics, acts of terrorism and even genocide, and Ayers is confident mental health can reap the benefits of such analysis: "It is very exciting to ponder the potential for a universal mental health emollient, like Vitamin D (a metabolite of sun exposure). But it will be years before our findings are linked to serious mental illness and then linked to mechanisms that may be included in treatment and prevention programs. Is it biologic, environmental, or social mechanisms explaining universal patterns in mental health information seeking? We don't know."

Though the San Diego team used its own mathematical formula to analyse the data, playing around with Google Trends immediately reveals some interesting results for the layperson. Entering "anorexia", "bulimia" and "eating disorders" for the years 2004 to the present day, for instance, reveals a stark drop in searches (the latter dropped by about 80 percent by 2013). That's in spite of a growing body of sites dedicated to the promotion of eating disorders.

However, many of these sites avoid using terms like anorexia and opt for more colloquial terminology so that only those looking for them, find them. This indicates direct search rather than discovery is on the rise, and it's factors like these the San Diego team must keep in mind going forward.



Searches on average that are down in percentage during Australian summers and United States summers



Play therapy with a transgender child

when the mermaid finds her pathway

PEER REVIEWED ARTICLE

Play Therapist | Alana Vaney
Parent of the child | "Jenna"

Alana

"Please, please, put your boy clothes on, so I can take you to school!" Jenna begged her five year old child, Tom.

They were late. His eleven year old sister was waiting in the car and the toddler, Asha, was hanging off her mother's dress, crying. It was getting harder and harder to convince her son that he couldn't be the girl he so wanted to be. Since he was two years old, he'd dressed up in girl's clothes. He loved singing and dancing as a girl and everyone thought he was funny. When his girl persona persisted, his parents thought that maybe he was gay and that was okay with them. But now that he was in school, Tom was unable to comply with the expectation to be a boy, when everything inside him was clearly telling him he was in the wrong body.

"They know me as Tom," he said. "As a boy. I can't write my real name. They'd say, "That's not your name." It's too hard to be a boy. Please, Mum, don't call me Tom any more. I don't want you to call me that ever again."

Tom was speaking from his heart. How could she insist he be something he couldn't be? He turned from her, went back to his bedroom, sadly peeled off the pink tutu and sequinned top he loved so much and replaced them with the boy's school uniform: checked shirt, grey shorts, black shoes. He was doing it for his mother but he wished, oh how much he wished, that she would understand that he couldn't be a boy for much longer.

Jenna called me after she and her husband, John, had visited a psychiatrist who told her he was seeing an increasing number of children with "gender dysphoria". Jenna saw the anxiety and frustration her son was feeling and thought play therapy could help him. The psychiatrist agreed. Tom was lucky. His family was stable, flexible and wanted to help him.

Although his parents felt anxious and confused, they were willing to listen to him, and consider his plea to be the girl he knew he was. In the Strengths and Difficulties Questionnaire, which the psychiatrist had conducted, Tom scored as a socially well adapted, considerate and creative child. There was nothing traumatic in his early life.

"Jenna"

When my four year old son, who had always been a very "girly" boy, and by that I mean dress ups and dolls were his play favourites, articulated to me that he felt like he was really a girl inside, I immediately knew that I had to pay attention. I sought help and guidance to assist us with how to progress as parents. I needed a safe, neutral place outside the home where we could explore what our child was telling us: that he felt like he was stuck in the wrong body.

Alana

According to the Diagnostic and Statistical Manual of Mental Disorders,(DSM) 2000, Tom could be diagnosed with gender identity disorder as his behaviour fits the descriptors. But why, in a well adjusted child, should this process be called a disorder? I began to rethink my ideas and to grasp the idea of gender spectrum and to explore the view that the disorder lay in our society's rigid interpretation of gender.

There is a change of thinking on gender identity disorder proposed for the DSM5, 2012-13. If the child is not experiencing clinical distress at their gender change, gender dysphoria or variance is suggested as a more acceptable descriptor than disorder, reflecting the spectrum nature of gender.

The statistics for emotional crises, particularly in adolescence, are disturbing for children like Tom. Moore, 2012, an Australian researcher, reports on the high numbers of transsexual children experiencing verbal and/or physical abuse. Self harm and suicide rates are also high.

BUT.. I hear you protest. Isn't this a hormonal imbalance? Didn't something go wrong in the pregnancy? Isn't there something dysfunctional about this family? Isn't this child just trying to be like his sisters? Isn't it just a phase? Why don't the parents force him to be a boy? I, too, in trying to understand Tom's situation, went through these questions. This child's unwavering certainty about her true gender has led me to understand that biological sex and gender identity can be different.

When a child is as confident about her gender as Tom, adults need to understand that the child is not being wilful or oppositional. It is an overwhelming need driving the child. The child's happiness is inextricably woven into the desired gender being fulfilled. However, the way the child is parented and understood will greatly affect the way he or she copes with the expression of this need.

Finding a suitable therapy for a child who is going through gender change can be difficult. Reid Vanderburgh, 2007, a psychologist who is transgender, writes: "Helping a child actualise their gender identity prior to the onset of puberty may well mitigate many of the mental health issues found in various studies of child/adolescent gender dissonant individuals."

The attitude of the therapist is critical. "A useful conceptualisation is to hold the view that the child's gender identity is what it is, and to encourage self-exploration and self-acceptance rather than trying to steer their gender identity in any particular direction." Vanderburgh R. 2008 P.141

Non directive, Child Centred Play Therapy proved to be a helpful therapy for Tom. In the playroom, Tom was safe and free to explore any issues. He could use toys to express all or any of his feelings. He could explore sand, symbols, paint, playdoh, water, Bop Bag [a large, blow up knockdown toy], shopping, dress ups, dolls, draw and explore scary toys. He could make

up his own play scenes or talk to me about anything he felt like, while receiving my undivided attention and empathy. His mother and little sister sat upstairs in case he needed to check up on them.

Jenna

Play Therapy allowed us a safe place where our child could freely and confidently express and explore gender and self in a healthy, supportive, non judgemental way. We all drew strength and affirmation from the process.

Alana

Tom had already given himself a new name: Tamara. She came to her first session of Play Therapy dressed as a girl in a stereotypical feminine outfit: a long hairpiece attached to her growing brown hair, frilly dress and shiny, red high heeled shoes. She was thrilled when I greeted her with "Hi Tamara!"

Tamara enthusiastically took to the playroom and began playing in the sand, which sits in a large wooden tray on a blue tarp. Miniature objects-{symbols] lay around it. Tamara created a scene in the sand with different types of people figures. She gravitated towards the people with disabilities-wheelchairs, crutches etc. [Am I disabled?] A baby fell out of its mother's arms into the sea [blue tarp] and had to be rescued. {I'm in trouble and I need help?} A figure with a cork on its head was placed at the edge of the tray and a Doctor figure stood in front of her. Tamara told me, "He wants to help her get the thing off her head."

Perhaps this was her way of telling me her problem. Later, she told me that a doctor can give special medicine that will turn your body into a girl. She also created a scene with a little boy standing away from a family group, looking very alone.

She drew pictures of the ocean and mermaid girls surfing freely. Mermaids were inspiring to her-girls with tails and free

> “Tamara entered quickly into the heart of the work. I felt in awe of her and realised that she had always known she was a girl and was waiting for the world to validate her. Her parents were moving in the same direction, even though it was painful and confusing.

to be themselves. Tamara was already playing out the life she wanted, beginning the process of transformation for herself and the world.

Tamara entered quickly into the heart of the work. I felt in awe of her and realised that she had always known she was a girl and was waiting for the world to validate her. Her parents were moving in the same direction, even though it was painful and confusing. She was intelligent and focused and I could see that she could not stop what was happening to her. Yet, she was still living a double life, going to school as a boy, only being her true gender when her parents told her it was safe.

In session two, she had moved into telling her story more significantly. Again she played out the baby and the mother but this time the baby jumped into the sea. Mother had to put on “scuba diving gear” to rescue her. This time it seemed that she was more purposeful about finding the freedom of the sea (freedom to be her true self?) and she also recognised that her mother needed help.

Playing with symbols allowed Tamara to say what she needed. At five years old, play was still a strong language for her. It was not easy to talk about her feelings. They were too deep and overwhelming.

Play sequences between the sand and the sea via a ladder were played out and many characters were buried beneath the sand. Although a play therapist needs to be tentative in interpreting play, it looked like Tamara was intent on working out a route between the freedom of being open and the pain of secrecy about her preferred gender.

The most powerful play for Tamara, was with the Bop Bag. She took a pen and drew a large picture of a boy on one side and a girl on the other. She labelled them Tom and Tamara. Tom looked very angry and sad whilst Tamara was glamorous and smiling. Tamara punched and kicked the drawing of Tom, yelling that he was fake. The picture of Tamara was hugged and loved. This was repeated several times. I reflected, “It’s hard to be Tom when you really feel like Tamara.” She nodded. I doubted after this, that Tamara could return to being Tom.

There was a gap in therapy of two months while the family had a holiday overseas. Tamara was given permission to be a girl whilst they were away. On return, the gender identity change seemed complete. Tamara had thrived on the holiday in Bali and could not return to her boy identity. She repeated the violent rejection of Tom on the bop bag and the rapturous acceptance of Tamara. Once this was played out, she wanted to explore her new learning from being in another country. As far as she was concerned she had made the outer gender change so now it was time to get on with other learning’s. Children in Play Therapy can move through huge challenges quickly while the adults around them still grapple with the problem.

Jenna

How could this child know? Especially in one so young. Trust me, this child knows her true gender. Play Therapy allowed us the space and insight to realise what was innate, true and authentic about the child’s sense of self. It allowed us to build on our own courage, support and acceptance. The Play Therapist played a huge role in supporting, not just the child, but the whole family. I don’t know where we would be without her.

Alana

Realising that returning to her old school as a girl could place Tamara at risk of teasing and bullying, her parents decided to temporarily home school. They decided to return to their home country, in the United Kingdom, by the end of the year, where they felt a fresh start in an accepting, inclusive school would help their daughter. A strong need for the support of family and friends contributed to this decision.

The next three sessions however, showed a deep expression of grief as Tamara mourned the loss of her friends and teacher. Perhaps she was also aware of her family’s loss of a son and brother. She played it out in the sand, where all the people characters fell and were sucked under by quicksand. Family members came to find their missing loved ones, calling out, “My sister! My brother!” before they too were engulfed.

Tamara felt the enormity of her situation and its effect on her family and friends. The quicksand play was repeated three times followed by dragon attacks and fires which annihilated everyone, except the little mermaid. The mermaid, perhaps Tamara’s beautiful, whole self, managed to leap over the whole sand tray. Being magical and able to fly, the mermaid rescued some of the people, who although dead, could still see each other. She seemed to be acting out the end of her world as a boy.

After these sessions, I felt my belief in Tamara even more strongly. In my notes I wrote: “I accept Tamara, I believe and support her unconditionally.” I had to keep reminding myself that she was only five years old.

In her next sessions, she showed signs of being ready to finish her therapy: less intensity in the play, play that was simply fun or educational. However, her parents and I observed anxiety in the form of perfectionism and felt it would be helpful if she continued therapy. Her behaviour was also regularly oppositional at home.

She now expressed reluctance about coming to see me, thinking that she had to keep playing out the gender issues. She said she would come back if her little sister came too. I reassured her that the playtime was for her to use “pretty much” how she wanted to and it would be great to have her little sister in the session. No doubt, she was tired of being “the problem” in her family.

I removed the bop bag with the drawn figures of Tom and Tamara and replaced it with a plain white one. Tamara wanted to know where the old bop bag was and I explained, “I wondered if you’d finished with that. If you want it back I can get it for you.” She said she preferred the white one and spent nearly the whole session in a huge anger release with it, bashing, insulting, kicking and playing a competitive game with it: Tamara: 90 points, BopBag:0 !! Perhaps she needed to reject the intensity of her process in therapy so she could get on with the next part of her childhood.

During her last session (there had been thirteen, plus frequent consultations with her parents) Tamara showed definite signs of mastery: “I’m too old for this now, Alana.” she said. In other words,” I’ve worked through the crisis.” She found it hard to tell me, feeling that I would be too upset. She did not need to thrash the bop bag much, except in fun. She did not even worry too much about slotting the pens back in the right place. More importantly, life at home had been easier, Tamara’s anger and anxiety abating. She no longer dressed in elaborate female costume. Now that she was more assured in her gender, her clothes of choice were still feminine but understated and casual.

Of course, many challenges lie ahead but this early therapy and her parents’ good sense have supported this child in her strong sense of self, determination and conviction. As her family and I became open and accepting about her gender, Tamara had been increasingly able to her sort through the early transgender issues at five years old.

At the end of her last session, I explained, “It’s okay to finish, Tamara. I say goodbye to lots of kids but I never forget them. They are always in my heart.”

She visibly relaxed. I returned to the playroom with tears in my eyes and a deeply grateful feeling that Tamara had been able to play out her changewith me. She had emerged into her girl self with the support of her parents and myself. We now

> “Tamara spent nearly the whole session in a huge anger release with it (the BopBag), bashing, insulting, kicking and playing a competitive game with it: Tamara: 90 points, BopBag:0 !! Perhaps she needed to reject the intensity of her process in therapy so she could get on with the next part of her childhood.

unconditionally accepted her chosen gender. We believed and listened to her, facilitating her continuing self-esteem and creativity. Her parents had struggled, rejected hiding and suppression and were now rewarded with a happy and confident child. I felt honoured to be part of her story.

Jenna

“The challenge remains for us as parents to find a way to raise a healthy, happy child who is “different”. Transgender children and adolescents are often bullied, mocked and discriminated against and statistics show that they are more likely to fall victim to substance abuse, depression, self-harm and suicide as young adults. Why? Because they do not represent the norm? Because they challenge us? Because they make us uncomfortable? Because they are “different”?

Gender is one of the first things that identifies us: “Boy or a girl” is the very first query made after our birth.

But what of children, such as ours, who go on to present as transgender? How do we respond to them? Do we shame them into suppression and denial and hiding? Do we stigmatize them? Pathologise their existence, diagnosing them as sufferers of a psychiatric disorder? Branding them as psychologically disturbed?

Are we so uncomfortable with difference? Are we so arrogant as adults as to assume we cannot be taught anything about our children by they themselves? That our children cannot know themselves? That difference and diversity equates with deviation and disorder?

Young people need to be allowed to explore gender identity in a safe, supported environment without the fear being imposed that such exploration will cause corruption or confusion. They need to be allowed to make choices that may indeed challenge us. Gender exploration might challenge us but it is not a corruption of gender norms: men will still exist as men and women will still exist as women: girls will still be girls and boys will still be boys. But we might go some way to preventing the depression and the suicide amongst young people who could otherwise contribute to society as much loved, valued and upstanding individuals if we just listen and learn and if we just open our hearts and our minds.”

References

Brill and Pepper: 2008 the Transgender Child, a Handbook for Families and Professionals 008-0158-5

Diane Ehrenstaff: 2011 Gender Born Gender Made Raising Healthy Gender non- conforming Children

Gherovici, P. (2011). Psychoanalysis needs a sex change. Gay and Lesbian Issues and Psychology Review, 7(1), 3-18. Retrieved from http://search.proquest.com/docview/894273130?accountid=28745

Goodman R. (1997) The Strengths and Difficulties Questionnaire: A Research Note. Journal of Child Psychology and Psychiatry, 38, 581-586.

Kenagy, G. P. (2005). Transgender Health: Findings from two needs assessment studies in Philadelphia. Health & Social Work, 30(1), 19-26. Retrieved from http://search.proquest.com/docview/210566275?accountid=28745

MS Magazine 2012-2013

APA Removes Gender Identity Disorder from DSM-V

Moore, S. (2012, Oct 29). Why it matters. Education, pp. 29-29. Retrieved from http://search.proquest.com/docview/1152160481?accountid=28745

The DSM Diagnostic Criteria for Gender Identity Disorder in Children (DSM-1v-TR) 1Vth Edition Text revision APA 2000

Response of the World Professional Association for Transgender Health to the Proposed DSM5 Criteria for Gender Congruence.

Vanderburgh, R. (2009). Appropriate therapeutic care for families with pre-pubescent Transgender/Gender-dissonant children. Child & Adolescent Social Work Journal, 26(2), 135-154. doi:http://dx.doi.org/10.1007/s10560-

Alana Vaney is a registered member of ACA and holds a Diploma Teaching, B.A. Graduate Diploma Children’s Literature, Graduate Diploma Learning Support and a Graduate Diploma in Play Therapy. Alana has worked as Primary school teacher in NZ and a Special Education Teacher at Gympie Special School, Learning Support Teacher at the Sunshine Coast Region and a Behaviour Support Teacher at Chancellor State College and is now a private practitioner. Email: respectworks@aapt.net.auand

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For reply please quote: *ECU/LW – TF/13/2421 – DOC/13/21794*

19 MAR 2013

Mr Philip Armstrong
Chief Executive Officer
Australian Counselling Association Inc
PO Box 88
GRANGE QLD 4051

Dear Mr Armstrong

I would like to convey my appreciation to Australian Counselling Association Inc for offering to assist Queenslanders in their time of need following the recent natural disaster.

Once again, hundreds of families across Queensland have been affected by devastating floods and damaging winds caused by ex-Tropical Cyclone Oswald. Many Queenslanders who have just recovered from the 2010–2011 natural disasters are again experiencing heartache with the loss of property and livelihoods. The level of need in flood-hit communities such as Bundaberg, Laidley, Maryborough, the Central Burnett and Rockhampton cannot be underestimated.

Your offer of counselling services to the disaster affected areas in Queensland is very much appreciated.

The rebuilding process for these communities will be much smoother because of Australian Counselling Association’s generosity. We are committed to helping the affected communities on the road to recovery and will continue to work in partnership with the Australian Government, local councils, Australian Red Cross and other non-government organisations and volunteers to help these communities rebuild.

I am certain the resilience of the people of our great State will be on display as the recovery effort gets underway.

Again, thank you for Australian Counselling Association’s generosity and willingness to assist Queenslanders in their time of need.

Yours sincerely

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SPECIALTY COURSES

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Indigenous Counselling

This course will offer an introduction on how to approach Indigenous clients from an understanding of their world view rather than from Western scientific worldviews.

Responding to Suicide Risk

This course provides a guide to best methods of response to suicide risk in clients while also providing an overview of potential risk factors.

Working with Subpersonalities

This course offers you information about subpersonalities: the theory behind the construct, the core understandings, and several exercises to guide your clients' work with them.

WORKSHOP VIDEOS

Crisis Counseling: The ABC Model

Dr. Kristi Kanel (California State University) reviews the history of crisis counselling, provides a background of crisis theory and explores 2 case studies: the first client is a rape survivor, and the second is a war veteran.

Crisis Stabilization for Children: Disaster Mental Health

Dr. Jennifer Baggerly (University of South Florida) worked with children in Louisiana following Hurricane Katrina and with children in Sri Lanka after the tsunami. This live demonstration video presents the guiding principles for responding to children after a disaster.

Therapies In-Action

Presented in an authentic and flowing style, this video includes five role plays where counselling professionals apply five different therapeutic approaches with clients.

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ACA Recognised Professional Development

SPECIALTY COURSES (Continued.)

Case Studies in Narcissism

Over this course you will have the opportunity to explore the NPD cases of a man, a woman, and a couple. You will be able to see the symptoms "in action" in the case study subjects' lives, and the huge impact the disorder has had on significant others in their lives.

Fostering Resilience in Clients

The purpose of this course is to help you enhance the emotional resilience of your clients. To do that, you will want to understand what resilience is and which skills or responses to circumstances tend to increase it.

Principles of Psychosynthesis

The purpose of this course is to acquaint you with the basic principles of Psychosynthesis: its assumptions, core constructs, and understandings about what makes a being human, and what, therefore, may be the best means of facilitating that being's growth toward its fullest potentials.

Understanding Will

Will is a central concept in the psychology of Psychosynthesis founder, Roberto Assagioli, who described will as operative on personal, transpersonal, and universal levels. This course is particularly oriented to those in the helping professions who may be seeing clients in the throes of transformational and other crises

Overview of the Principal Personality Tests

This course aims to give you an overview of the most common personality test types used today, the applications of their usage, and a sample of the types of questions they ask. The discussion of each test includes a short section outlining some of the major criticisms or limitations of the test.

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WORKSHOP VIDEOS (Continued.)

Play Therapy: Basics for Beginning Students

This video is the place to begin instruction in play therapy - it is upbeat and entertaining with great visuals, but also includes the critical basics for students with many live demonstrations. The presenter uses puppets to help communicate the rationale, principles, and basic skills of play therapy. Each skill is demonstrated through video clips of play therapy sessions with culturally diverse children.

Brief Counseling: The Basic Skills

In this video John Littrell (Colorado State University) shows how to teach brief counselling from a microskills framework. You will learn how to search out positives and solutions early in the session; how to structure a five-stage brief interview; how to ask questions that make a difference; and how to manage difficult clients.

Attachment and the Therapeutic Relationship

When a child is referred for therapy it is common to discover that the child has experienced disruption to a significant attachment relationship which has impacted that child in serious ways. This presentation draws upon a number of actual cases, and shows experiential techniques to explore the topic.

Using Undercover Teams to Re-story Bullying

This workshop uses real-life stories to describe how the school counsellor uses the Undercover Team Approach in a strategic way to disrupt a story of bullying relations in a secondary school classroom and rewrite an alternative story of support for the victim.

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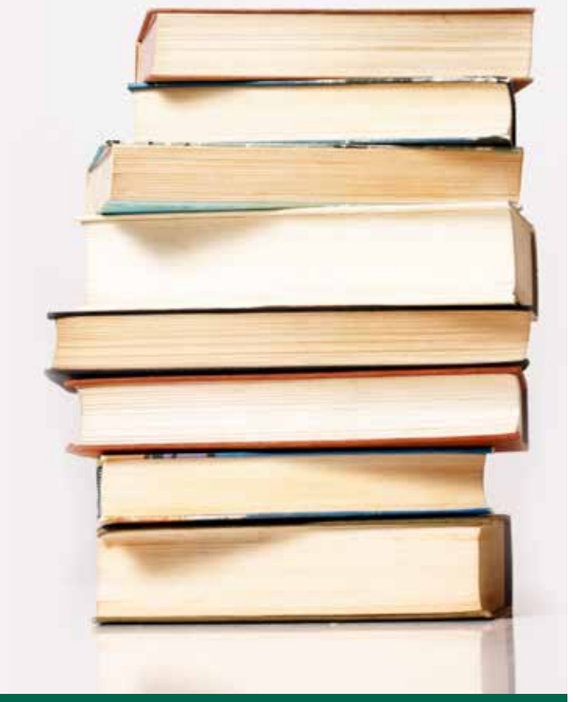


Book and DVD reviews

Karli Yoga, Volume 1

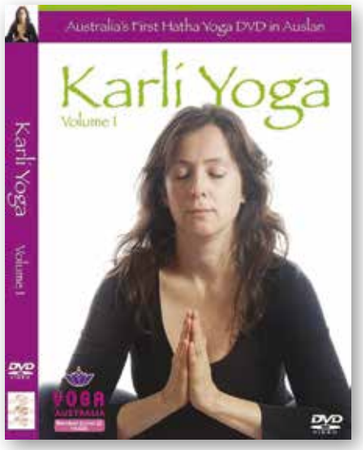
To enquire about the DVD go to
www.karlideafhealth.com.au
Price: $39.95

Review by Philip Armstrong

This is Australia's first Hatha Yoga DVD in Auslan and it has been put together by ACA registered member Karli Dettman. Although the DVD is for everyone it has been produced with the hard of hearing, deaf and blind in mind. The DVD comes with English captions, voice over, Auslan instruction and audio descriptions.

This DVD is really for everyone and anyone interested in Yoga or learning Yoga. I found Karli's instruction simple and easy to follow. As someone who does not have hearing or seeing issues I actually found the captions and other inbuilt features actually enhanced the instruction and made it easier for me as a novice to follow Karli's instruction. The video goes for approximately 75 minutes which includes a 20 minute warm up session. The DVD includes some mini classes that explain the philosophy behind Hatha yoga and its concepts, I found these to be very informative.

This is a great product and I would highly recommend the DVD to anyone interested in Yoga themselves or works with clients who would benefit from Yoga. A great tool for counsellors.



Clinical Handbook of Adolescent Addiction

Rosner, Richard. [ed.]
Chichester, John Wiley & Sons, 2013
ISBN 978-0-470-97234-2
Available for purchase: www.wiley.com
Hardback, 520pp, US$90.00

Review by Karen Adler

Richard Rosner states that by the time teenagers have reached the final year of school, their use of illegal substances has become almost statistically 'normal'. The statistics in Clinical Handbook of Adolescent Addiction for adolescent substance abuse are disturbing but not surprising. One need not be directly involved in the arena of health care to realise the huge negative impact upon our society of substance abuse disorders.

In regard to adolescent illness as a whole, Rosner notes the long-term change since 1960 from the traditional causes of disease to more behaviour related problems such as drug abuse. This major historical shift away from the physical causes of disease in youth is one of the most disturbing facts presented in the book. Rosner's background in adolescent and addiction psychiatry eminently qualify him to be the editor of this book which is designed to fill an information gap in the literature and to be a practical tool for those dealing with adolescent addiction.

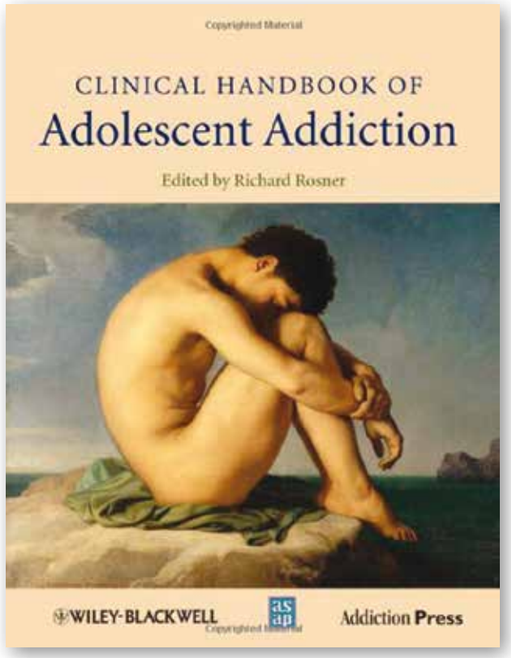
In his Preface, Rosner cites the 1995 report of the Carnegie Council on Adolescent Development - 'Instilling in adolescents the knowledge, skills and values that foster physical and mental health will require substantial changes in the way health professionals work and the way they connect wth families, schools and community orgainisations.' [p. xv]

Two statements by Pamela Taylor and John Gunn in the Foreword reinforce the serious nature of this issue. The first statement is that, 'the figure of around 90% of substance abusing adults having started ... in their teenage years, keeps emerging.' The second is that, 'Whether the teenaged brain can ever recover from a drug-induced developmental delay or arrest is unknown at this time.'

That a change-orientated, educational, holistic approach is necessary to address such a major international public health issue is reflected in the wide scope of Rosner's book. As a transpersonal art therapist, however, I was disappointed to see no mention of the use of expressive arts therapies or of transpersonal psychology, particularly taking into account Jung's role in the origins of AA. With an issue such as adolescent addiction, which has such far-reaching individual and societal consequences, it is imperative to utilise all avenues of potential problem solving and healing.

References

Carnegie Council on Adolescent Development, Great Transitions : Preparing Adolescents for a New Century, Concluding Report, New York, Carnegie Corporation of New York, 1995.



About Reviewer

Karen is an ACA registered Counsellor, a Transpersonal Art Therapist, an artist, writer, curator and researcher. Karen has run art therapy workshops for the treatment of drug and alcohol addiction, self-harming behaviour and eating disorders, for people seeking to bring about positive change in their lives and most recently, for health professionals working with trauma as a result of this year\'s floods in Queensland, Australia.
I use Art Therapy to help in the resolution of my own life difficulties and am continually surprised and delighted by the insight it brings.

Want to be published?

then submit an article to Counselling Australia

Contributor's Guidelines

Why? Get publishing points on the board, being published is part of most career advancements for professional counsellors/psychotherapists, particularly those who wish to advance in academia. All peer reviewed articles are eligible for OPD points and publishers can claim on their CV's to have been formally published. Counselling Australia is now calling for articles and papers for publication. Counselling Australia is a peer reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285).

Counselling Australia is designed to inform and discuss relevant industry issues for practicing counsellors, students, and members of the Australian Counselling Association. Note publishing dates: The journal is published quarterly every March, June, September and December.

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

Editorial Policy

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

Previously Published articles

Articles that have been previously published can be submitted as long as permission for reprint accompanies the article.
Articles for peer review (refereed):

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

Conditions:

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

Deadline

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

ACA College of Supervisors (COS) Register

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Ellis Lee	Singapore		N/A	N/A	N/A
Indumathi Balasubramanian	Singapore		N/A	N/A	N/A
Narinder Kaur	Singapore		N/A	N/A	N/A
Prem Kumar Shanmugam	Singapore		N/A	N/A	N/A

AIPC

Gain Entry Into An ACA Professional College

With An ACA Accredited Specialty Vocational Graduate Diploma

At the 2011 ACA Annual General Meeting ACA publicly launched its Professional Colleges. ACA Professional College membership is available to members that have specialist training, skills and experience in specialty areas of practice. The benchmark training standard for most Colleges (all except Hypnotherapy) is an ACA Accredited Vocational Graduate Diploma in the area of specialty practice.

Currently the Professional Colleges include: Addictions (Alcohol And Other Drugs), Grief And Loss, Family Therapy, Supervision, Counselling Hypnotherapy and Creative Arts.

The Professional Colleges will serve to establish national standards for specialty areas of practice within Australia – something that has been substantially missing for some time.

Get Direct Entry Into A Professional College

AIPC currently delivers a Vocational Graduate Diploma of Counselling with a choice of 3 specialty areas that provide you with direct entry to a Professional College upon graduation. The specialties cover the following fields: 1. Addictions 2. Family Therapy 3. Grief & Loss

Flexible And Cost Effective

Each of the VGD's can be undertaken externally at your own pace. Here's how a graduate qualification can advance your career:

- Demonstrate your specialty expertise through ACA College Membership.
- Develop a deeper understanding of your area of interest and achieve more optimal outcomes with your clients.
- A graduate qualification will assist you move up the corporate ladder from practitioner to manager/ supervisor.
- Make the shift from being a generalist practitioner to a specialist.
- Formalise years of specialist experience with a respected qualification.
- Maximise job opportunities in your preferred specialty area.
- Gain greater professional recognition from your peers.
- Increase client referrals from allied health professionals.

PLUS, you'll **save almost $9,000.00** (63% discount to market) and get a second specialty FREE. A Graduate Diploma at a university costs between $13,000 and $24,000. BUT, you don't have to pay these exorbitant amounts for an equally high quality qualification.

Learn more and secure your place here now: www.aipc.edu.au/vgd

Alternatively, call your nearest Institute branch on the FreeCall numbers shown below:

Sydney	1800 677 697	Brisbane	1800 353 643	Reg QLD	1800 359 565
Melbourne	1800 622 489	Adelaide	1800 246 324	Gold Coast	1800 625 329
Perth	1800 246 381	Reg NSW	1800 625 329	NT/Tasmania	1800 353 643

Become A Self Employed Mental Health Social Support Trainer

As a licensed Mental Health Social Support Trainer you can earn very good money delivering MHSS programs. You have the freedom to advertise and schedule programs wherever, whenever and to whomever you want.

As you have absolute freedom over your time, you can deliver as many or few programs as you wish. This allows you to supplement your current work; work part time; or deliver MHSS full time.

The deterioration of mental health in our communities, along with underfunding by government, is fuelling urgent demand for solutions. As a MHSS Facilitator, you would be ideally positioned to service this growing need.

As a Licensed Trainer you would deliver the MHSS program by way of a 2-day Workshop plus a Participant Workbook. You receive training on how to deliver the workshop, as well as a detailed Facilitator Guide that directs you specifically on what to cover, and provides all the supporting material and resources required.

Program Participants attend your workshop where you provide them with the Participant Workbook and 2-days of guided training. They complete additional learning via the interactive Workbook and then undertake an online assessment at their own pace to receive their Certificate of Achievement in Mental Health Social Support.

Once MHSS Certified you can be listed on the Australian Counselling Association's MHSS Register, which may be utilised in disaster situations by government and NGO's to identify those people with relevant social support competencies.

What Training is Required?

To become a Licensed Mental Health Social Support Trainer, you simply need to become MHSS certified and complete an online training module. Training and assessment takes approximately 10-hours.

You can complete the modular-based program entirely online, at your own pace. At the end of each module there is multiple-choice and true/false competency assessment. If you don't pass the assessment first time, you can simply retake it (at no extra cost and in your own time).

You're Fully Supported

Once you successfully complete your MHSS Trainer program you're issued with a Facilitator ID and secure access to the MHSS Trainer Portal. The MHSS Trainer Portal gives you access to:

- Facilitator Workshop Guide.
- Flyer promotional artwork.
- Poster promotional artwork.
- Advertising templates.
- Workbook order system.
- Marketing strategies.
- Business development and education support.
- And much more.

You'll be part of a national team delivering MHSS training. You'll be supported and coached over phone, teleconference and video conference. And you'll be invited to attend conferences and national meetings.

Take the first step now.

If you are **NOT YET MHSS Certified**, visit **www.mhss.net.au** and register now. Just after your registration has been completed, you will be invited to register for the MHSS Trainer program with a 63% discount ($1,000 savings).

If you are ALREADY MHSS Certified, visit **www.mhss.net.au/facilitator2** now to complete your MHSS Trainer program.

Mental Health Social Support is in collaboration with Australian Institute of Professional Counsellors