COUNSELLING AUSTRALIA

Volume 14
Number 4
Summer 2013

Online and IT resources

News and research from around the world

ACA College of Supervisors register

Happiness in counselling

Promoting client wellbeing

ACA AUSTRALIAN COUNSELLING ASSOCIATION Inc

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On happiness in counselling
by E.A. Cocodia
For many individuals the word happiness conjures up images of positivity, good feelings and sometimes even warm, fuzzy emotions. However, the concept of happiness remains vague. As the wellbeing of the client is uppermost in the counsellor's role as a helper, this therefore suggests that if the client's wellbeing is ignored its impact on the individual becomes evident.

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See page 32 for peer-reviewed article submission guidelines.

www.aca.asn.au

EDITORIAL

by Philip Armstrong

In the last few months I have travelled all across Australia meeting ACA members in most states and having great discussions with ACA registered and non-registered therapists. The one constant I kept coming across is a lack of self-belief in ourselves as professionals, i.e. "Counsellors". I continually found myself correcting counsellors as they instinctively referred to themselves as "just a counsellor", as though they were apologising for being a counsellor.

I also became alarmed as counsellors spoke about other similar professionals with reverence, as though they could only dream of reaching the heights of these god-like beings. It was as though we should hide in the shadows of other mental health professionals and thank them for any scraps that are sent our way but never venture out into the sunlight for fear of being labelled a second rate therapist. As though we should be spending all waking hours thanking those of a higher ilk for allowing us to exist, albeit not on the same plain, as long as we don't seek equity in status with the powers that be.

When I challenged the counsellors I spoke with as to how this lack of self-esteem crept into their professional lives I was informed that they were constantly reminded by lecturers whilst training, who predominantly came from other disciplines, of the fact they were to consider themselves second rate. Apparently a hierarchy exists and it was the job of the lecturer to ensure the counsellors in the audience were painfully aware of their position within this hierarchy. They were not to assume they were in any way equal to their more esteemed cousins.

I remember one member simply repeating to me after I challenged him about a point he made, "but so and so, who is a psychologist, said so", as though the fact a psychologist had said it is so, actually made it so. Therefore, that was the end of the discussion; just pack up and go home, the gods have spoken. My response left him with his mouth open and those within hearing distance shocked.

"So what? Being a psychologist on its own means diddly squat. What does being a psychologist actually mean in that context anyway?"

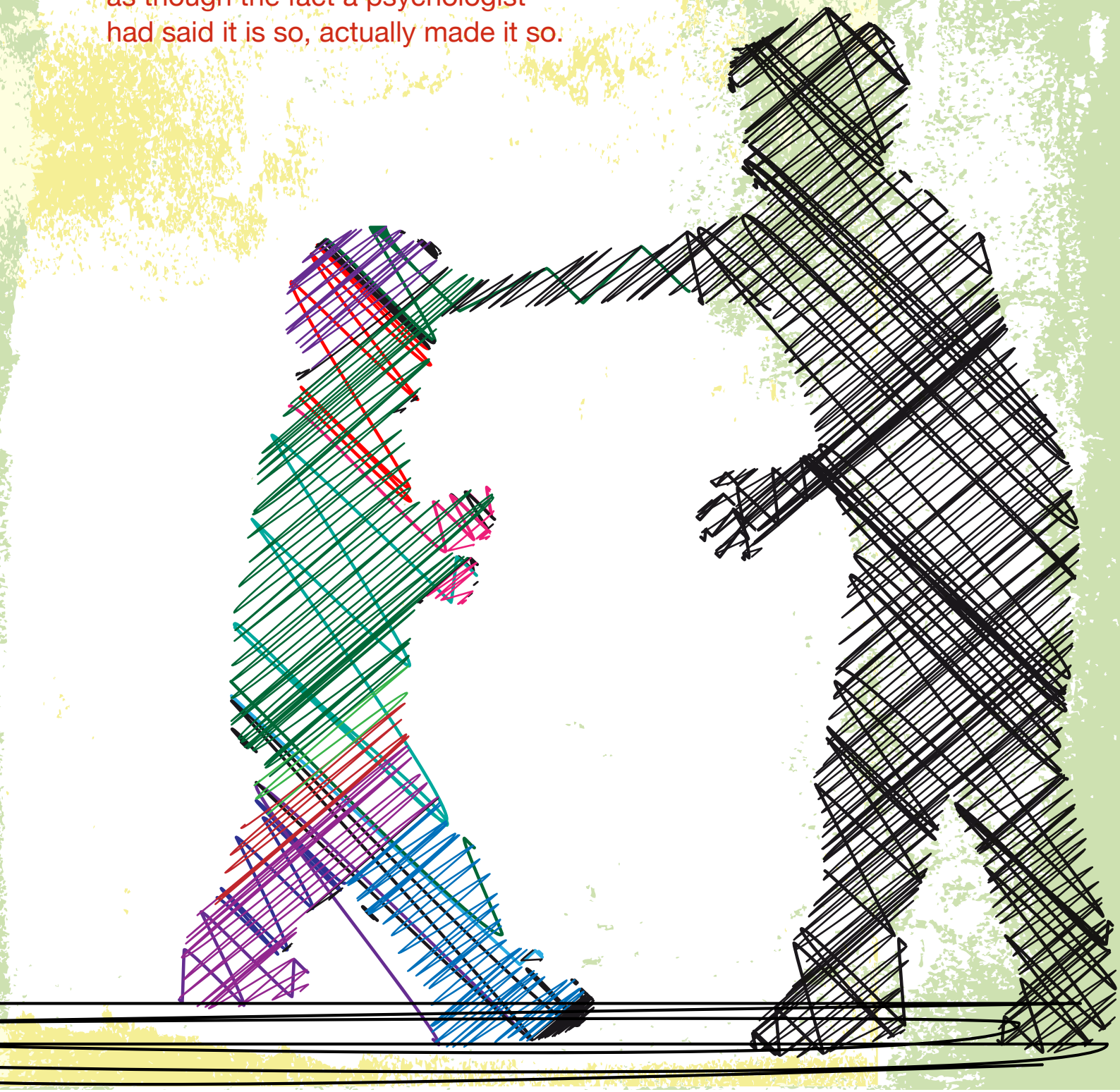
This was not said with any intentional disrespect to psychologists, my wife and brother are psychologists and I greatly respect both, however, just being one does not make one god-worthy. I don't take what a psychologists states at face value any more than I do a counsellor or any other mental health professional.

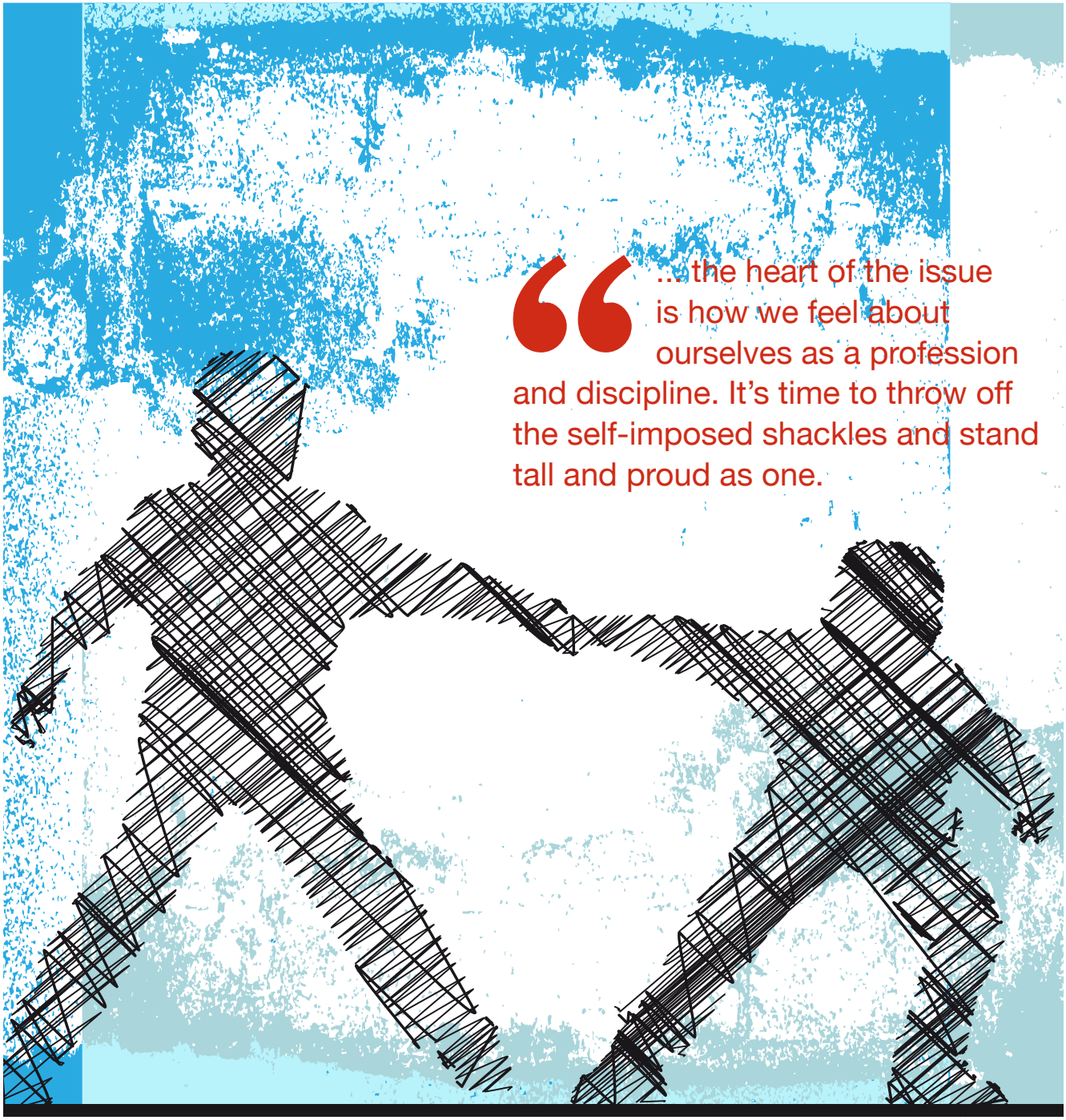
Others told me that they were constantly reminded in the workplace that we are the poor cousins of other more established professions. They had adopted a stance of being subservient to the opinions and statements of others after it had been impressed on them where they stood in the foodchain – and it was not high. This situation took me back to a schoolyard bully who was running rampant at a suburban primary school I was new to as a youngster.

We had just moved from country Victoria to the suburbs of Melbourne. The bully had set about determining where each child at the school belonged according to his own hierarchy of importance. Anyone who disagreed was threatened with a knuckle sandwich, and this threat seemed to work for him. The problem he had with a newcomer such as me was I didn't know the rules. Coming from the country, where a sense of community is strong and reliance on your community for survival is a given, operating from a communal mentality comes naturally. At school, playing with red belly black snakes during lunch breaks and engaging in duels throwing 'yonnies' (Aussie slang for stones) was how status was earned. Verbal threats didn't score highly in the scheme of things, so I didn't take him seriously. A quick smile followed by a 'who's got the football, let's have a game' attitude left him totally disempowered. Particularly as he wasn't about to take to the sporting field where he would be isolated and vulnerable to the group.

It didn't take long for other kids to work out that their fear was in their minds and protection lay in the group. One bully could hardly take on every kid and he couldn't hide from the group anyway. The schoolyard bully was disempowered not through matching violence with violence but through something stronger: the self-belief and strength of the group acting as one. The schoolyard bully, in many cases, is someone with low self-esteem. I actually became mates with him in time and learnt he was a foster kid who was just looking for acceptance but didn't know how to achieve it.

> I remember one member simply repeating to me after I challenged him about a point he made, "but so and so, who is a psychologist, said so", as though the fact a psychologist had said it is so, actually made it so.





Now, I am not suggesting other mental health disciplines are bullies, however, if they feel threatened they may take to bullying tactics in the many forms these come in, something I have experienced firsthand in my lobbying efforts – other disciplines' lobbyists harping on about lack of standards or referring to counsellors as "the unregulated profession", as though we had some infectious disease. I actually take pride in being in a profession that has been successful in self-regulating itself when others haven't. Having said all of the above, I really don't think the issue actually lies with other disciplines. I believe the heart of the issue is how we feel about ourselves as a profession and discipline. It's time to throw off the self-imposed shackles and stand tall and proud as one.

The research is solid, we produce results (efficacy). What we do works and our outcomes are no less than that of psychologists, social workers or any other mental health professional. In other words we stand as equals. Be prepared to add the word "peer" to your vocabulary as that is what the other disciplines are to us. We are all peers regardless of what position we may hold, whether we are academics, employed or self-employed, regardless of our discipline. "I am a counsellor" is how we refer to ourselves and we say this with pride and in the open light of the day. And if anyone has a problem with this, I am always up for a game of football.

Counsellors and Therapists Required for Research.

Participate at www.psyence.com.au/survey

My name is Paul Kremer and as part of my PhD studies I am conducting a research project under the supervision of Dr Mark Symmons (Senior Lecturer) in the Department of Psychological Studies (Arts Faculty), and Dr Brett Furlonger (Lecturer) in Counselling (Education Faculty) at Monash University.

Contact: paul.kremer@monash.edu

This online research is looking at counsellor behaviours and associated ethical status and should take about 25-30 mins.

Participation in this research is voluntary and a full explanatory statement is available when you visit the web-link.

Ref: CF13/2485 - 2013001319

MONASH University

GROUP OF EIGHT

Australia ▪ China ▪ India ▪ Italy ▪ Malaysia ▪ South Africa

with Angela Lewis

Windows XP Microsoft support

Microsoft will end support for Windows XP on April 8, 2014. At the same time, support is also ending for Office 2003.

As I've said before, those programs won't just stop working, but there will be no more security updates or bug fixes from Microsoft. That also means third-party security providers like Symantec won't be able to guarantee that they can keep XP systems safe from viruses and malicious attacks. In fact, XP systems will be a prime target for those with bad intentions. You've been warned! ☺

Facebook symbols

Facebook is being used by people of all ages nowadays as a way of keeping in contact with friends and family all over the world. You can use the same smiley and sad faces that are utilised in Word and Outlook [colon right bracket for a smiley :) and colon left bracket for a sad face :( ], however, there are lots of others, including the four below, that you can incorporate if you are a Facebook user.

- thumbs up graphic: type (y)
- grumpy face graphic: type >: (
- heart graphic: type <3
- a face with tongue poking out: type :p

(y)

>: (

<3

:p

Private Apple iPhone text messages

Don't like stickybeaks reading the auto preview of your text messages on the iPhone (even if pin-locked)? Well, here's how to stop it appearing on the iPhone 4s and 5.

1. Tap the Settings icon.
2. Tap Notifications.
3. Scroll down to the Messages section and select tap.
4. Scroll down to Show Preview, about half way down the screen. From there, you can switch it either on or off.

Internet Explorer

Control your IE pop-ups

If, like me,you get a tad annoyed by random pop-up windows appearing when using Internet Explorer, take control by following these steps.

1. Click the little gear symbol to the far right of the Internet Explorer window, under the red 'X'.
2. Click on Internet Options.
3. The Internet Options window will open. Click the Privacy tab.
4. Put a check in the box next to Turn on Pop-up blocker.
5. If you'd like to set it so that pop-ups are allowed from some sites, click the Settings button.
6. You'll see options to control pop-up permissions. Under Exceptions, you can choose sites where you want to see pop-ups, for example, sites where you play games or need to fill out forms.
7. Click Close and then choose Ok to apply settings and leave this area.

ONLINE AND IT RESOURCES

with Angela Lewis

How do I clear my browsing history in Firefox?

While most of us tend to use Internet Explorer, there is nothing stopping people from having two browsers installed, with the second favourite frequently being Mozilla Firefox. I actually use it myself, as I have Wordpress websites that I maintain, and Wordpress doesn't seem to like Internet Explorer all that much.

So, if you are a Firefox user like me and want to clear your recent browsing history, it only takes a minute.

1. Click the Firefox drop-down menu.
2. Choose History and then click Clear Recent History. Job done!

Mentoring programs for Indigenous youth
www.aihw.gov.au/uploadedFiles/ClosingTheGap/Content/Publications/2013/ctgc-rs22.pdf
Resource sheet no. 22, produced for the Australian Institute of Family Studies.

Crowd Funding
www.fundster.com
www.fundable.com
A way of raising money for a project using investors from the general public.

Jargon

Twerking

Hands up if you saw Miley Cyrus so-called 'twerking' and wondered what that meant? Well I didn't know, which sent me to Wikipedia. It explained that twerking is "a type of dancing in which the dancer, usually a woman, shakes her hips in an up-and-down bouncing motion, causing the dancer's buttocks to shake, 'wobble' and 'jiggle'".

Crowd funding

Also known as crowd financing or crowd-sourced funding, crowd funding is a way of raising money for a project using investors from the general public, as opposed to seeking funding from a bank or traditional source capital. In this model a collective of individuals pool their money, usually via the internet, to support efforts initiated by other people or organisations. It is used in support of a wide variety of activities including disaster relief, support of artists by fans, political campaigns(for example, the free Julian Assange campaign), free software development, inventions and civic projects. Two platforms that people use for this are kickstarter.com and fundable.com.

As always I welcome your comments, so please feel free to email your thoughts after reading.

Warm regards, Angela
angela@angelalewis.com.au.

More free IT hints are available at www.angelalewis.com.au/blog.

Please note that all internet addresses were correct at the time of submission to the ACA and that neither Angela Lewis nor the ACA gain any financial benefit from the publication of these site addresses.

Readers are advised that website addresses in this newsletter are provided for information and learning purposes and to ensure our member base is kept aware of current issues related to and delivered by technology.

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As you know, Ongoing Professional Development (OPD) is a mandatory requirement for continued membership of ACA.

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4. The Counselling Relationship
5. Therapy and the Brain: What has the brain got to do with it?
6. Counselling and the Counselling Process
7. Communication and the Counselling Interview

Learn more and register: www.mentalhealthacademy.com.au/aca

Pigging out can be all in the genes, study finds

A study of more than 1000 pigs has revealed gene variants likely to be linked to overeating and obesity in humans. The research, by Danish scientists, confirmed that genetics has a powerful influence on eating behaviour as well as how likely a person is to put on weight.

Professor Haja Kadarmideen of the University of Copenhagen, who led the work, said people have "genetic barcodes" that predict whether they are likely to eat compulsively or be more attracted to fatty foods.

"Our research indicates that eating behaviours run in families," he said.

"If a mother or father, or both, had unhealthy eating habits they are likely to pass on some part of their habits to their children through their DNA."

The study, which monitored 1200 Duroc pigs for four years, found that 12 to 15 per cent of the differences in the animals' eating behaviour were explained by genes alone.

The finding was welcomed by scientists working on the genetics of obesity as a strong confirmation of previous evidence from human studies.

Obesity rates in Britain have increased dramatically – in 2011, 24 per cent of men and 26 per cent of women were obese compared with 13 per cent of men and 16 per cent of women in 1993.

Professor Sadaf Farooqi, a metabolism specialist at the University of Cambridge, said, "We've known for a long time that body weight is heritable. However, while we can get good data on weight in humans, it's very difficult to get reliable data on what people were eating."

In the latest research, published in the journal PLoS One, the pigs were given unfettered access to food for a period of four years. Each day, the pigs were monitored for how often they ate, how much time they spent visiting the feeder, how quickly they ate and what food they chose, while their overall weight gain was constantly mapped.

The DNA of each of the 1200 pigs was assessed using a genomic chip technology that simultaneously created a genetic profile at 60,000 locations across the entire DNA of each pig. The study was originally designed to help farmers pinpoint gene variants associated with pigs being lean and 'feed efficient'. However, Professor Kadarmideen saw the data as an opportunity to study the genetics of obesity at a scale and level of detail that would be impossible in a human trial.

"Pigs are a great model because their genome is more than 95 per cent similar to humans and their digestive systems and metabolism are very similar," he said. The study found that certain genes were linked to spending longer at the feeder, while others were linked to eating more quickly or putting on weight more readily.

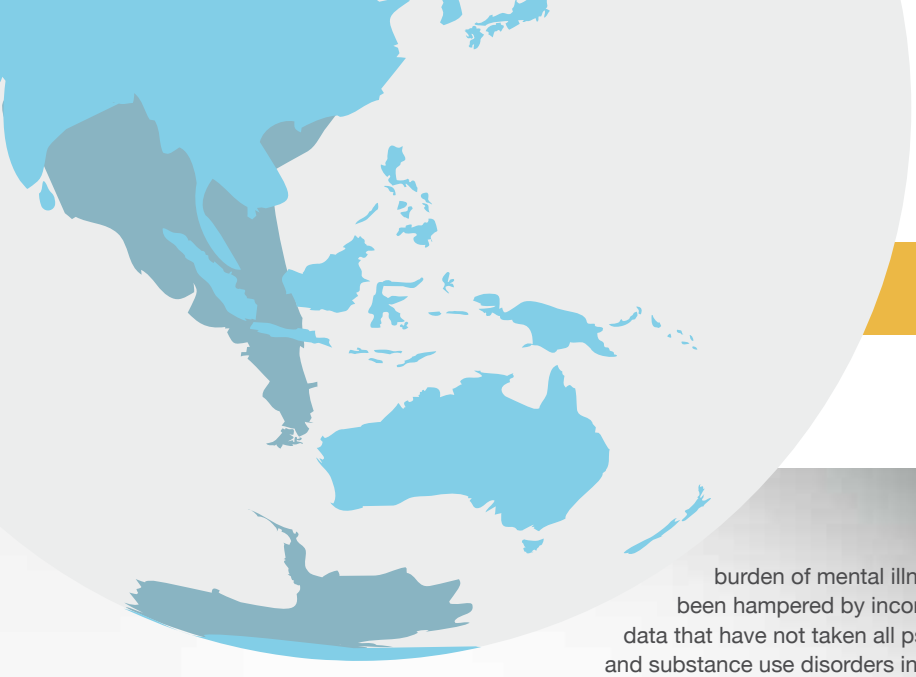
Some of these genes had previously been linked to obesity in humans, but it was not clear whether the association was due to eating behaviour or metabolism. The findings in pigs suggest that eating behaviour plays a predominant role.

"We are looking at one in five people who is simply programmed to eat like that," said Professor Kadarmideen. "It links your attitude towards food and obesity genes. I really believe that eating behaviour is a significant part of gaining weight."

Professor Farooqi said the findings had important implications for treatments aimed at weight control. "It suggests there's a strong biological drive to eating behaviour – we can even find it in pigs – so just telling people to eat less is unlikely to work," she said.

By Hannah Devlin, The Times

From: http://www.theaustralian.com.au/news/world/pigging-out-can-be-all-in-the-genes-study-finds/story-fnb64oi6-1226732794326#sthash.5XqxG6Cp.dpuf



Mental disorders leading cause of nonfatal illness worldwide

Mental and substance use disorders are the leading cause of nonfatal illness worldwide, with a global disease burden that trumps that of HIV/AIDS, tuberculosis, diabetes or transport injuries, new research shows.

A team of investigators from the United States and Australia led by Professor Harvey Whiteford found that in 2010, mental disorders and substance use disorders were the fifth leading contributor to death and disease worldwide and that at 40 per cent, depressive disorders account for the largest proportion of this burden.

"Mental and substance use disorders are major contributors to the global burden of disease and their contribution is rising, especially in developing countries. Cost-effective interventions are available for most disorders but adequate financial and human resources are needed to deliver these interventions," Professor Whiteford of the Queensland Centre for Medical-Health Research at the University of Queensland said in a statement.

The results of the Global Burden of Diseases, Injuries and Risk Factors Study (GBD 2010) were published online August 29 in The Lancet.

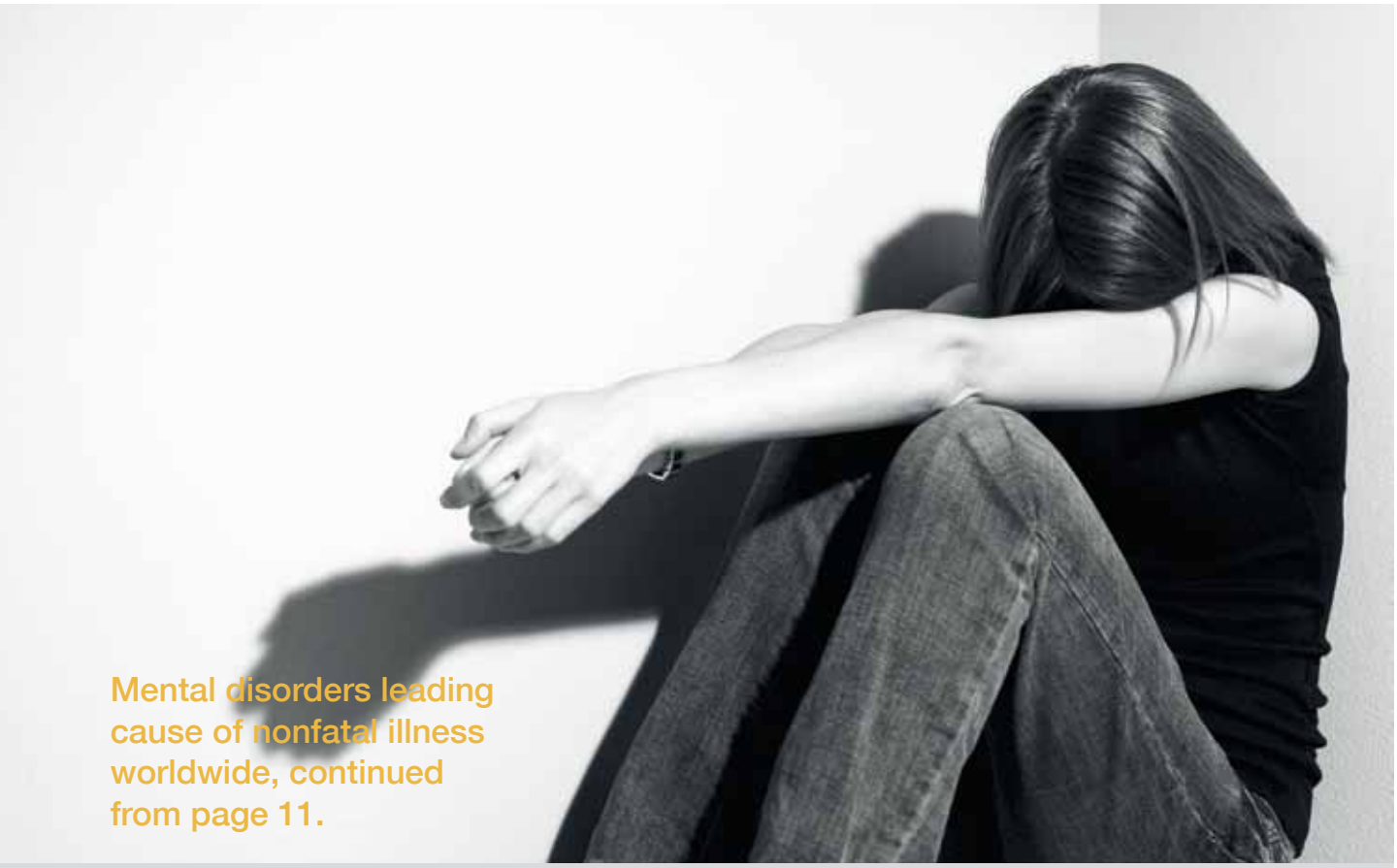
Biggest disability burden in the young

Historically, the researchers note psychiatric disorders have not been a global health priority. In addition, previous estimates of the global burden of mental illness have been hampered by incomplete data that have not taken all psychiatric and substance use disorders into account.

The current number of specific mental and substance use disorders has been expanded in the GBD study to reflect updated epidemiologic evidence for certain disorders. The GBD 2010 study included 20 disorders that consisted of all anxiety disorders, eating disorders, childhood behavioural disorders, pervasive developmental disorders and idiopathic intellectual disability in 187 countries.

The aim of the study was to "summarise fatal, non-fatal,and total burden for 11 classes of mental and substance use disorders for 2010 with reference to changes in burden since 1999".

The investigators used data from GBD 2010 to estimate the burden of disease attributable to mental and substance use disorders in terms of disability-adjusted life-years (DALYs), years of life lost to premature mortality and years lived with disability (YLDs).



Mental disorders leading cause of nonfatal illness worldwide, continued from page 11.

When the researchers analysed the contribution of mental and substance disorders to nonfatal illness only, they found they were responsible for more than a fifth (22.8 per cent) of all disease burden, the leading cause worldwide.

The researchers found that mental and substance use disorders were the leading cause of YLDs worldwide. Depressive disorders accounted for 40.5 per cent of DALYs caused by mental and substance use disorders, with anxiety disorders accounting for 14.6 per cent, illicit drug use disorders for 10.9 per cent, alcohol use disorders for 9.6 per cent, schizophrenia for 7.4 per cent, bipolar disorder for 7.0 per cent, pervasive developmental disorders for 4.2 per cent, childhood behavioural disorders for 3.4 per cent, and eating disorders for 1.2 per cent.

The researchers also report the highest proportion of DALYs occurred in people aged 10 to 29 years.

Mental illness burden higher in females

Girls and women had a greater burden of death and disease from mental disorders than boys and men. However, men had a greater burden from drug and alcohol dependence. According to investigators there were significant differences between world regions for some of the disorders analysed, with eating disorders showing the greatest overall variation.

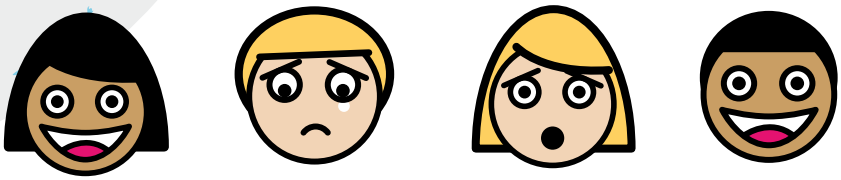
China, North Korea, Japan and Nigeria had burdens of death and disease from mental and substance disorders that were statistically lower than the global average.

"Despite personal and economic costs, treatment rates for people with mental and substance use disorders are low, and even in developed countries, treatment is typically provided many years after the disorder begins.

"In all countries, stigma about mental and substance use disorders constrain the use of available resources, as do inefficiencies in the distribution of funding and interventions. If the burden of mental and substance use disorders is to be reduced, mental health policy and services research will need to identify more effective ways to provide sustainable mental health services, especially in resource constrained environments," said Professor Whiteford.

By Caroline Cassels, The Lancet

From: http://www.medscape.com/viewarticle/810132



Higher depression rates in women a myth?

Women have long been thought to have much higher rates of depression than men, but when alternative and traditional symptoms of depression are considered, these sex disparities disappear, new research shows.

"The sex differences framework is rooted in the idea that the construct of depression is the same in men and women and seeks to investigate sex differences in a range of related variables, including symptoms," investigators led by Lisa A. Martin, PhD, from the University of Michigan, Dearborn, write.

"Although this has been a popular approach to date, it is often critiqued for relying on oppositional binaries that understand 'male depression' only as it is contrasted with 'female depression', which fails to acknowledge the heterogeneity that exists within these groups."

The study is published online August 28 in JAMA Psychiatry.

More anger, aggression in men

The aim of the study was to explore whether sex disparities in depression rates disappear when other symptoms besides conventional depression symptoms are considered.

The researchers used data from the National Comorbidity Survey Replication (NCS-R), a nationally representative survey of the incidence and prevalence of mental disorders among English-speaking adults in the United States. The survey included 3310 women and 2382 men. Their mean age was 45.2 years,

continued over page >

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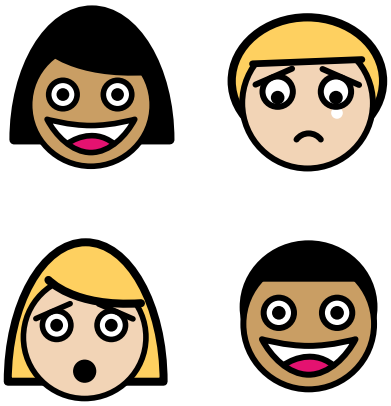


Higher depression rates in women a myth, continued from page 13.

73.4 per cent were non-Hispanic white and 51.6 per cent had some education beyond high school. The mean annual household income was $59,575. The mean income for men was $63,365 and for women it was $49,327.

The researchers developed two scales. The first, the Male Symptoms Scale (MSS), included alternative male-type symptoms of depression, including irritability, anger attacks/aggression, sleep disturbance, alcohol or drug abuse, risk-taking behaviour, hyperactivity, stress and loss of interest in pleasurable activities. The second scale, the Gender Inclusive Depression Scale (GIDS), included all of the MSS symptoms, plus seven traditional symptoms of depression including sad/depressed mood, loss of vitality, tiredness, ambivalence, anxiety/uneasiness, and complaintiveness or feeling pathetic.

Using the MSS scale that included alternative, male-type symptoms of depression, the researchers found a higher prevalence of depression in men (26.3 per cent) than in women (21.9 per cent) (P = .007). The researchers also found that men reported significantly higher rates of anger attacks/aggression, substance abuse and risk-taking behaviour compared with women.

More stress, irritability in women

Women, on the other hand, reported significantly greater rates of stress, irritability, sleep problems and loss of interest in things they usually enjoyed, such as work, hobbies and personal relationships. No sex difference in the prevalence of depression as assessed by the GIDS that included alternative and traditional depression symptoms was found. According to that scale, 30.6 per cent of men and 33.3 per cent of women met criteria for depression.

In terms of severity of depression, the researchers found that 63.2 per cent of men and 62.0 per cent of women fell into the mild category, meaning that they had one to four symptoms; 28.3 per cent of men and 28.9 per cent of women fell into the moderate category, with five to nine symptoms; and 8.5 per cent of men and 9.1 per cent of women fell into the severe category, with 10 to 15 symptoms. No significant sex differences were demonstrated at any severity level, they report.

"These results suggest that relying only on men's disclosure of traditional symptoms could lead to an underdiagnosis of depression in men and that clinicians should consider other clues when assessing depression in men,"" the authors write. They also point out that "despite the significant findings reported in this study, there are noteworthy limitations."

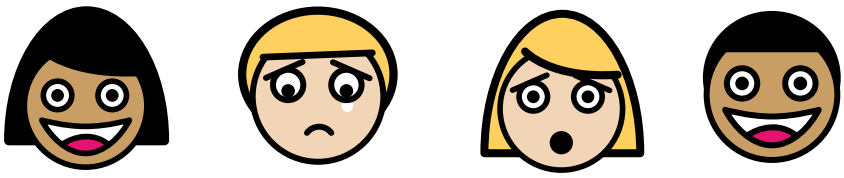
One limitation was that the study did not include symptoms among men such as overworking, overexercising, changing their sexual behaviour or gambling. Also, items that assessed taking chances or reckless behaviour were not linked to an emotional condition. Future studies should include items that assess the excluded

behaviours, the authors suggest.

They conclude that the results of their study have the potential to bring "significant advances to the field in terms of the perception and measurement of depression. These findings could lead to important changes in the way depression is conceptualised and measured."

By Fran Lowry, JAMA Psychiatry

From: http://www.medscape.com/viewarticle/810193



Physical activity and brain health

People who do regular physical activity have healthier brains and reduce their risk of Alzheimer"s disease, according to a report released to mark dementia awareness week.

Apart from overall health benefits, physical activity significantly improves brain health, says Dr Maree Farrow, co-author of a paper released by Alzheimer's Australia and Fitness Australia. "About half of Alzheimer's disease cases are potentially attributable to risk factors you can change," says Dr Farrow, whose paper is based on recent Australian and international research.

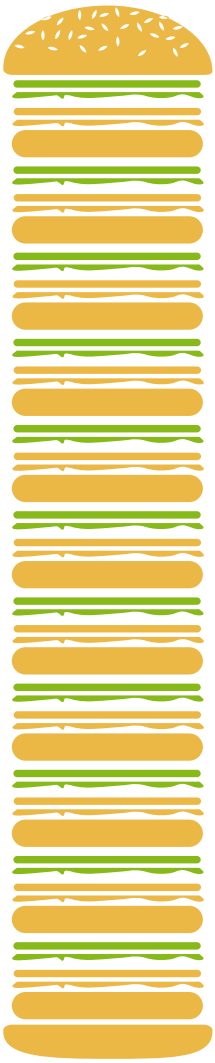
A study by US researchers shows that around 13 per cent of Alzheimer's disease cases are attributable to physical inactivity. And Australian research shows a small increase in the number of physically active people could have a dramatic impact on the number of dementia cases.

It is normal for the brain to shrink a little as people age, says Dr Farrow. But this is reduced in people who engage in regular physical activity. "Whatever your stage of life, being fit and healthy matters," Dr Farrow says. "We can't yet cure dementia but we can reduce our risk by simply becoming more physically active," says Fitness Australia CEO Lauretta Stace.

"This can be as easy as going for a regular walk."

From: http://www.news.com.au/lifestyle/health/exercise-keeps-brain-healthy-reduces-alzheimers-risk-research/story-fneuz9ev-1226721400413

News and research from around the world



Impact of obesity on future dieting

Indulging in fatty foods could ruin your ability to successfully diet in the future by destroying stomach signals to the brain. New University of Adelaide research has found the nerves in the stomach which signal fullness to the brain appeared to be desensitised after long-term consumption of a high-fat diet.

The findings could explain why many dieters tend to regain the weight they have lost. PhD student Stephen Kentish investigated the impact of high-fat diets on the ability of the gut to signal its fullness and whether those changes revert back to normal by losing weight. Study leader Associate Professor Amanda Page said laboratory studies showed the stomach's nerve response does not return to normal upon a return to a normal diet.

"This means you would need to eat more food before you felt the same degree of fullness as a healthy individual," she said. "A hormone in the body, leptin, known to regulate food intake, can also change the sensitivity of the nerves in the stomach that signal fullness. In normal conditions, leptin acts to stop food intake. However, in the stomach in high-fat diet induced obesity, leptin further desensitises the nerves that detect fullness."

Associate Professor Page said the two mechanisms combined meant that obese people needed to eat more to feel full, which fuels their obesity cycle. She said the results had "very strong implications for obese people, those trying to lose weight and those who are trying to maintain their weight loss".

"Unfortunately, our results show that the nerves in the stomach remain desensitised to fullness after weight loss has been achieved," she said. Associate Professor Page says the researchers were not yet sure whether the effect was permanent or just long-lasting. "We know that only about 5 per cent of people on diets are able to maintain their weight loss, and that most people who've been on a diet put all of that weight back on within two years," she said. "More research is needed to determine how long the effect lasts, and whether there is any way – chemical or otherwise – to trick the stomach into resetting itself to normal."

The results were published in the International Journal of Obesity.

By Jordanna Schriever, The Advertiser

From http://www.theaustralian.com.au/news/university-of-adelaide-research-finds-highfat-diets-interrupt-stomach8217s-signals-to-the-brain/story-e6frg6n6-1226720158465#sthash.HLyOeFqG.dpuf

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News and research from around the world

Screen time a factor in kids' weight woes

Screen time, and not physical activity, could have more to do with whether a child is fat or not. If your child is fat it could have more to do with how much time they spend behind a screen rather than how active they are.

Queensland researchers have studied the habits of 144 kids, with surprising results. They looked at the children's level of physical activity, body mass index and how much time they spent staring at screens, from computers to TVs and video games. And physical activity was not the deciding factor in whether a child was overweight or not.

"Most of the children were reasonably active and overall did similar levels of physical activity, which had no direct correlation with their weight," says Dr Rachael Sharman, from the University of the Sunshine Coast. "However, those who were overweight spent significantly more time sitting watching television or playing computer games than those in the normal weight range."

She said the study, which looked at kids aged five to 13, showed how important it was for parents to limit screen time. "Parents need to encourage and support children to be physically active but they also need to set limits for screen time to ensure the benefits of physical activity aren't negated by too much time spent sitting." The study also found kids who were involved in sport at a club or team level were less likely to trade off physical activity for screen-based activities.

From: http://www.theaustralian.com.au/news/latest-news/screen-time-a-factor-in-kids-weight-woes/story-fn3dxiwe-1226735182448

The dark side to night owls

Think back to this morning's alarm. Were you up at the crack of dawn before it even sounded, awake and alert? Or did the repetitive blaring eventually drag you from your slumber, dazed and slapping at the snooze button with one hand before staggering for a cup of coffee?

The preference for morning or evening is known as our sleep chronotype, which is when we reach peak cognitive and metabolic functioning. Science has shown a host of differences between early birds (morning-sleep chronotypes) and night owls (evening-sleep chronotypes) – and the evidence weighs against those with an aversion to sunrise.

Recent international studies have revealed late risers tend to be hungrier and fatter than morning people, suffer from poorer memory and more pain, may be extroverted and have sex more often. But evening-sleep chronotypes are also at higher risk of cancer. Yet there is little anyone can do, as the division is down to evolution: we are genetically predisposed to mornings or evenings.

"Circadian rhythms and sleeping patterns are a matter of biology, not preference," says psychology professor Leon Lack, from Flinders University. The latest study has also found evening types more likely to exhibit personality traits linked to the so-called 'Dark Triad' – machiavellianism, narcissism and psychopathy.

Peter Jonason, expert in social, personality, and evolutionary psychology at the University of Western Sydney, says his research has suggested "those who have a night-time chronotype have darker personalities and these are related to promiscuity, mate poaching, psychological dysfunction, for example, depression, sensitivity to rewards, dishonesty and likely a boom-and-bust work pattern".

But sleeping in or trying to 'catch up' on missed sleep on the weekend only worsens the pattern. "By staying in bed, night owls remove the major external force for rewiring the body clock, which is morning bright light. Sunlight helps increase alertness by suppressing melatonin, the hormone associated with sleepiness," Professor Lack says.

Gordon baker Darren Kennedy starts work as early as 3.30am. He said it would often take a new baker two or three weeks for their body clock to adjust to the hours. "It is something I've adapted to and I guess my body is used to being all over the place," he said.

The key was in taking up good habits. He said he has learnt over the years to maintain a balanced diet and get enough exercise and sleep to continue feeling fresh.

By Melissa Shedden, The Age

From: http://www.theage.com.au/lifestyle/diet-and-fitness/the-dark-side-to-night-owls-20130831-2sxe3.html#ixzz2dgF4rtU6

On HAPPINESS in counselling practice

By E. A. Cocodia PhD

For many individuals the word happiness conjures up images of positivity, good feelings and sometimes even warm, fuzzy emotions. However, the concept of happiness remains vague. For instance, the Oxford English Dictionary defines happiness as "The state of pleasurable content of mind, which results from success or the attainment of what is considered good". While the word happy is described as "feeling or showing pleasure or contentment". For the purpose of this article, happiness in counselling and psychotherapy may be viewed from a therapist's perspective. Happiness may be termed as looking after the client's subjective wellbeing. The wellbeing of the client is uppermost in the counsellor's role as a helper. This therefore suggests that if the client's wellbeing is ignored its impact on the individual becomes evident (i.e. quality of life and mental health may be affected).

Ancient perceptions of happiness

Ancient philosophers have also explored the concept of happiness. Miller (595) pointed out that Epicurus, Plato, the Stoics and Aristotle have all documented various perceptions of happiness in ancient times. For example, Miller noted that Aristotle's notion of happiness suggests that living well and doing well may to some degree impact on the individual's levels of happiness. Aristotle also separated perceptions of "ordinary people" and "experts" thus suggesting that non-experts in the field may have very different notions of happiness from the

experts. Similarly, experts in the field of psychology have also researched and debated notions of happiness (Grinde 331–354). These will be discussed at length in subsequent sections of this article.

With significant interest on what happiness is, there exists substantial interest in the discipline of counselling with much of the focus being on happiness and links to therapy (Faugier 22-23). The next section will deal with professional counsellors' views of unhappiness and whether it is perceived as an illness during the counselling process.

I then move on to outline various theoretical approaches developed by pioneers in the field of counselling and their perspectives on happiness in therapy. Other facets of the happiness debate questions whether goals of therapy may be linked to happiness. This issue is dealt with in subsequent sections.

In addition, the influence of a positive psychology approach on counselling practice is relevant and will be discussed in later sections. Finally, recommendations for counselling during the therapeutic process and conclusions are offered.

Unhappiness as an illness in counselling practice

I commence this section by examining the opposite of the word happiness, i.e. unhappiness. Pertinent research in this area question whether unhappiness may be viewed as an illness. From a counselling perspective this is a valid question. Some may argue that mental health issues may be disguised as unhappiness. Thus some clients present in the counselling session with mental health problems and issues which may be comorbid or otherwise (Amer. Psychiatric Assco., DSM-IV-TR, 4th ed., text rev).

This suggests that mental health issues can be disguised as unhappiness in some instances. Diagnoses may include but not limited to several types of anxiety disorders, depression or even trauma, which may be associated with past or current events in one's life.

Then the main issue is whether it is appropriate to consider whether unhappiness may be viewed as an illness from a counselling perspective. In many cases the manifestation of mental health problems, and subsequent diagnosis, suggest that the client is unable to function well or live well due to the drawbacks and symptoms of the presenting mental health problem. This may be likened to unhappiness in general For instance, take the case of a hypothetical client, Des (a pseudonym), who presents with an anxiety disorder. The following case scenario is provided for illustrative purposes only and will be referred to throughout this article. The client bio is shown below:

Name:
Des (pseudonym)

Age:
30

Presenting problem:
Des, the client, was referred to the community counselling centre after being diagnosed with Obsessive Compulsive Disorder (OCD) by the specialist.

The client informed the counsellor that symptoms became unmanageable six months ago and he was unable to carry out every day duties at work and home.

The client stated that some days he spends an additional two hours going through the house, turning off switches, and re-checking locks on doors and windows.

Other days, Des admits that he is unable to leave the house for fear of coming home to a burning home.

These irrational thoughts, Des noted, prevents him from leaving home or going to work at times.

The client acknowledged that he has little or no social network and has shut family and friends out of his life because he feels ashamed and does not wish to burden them with his OCD.

The case of Des suggests that there may exist other underlying issues, which may be explored by the counsellor over a series of sessions. The initial concern is that the client consistently seeks professional help so he can manage the diagnosed disorder. It may be argued that as the client is unable to function successfully, by avoiding everyday activities, then according to the notion of happiness do we then imply that the client is not "living well?" The second factor to note is that although the client's mental health problem is a recognised disorder (Amer. Psychiatric Assco., DSM-IV-TR, 4th ed., text rev) labelling the client as "unhappy" at this stage may not necessarily assist during the counselling process. As such, in my practice, there is usually a high level of optimism for clients who are seen to be flourishing with a focus on their wellbeing during the counselling process.

Experts' notions of happiness

As mentioned earlier, notions of happiness may vary amongst laypersons, researchers and philosophers. Similarly, notable personalities in the field of counselling and psychotherapy have varying perceptions of happiness and its association to their practice. This may in turn impact on client care during the counselling process. This section explores the views of three seminal figures in the field. Carl Jung, Sigmund Freud and Carl Rogers' approaches and theories of counselling and psychotherapy laid the foundation for contemporary counselling approaches and continue to influence counselling practice today.

Sigmund Freud was a central figure in the field of psychology in the nineteenth and twentieth century. Freud's psychoanalytic approach posits that sex and aggression are human drivers which influence human behaviour in various ways (Nye 7-44). With the id, ego and superego guiding much of his personality-based practice, Freud's approach consists of four main parts. Firstly, during therapy the aim is to make the unconscious to become conscious. Second, is to reconstruct the client's personality during therapy. Third, is to help relieve earlier experiences. Lastly, is to support the client in the achievement of intellectual and emotional awareness. Freud emphasised that the aim of therapy is largely to help clients move from a state of neurotic misery to ordinary unhappiness (Thompson 136). Thus this indicates that happiness was as elusive expectation in Freud's approach and was not necessarily a goal for client recovery in therapy. Freud was sceptical about the attainment of individual happiness and also viewed the concept of happiness as an unrealistic goal (Nye 2). An overview of Freud's approach suggests that happiness does not have a place within his psychoanalytic approach. Rather the expected end for therapy appears to be more concerned with

Sigmund Freud was a central figure in the field of psychology in the nineteenth and twentieth century.

lowering levels of panic and neurotic symptoms.

Freud's approach when utilised by the counsellor in the case of the OCD client, Des, may focus on bringing the unconscious to the conscious and reconstructing Des' personality. According to Freud's psychoanalytic approach one of the aims of therapy may include focusing on moving the client from one level of dysfunctional behaviour to a more manageable level with the core objective being to function well in everyday activities. Happiness therefore does not seem to be one of the goals of the psychoanalytic therapist.

Another seminal figure whose work influenced contemporary counselling practice was Carl Jung. Jung played a significant role with his analytical psychology approach. Jung began his practice based on an early association with Freud. However, over time Jung's mode of therapy evolved from the Freudian approach. He developed many of his analytical psychology ideas drawing from the environment, artistic works and dreams by using these as explorative tools (Storr 1-447). Jung outlined his views on happiness (Jung 359-364). Jung believed that having a good standard of living and good relationships with others such as family and spouses or friends may lead to happiness. He also pointed out that individuals could maintain happiness by keeping healthy both mental and physically. Interestingly, Jung emphasised that individual happiness may also be linked to the ability to appreciate aesthetic works. Finally, Jung suggested that a sound religious or philosophical point of view makes happiness a reality in our lives. However, Jung cautioned that the attainment of all the above-listed options does not necessarily lead to happiness in life. This suggests that although the road to achieve happiness is clearly outlined, Jung does not commit to these factors. Rather, he noted that happiness is not assured whether during therapy or otherwise. Hence, following this framework for achieving happiness does not necessarily lead to a happy life for all individuals.

Using an analytical psychology approach, the Jungian counsellor consequently pays attention to the hypothetical OCD client's mental and physical health in the first instance. In addition, Des' relationships and general standard of living are essential areas to explore in therapy. Examining ways to help the client manage the disorder is a primary priority for therapy. However, the counsellor remains cautious by acknowledging that treatment does not necessarily lead to individual happiness as described by Jung.

The third seminal figure whose approach is discussed here is Carl Rogers. Rogers played a significant role with the development of the person-centred approach to counselling. The corner stone of

Jung began his practice based on an early association with Freud. However, over time Jung's mode of therapy evolved from the Freudian approach. He drew many of his analytical psychology ideas from the environment, artistic works and dreams.

Happiness may be termed as looking after the client's subjective wellbeing. The wellbeing of the client is uppermost in the counsellor's role as a helper. This therefore suggests that if the client's wellbeing is ignored its impact on the individual becomes evident.

this theory is the emphasis on unconditional positive regard and empathy in counselling practice (Rogers 1-440). Rogers' approach, also known as a humanistic psychology approach, is well regarded by experts in the field. Much of Rogers' work evolved from his extensive clinical counselling experience gained while working with various disadvantaged and minority groups. Rogers' counselling practice emphasises the need for congruence of the self and self-actualisation during counselling. In addition, Rogers emphasised the importance of not having an apologetic attitude toward self-enjoyment.

Using a client-centred approach, Rogers focused on the client's self-growth, as he believed that individuals may flourish well in an environment that provides unconditional positive regard. Also important in the person-centred approach is the focus on the self in relation to one's self rather than others. Within this process the counsellor's role is that of encourager. The aim is to lead the client to self-exploration and finding meaning in life while exploring life fully. Hence, Rogers' views on the notion of happiness in counselling practice are drawn from his therapeutic approach. Rogers emphasised that the individual must strive to enjoy oneself in all that they do. His core theory is that with self-enjoyment may come happiness. This suggests that Rogers' person-centred approach views the individuals as responsible for their own individual happiness. He also did not perceive happiness in counselling practice as elusive, which contrasts significantly with Freud's notions of happiness and the psychoanalytical approach.

Drawing on the case of the hypothetical OCD client Des, the aims of therapy utilising a Rogerian approach may include focusing on self-growth, showing empathy and unconditional positive regard during the counselling process. When the therapist shows the client that they are responsible for their own individual happiness, the counselling process may begin to take a new turn with other approaches employed. As Rogers' approach focuses on self-enjoyment, the role of the Rogerian counsellor may also include helping the client reach that place of enjoyment and possibly happiness as described by Rogers.

Happiness within our therapy

Whether happiness should be a goal for therapy is another issue. Goals of therapy may vary depending on factors such as the counselling approach used by the therapist as well as issues presented by clients during the counselling session. However, Feltham (10) points out that there is consensus in the literature that goals of therapy are quite specific and usually include assisting the client with support, self-actualisation, psycho-education, adjustment and resource provision. Other goals of counselling listed are crisis intervention and management, problem solving and decision-making,

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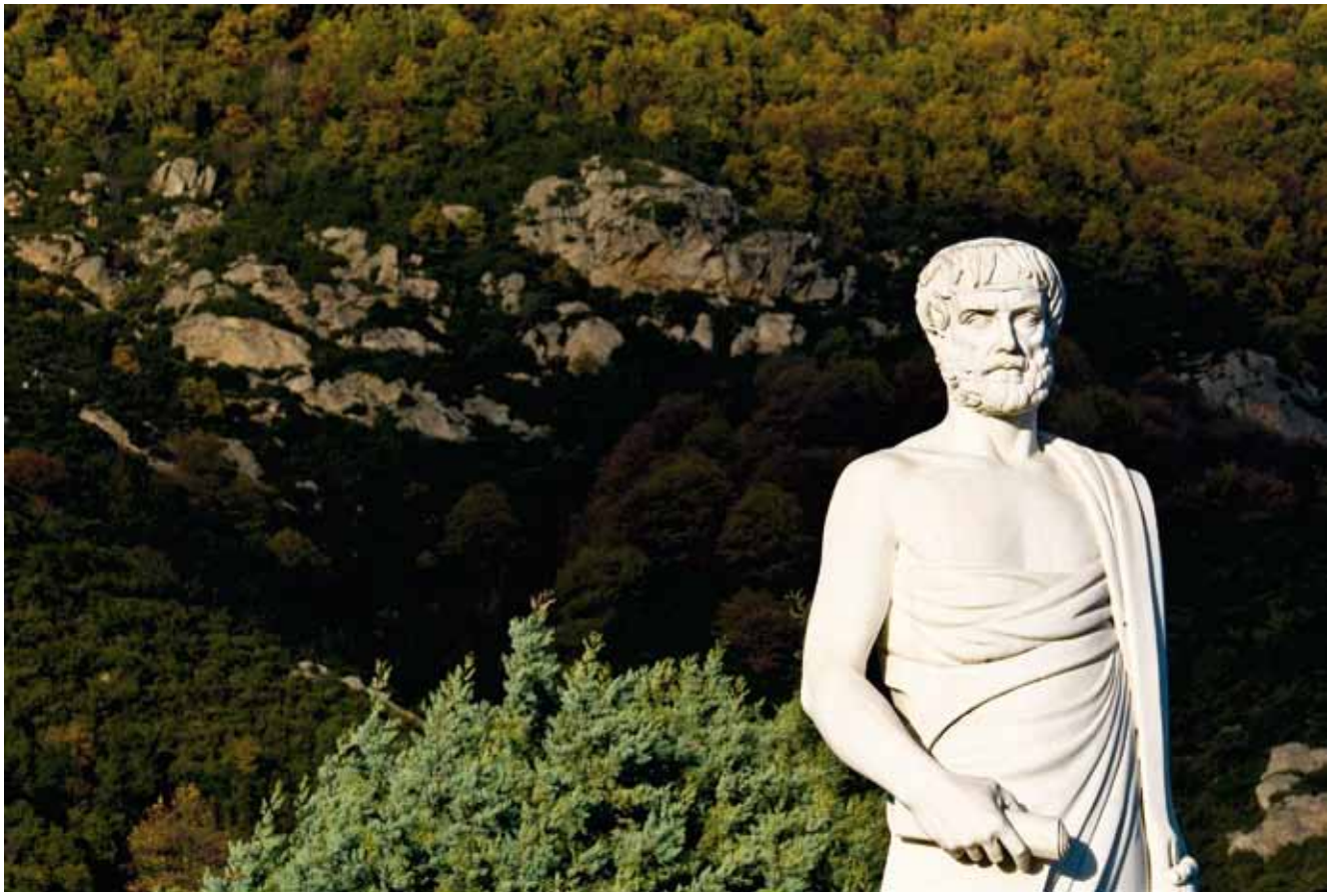
symptom elimination, insight and understanding. Also, guiding the client with personality change, discovery of meaning, systemic, organisational or social change are also goals of therapy. However, happiness as a goal for therapy remains a contentious issue.

In the case of the example OCD client Des, core goals of therapy for the client may generally include focusing on the client's immediate wellbeing. This entails the ability to get out of bed each morning and the management of the anxiety disorder from day to day so Des can function well in his daily activities. The counsellor may not lay emphasis on happiness as a priority for counselling practice. Rather as his counsellor, the focus may include other goals as listed above, based on the individual client's needs.

The role of positive psychology and happiness in counselling practice

More recently, the talking therapies have shifted toward a positive psychology approach in counselling. Talking therapies are those therapeutic approaches utilised by counsellors, psychotherapists, psychologists, social workers and therapist in the treatment for diagnosed mental health issues. With widespread attention in the growth of positive psychology there has also developed an interest in the pursuit of happiness amongst the experts. As such, the idea of maintaining one's optimism in the face of genuine adversity is a goal of this approach (Christopher, Richardson and Slife 555–561). In addition, positive psychology resonates well with a humanistic psychology approach to counselling practice. Thus Rogers' theory is considerably aligned within this framework. Much of the positive therapists' role in counselling practice is the focus on happiness rather than misery in therapy. The therapist engages with the client to focus on strengths rather than deficits, and functional, rather than dysfunctional, behaviours. Other goals of therapy include helping the client develop coping skills and encouraging deep relationships. This is also consistent with Carl Jung's emphasis on the importance of relationships and its impact on the individuals happiness.



Aristotle's notion of happiness suggests that living well and doing well may to some degree impact on the individual's levels of happiness. He separated perceptions of "ordinary people" and "experts" thus suggesting that non-experts in the field may have very different notions of happiness from the experts.

Other features of the positive psychology approach which lines up with Jung's therapeutic approach include the emphasis on individual wellbeing and mental health improvement. However, there has been some criticism of the positive psychology approach. For instance, a major focus during counselling is on the future while ignoring the client's past with little or no interest in major mental health problems.

Does therapy resolve unhappiness?

Whether counselling resolves unhappiness remains a contentious issue. One may argue that the counselling process does not necessarily bring the client's perceived unhappiness to an end. For instance, the case of the OCD client indicates that the aims of therapy will not necessarily comprise making the client happy. However, if happiness may be termed as looking after the client's subjective wellbeing then that goal may be achieved over a period of time in and with the aid of counselling. In addition, this is consistent with the idea that counselling and psychotherapy practice should be focusing less on happiness and more on the clients' subjective wellbeing. It may also be described as helping the client to live well as described by Aristotle rather than seeking happiness.

Conclusion

This article explored happiness in counselling practice. Firstly, ancient perceptions of happiness from the perspective of philosophers were discussed in the introduction. More relevant to the field of counselling, this was followed by therapists' notions of happiness. Approaches of three seminal figures in the field of counselling and psychotherapy was discussed and linked to goals of therapy. Specific goals of therapy were presented based on the literature in the field of counselling. It may be argued that counselling practice aims to assist the client with achieving subjective wellbeing rather than seeking happiness. However, as Carl Rogers (1-441) noted if self enjoyment can be established then the client may indeed reach a state of happiness.

Many of the approaches utilised in counselling practice provide some guidelines for the client to maintain their wellbeing. These include increasing self-awareness and mastery of those positives in one's life that leads to individual's subjective wellbeing and thus happiness. In addition the role of the counsellor is to help explore what makes the client maintain their subjective wellbeing. In doing so the counsellor, in collaboration with the client, may explore ways to attain their goal of happiness. These may include attending specific pleasant events and maintaining strong meaningful relationships as described by Carl Jung. It is also important that the client draws on the positives in their life rather than focus on the negatives.

Michalos (37) suggests that clients should be encouraged to pull together a portfolio of desires and interests. Hence, helping clients move closer to individual goals of living well and flourishing in their everyday life. He also noted that goals do not necessary have to be long-term as they may also be short-term or longer term. This suggests that as counsellors, our practice does not require that we focus on happiness in counselling. Rather flourishing in life, subjective wellbeing and living well are some of the aims during the counselling process.

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Nancy Grand	**Surfers Paradise**	0408 450 045	upon enquiry	Face to Face
David Hamilton	**Beenleigh**	07 3807 7355 0430 512 060	upon enquiry	Face to Face
Roni Harvey	**Springwood**	07 3299 2284	$70 ACA members, normal rate $90	Face to Face Group Phone Skype
Valerie Holden	**Peregian Springs**	0403 292 885	upon enquiry	Face to Face
Beverley Howarth	**Mitchelton**	07 3876 2100	upon enquiry	Face to Face
David Kliese	**Sippy Downs [Sunshine Coast]**	07 5476 8122	80	Face to Face Group Phone
Kaye Laemmle	**Helensvale**	0410 618 330	upon enquiry	Face to Face
Stacey Lloyd	**Mount Gravatt**	07 3420 4127	upon enquiry	Face to Face
Sharron Mackison	**Caboolture**	07 5497 4610	upon enquiry	Face to Face
Neil Mellor	**Pelican Waters**	0409 338 427	upon enquiry	Face to Face
Ann Moir-Bussy	**Sippy Downs**	07 5476 9625 0400 474 425	upon enquiry	Face to Face Group Phone Long Distance Skype
Judith Morgan	**Toowoomba**	07 4635 1303	upon enquiry	Face to Face
Diane Newman	**Bundaberg**	07 4159 3383	upon enquiry	Face to Face
Kate Oosthuizen	**Worongary**	0411 469 222	upon enquiry	Face to Face Skype
Christine Perry	**Beerwah**	0412 604 701	upon enquiry	Face to Face Group Phone
Brenda Purse	**Sunshine Coast**	0402 069 827	upon enquiry	Face to Face
Dorothy Ratnarajah	**Point Vernon**	0400 824 358	upon enquiry	Face to Face Phone
Virginia Roesner	**Kawungan**	07 4194 0240	upon enquiry	Face to Face
Yildiz Sethi	**Hamilton**	07 3268 6016	$90 Ind $45 Grp	Face to Face Group Phone Skype
Frances Taylor	**Redland Bay**	0415 959 267 or 07 3206 7855	upon enquiry	Face to Face
Menaka Thomas	**Moorooka**	0421 345 699	upon enquiry	Face to Face
Pamela Thiel-Paul	**Pacific Fair**	0411 610 242	upon enquiry	Face to Face
SA				
Adrienne Jeffries	**Stonyfell**	08 83325407	upon enquiry	Face to Face
Pamela Mitchell	**Burnside**	0418 835 767	upon enquiry	Face to Face
Pamela Mitchell	**Waterfall Gully**	08 8338 6960	upon enquiry	Face to Face
Carol Moore	**Old Reynella**	08 8297 5111 bus hrs or SMS 0419 859 844	Indiv $99 pr hr, Grp $35	Face to Face Group Phone

ACA Supervisor College List				
Name	Suburb	Contact number	Per person hourly rate	Medium
Christopher White	**Gilberton**	08 8344 3837 or 0414 884 637	$75 pr hr (30% discount for students)	Face to Face Phone Long Distance Skype Group
TAS				
Veronika Basa	**Chelsea, Moorabbin**	03 9773 3487 or 0418 387 982	Indiv/Grp ranges from $85 to $160	Face to Face Group Phone Long Distance Skype
Michael Beaumont-Connop	**Newstead**	0429 905 386	$60	Face to Face Phone Skype
David Richard Hayden	**Howrah North**	0417 581 699	upon enquiry	Face to Face Group Phone
VIC				
Joanne Ablett	**Phillip Island**	0417 078 792	$100	Face to Face Group Phone Long Distance Skype
Anna Atkin	**Cheltenham**	0403 174 390	upon enquiry	Face to Face
Anna Atkin	**Berwick**	0432 331 361	upon enquiry	Face to Face
Judith Ayre	**Bentleigh**	0417 105 444	upon enquiry	Face to Face
Nyrelle Bade	**Geelong**	0402 423 532	upon enquiry	Face to Face
Marie Bajada	**Ballarat**	0409 954 703	upon enquiry	Face to Face
Zohar Berchik	**South Yarra**	0425 851 188	upon enquiry	Face to Face
Sandra Bowden	**Lysterfield**	0438 291 874	upon enquiry	Face to Face
Sheryl Brosnan	**Carlton North/ Melbourne**	03 8319 0975 or 0419 884 793	upon enquiry	Face to Face Group Phone Skype
Sandra Brown	**Frankston, Mount Eliza**	03 9787 5494 and 0414 545 218	$90	Face to Face Group Telephone Skype
Molly Carlile	**Inverloch**	0419 579 960	upon enquiry	Face to Face
Rosemary Carracedo-Santos	**Ocean Grove**	03 5221 2767	upon enquiry	Face to Face
Tim Connelly	**Healesville**	0418 336 522	upon enquiry	Face to Face
Roselyn Crooks	**Brookfield**	0406 500 410	$60	Face to Face
Patricia Dawson-Davis	**Mooroolbark**	0424 515 124	Indiv $80 pr hr, Grp $60 1 1/2 to 2 hrs	Face to Face Group Phone Skype
Lisa Derham	**Camberwell**	0402 759 286	upon enquiry	Face to Face Skype
Theodore Dimopoulos	**Altona**	0421 256 214	upon enquiry	Face to Face
John Dunn	**Colac/Mtgambier**	03 5232 2918	upon enquiry	Face to Face
Sara Edwards	**Dingley**	0407 774 663	upon enquiry	Face to Face
Vicki Gekas	**Mill Park**	0403 004 710	upon enquiry	Face to Face
Jenni Harris	**Kew**	0406 943 526	small grp only: $90 per 3 hr session	Face to Face
Melissa Harte	**Pakenham/South Yarra**	0407 427 172	$132 to $143	Face to Face
Graham Hocking	**Park Orchards**	0419 572 023	upon enquiry	Face to Face
Keith Hulstaert	**Belgrave**	0409 546 549	upon enquiry	Face to Face
Paul Huxford	**Yarraville**	0432 046 515	upon enquiry	Face to Face
Beverley Kuster	**Narre Warren South**	0409 938 397	upon enquiry	Face to Face
Keren Ludski	**Malvern**	03 9500 8381 0418 897 894	upon enquiry	Face to Face/ Phone Skype
Barbara Matheson	**Narre Warren**	03 9703 2920	upon enquiry	Face to Face
Peter Mauger	**Bairnsdale**	0412 141 340	upon enquiry	Face to Face
Robert McInnes	**Wheelers Hill**	0408 579 312	upon enquiry	Face to Face

ACA Supervisor College List				
Name	Suburb	Contact number	Per person hourly rate	Medium
Paul Montalto	**Thornbury**	0115 315 431	$75	Face to Face Phone Skype Group
Jennifer Reynolds	**Lower Templestowe**	0425 714 677	upon enquiry	Face to Face
Graeme John Riley	**Gladstone Park**	03 9338 6271 0423 194 985	$85	Face to Face Skype
Lynne Rolfe	**Berwick**	03 9768 9902	upon enquiry	Face to Face
Claire Sargent	**Canterbury**	0409 438 514	upon enquiry	Face to Face
Hans Schmid	**Knoxfield**	03 9763 8561	$70	Face to Face Phone
Kenneth Scott	**Bunyip**	03 5629 5775	upon enquiry	Face to Face
Gabby Skelsey	**Elsternwick**	03 9018 9356	upon enquiry	Face to Face Phone Skype
Cheryl Taylor	**Port Melbourne**	0421 281 050	upon enquiry	Face to Face
Suzanne Vidler	**Newport**	0411 576 573	$110	Face to Face Phone
Helen Wayland	**St Kilda**	0412 443 899	upon enquiry	Face to Face
Cas Willow	**Newport/Traralgon**	03 9327 2293 0428 655 270	$130	Face toFace Phone Skype
Rosslyn Wilson	**Knoxfield**	03 9763 0772 03 9763 0033	Indiv $70 pr hr, Grp $40 pr hr	Face to Face Group Phone Long Distance Skype
Michael Woolsey	**Seaford/Frankston**	0419 545 260 03 9786 8006	upon enquiry	Face to Face
Joan Wray	**Mobile Service**	0418 574 098	upon enquiry	Face to Face
WA				
Deidree Brereton	**Canning Vale**	0409 901 351	upon enquiry	Face to Face
Amanda Lambros	**East Victoria Park**	0423 151 743	upon enquiry	Face to Face Group Phone Skype
Eva Lenz	**South Fremantle**	0409 405 585	upon enquiry	Face to Face
Salome Mazikana-Mbenjele	**South Headland**	08 9138 3000 08 9172 2212	upon enquiry	Face to Face
Carolyn Midwood	**Duncraig**	08 9448 3210	Indiv $110 pr hr, Grp $44	Face to Face Group Phone Skype
Patricia Sherwood	**Boyanup**	08 97261505	upon enquiry	Face to Face
Lillian Wolfinger	**Yokine**	08 9345 0387 0401 555 140	$60.00	Face to Face Phone
INTERNATIONAL				
Deborah Cameron	**Singapore**		$100	Face to Face Group Phone Long Distance Skype
Eugene Chong	**Singapore**	+65 6397 1547	upon enquiry	Face to Face
David Kan Kum Fatt	**Singapore**	+65 9770 3568	upon enquiry	Face to Face
Cecilia Lee Ching Hoon	**Singapore**	+65 9029 6543	upon enquiry	Face to Face
Gan Su Keng	**Singapore**	+65 6289 6679	upon enquiry	Face to Face
Robert Tai Lee Lieh	**Singapore**	+65 9631 8622	$95	Face to Face Phone
Ruby Murty	**Malaysia**	+60 166809499	upon enquiry	Face to Face
Jeffrey Gim Tee Po	**Singapore**	+65 9618 8153	$100.00	Face to Face Group Phone Skype
Nadia Rahimtoola	**Singapore**	+65 9647 1864	upon enquiry	Face to Face
Emilia Yee	**Singapore**	+65 9183 5007	upon enquiry	Face to Face

SUBMISSION GUIDELINES

WANT TO BE PUBLISHED?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

Why submit to *Counselling Australia*? To get publishing points on the board!

Being published is part of most career advancements for professional counsellors and psychotherapists, particularly those who wish to advance in academia.

All peer reviewed articles are eligible for OPD points and publishers can claim on their CVs to have been formally published. *Counselling Australia,* a peer reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285), is now calling for articles and papers for publication.

Counselling Australia is designed to inform and discuss relevant industry issues for practicing counsellors, students and members of the Australian Counselling Association. It 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.

The quarterly journal is published every March, June, September and December.

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 their contributions, we hope to give contributors an opportunity to be published, to foster Australian content and to provide information to readers that will help them to improve their own professional development and practice. We wish to 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)

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

Conditions

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

Deadline

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

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.

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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.

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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

Australian Institute of Professional Counsellors – www.aipc.edu.au/vgd

AIPC

Become A Counsellor Or Expand On Your Qualifications

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We are accepting enrolments and expressions of interest into our Bachelor of Counselling. If you want to gain a Bachelor of Counselling qualification you should act now as places are being filled very fast.

You can gain up to a full year's academic credit (and save up to $8,700.00 with RPL) with your Diploma qualification. And with Fee- Help you don't have to pay your subject fees upfront.

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- Save up to $26,400.00 on your qualification.
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- You will be supported by a large team of highly-qualified counselling professionals.
- Can study externally with individualised personal support.
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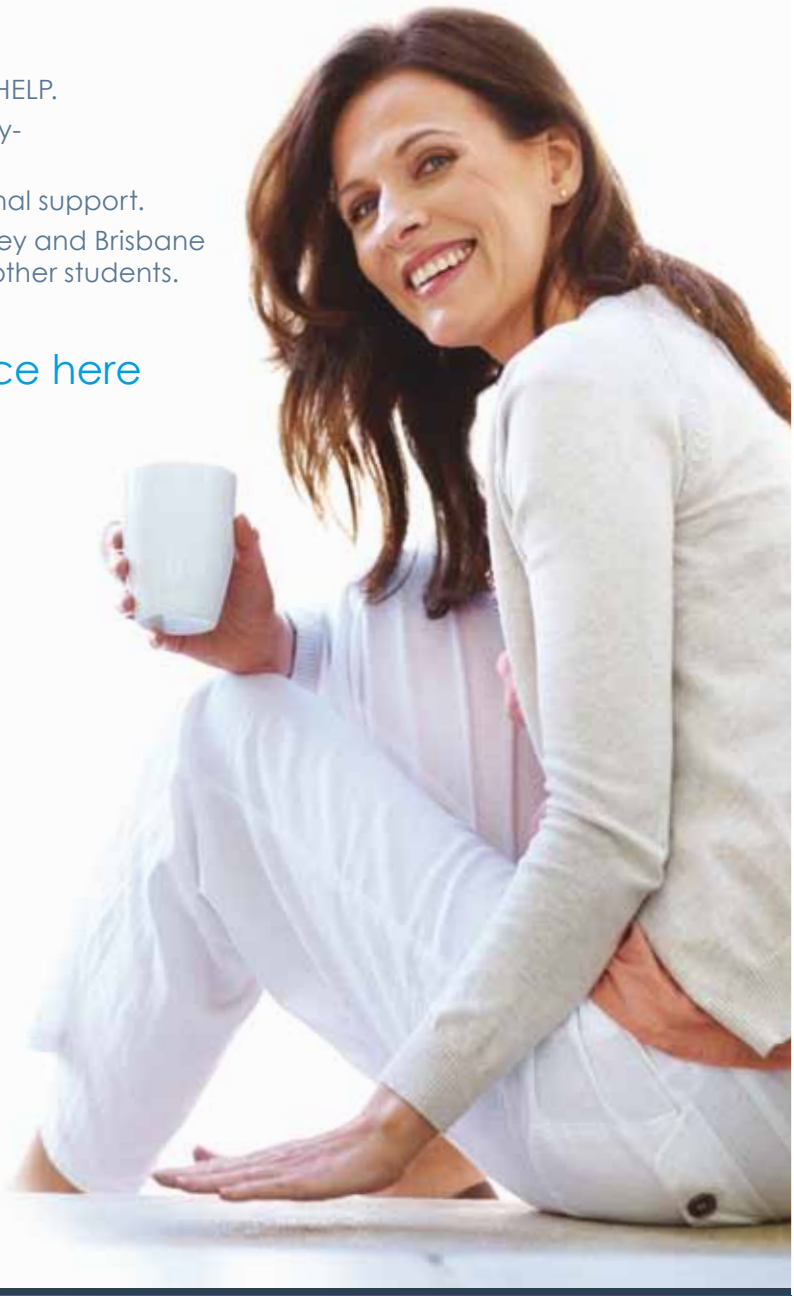

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