COUNSELLING AUSTRALIA

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Second Frankfurt Policy Statement on Counselling

Child drowning support

Boundaries in client-counsellor relationships

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REGULARS

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EDITORIAL

by Philip Armstrong

"The ACA would like to wish you a very merry Christmas and a happy new year."

ACA ideas exchange: Indonesia, Malaysia and Singapore

The last few months have proved to have been very busy particularly in relation to travel and outreach work. In specific I was kindly invited to speak at the Krida Wacana Christian University in Jakarta, Indonesia about Counselling Practices in Australia and was joined on stage by the very well known Professor Johana Prawitasari. We engaged in a Q & A process after speaking about counselling in our respective countries discussed in the main multicultural issues. Whilst in Jalkarta I was also invited to meet with the faculty at the University Pelita Harapan.

My host during my visit to Jakarta was Mr Karel Karsten who is the inaugural Chair of the newly founded Indonesian Counselling Association (ICA). Counselling in Indonesia is a new vocation and in its infancy with programs only just being made available. ACA is working with ICA in an outreach capacity to help them develop counselling as an independent discipline separate from psychology. There is a lot of energy and interest in Indonesia for counselling to develop as an independent discipline and ACA is honoured to be allowed to share in this experience.

I also spent some time in Singapore addressing the members of the Association of Psychotherapy and Counselling Singapore (APACS) in relation to private practice and clinical supervision. In Singapore counselling has come a long way as a new discipline and is well entrenched as a vocation with several Universities offering degrees in counselling and several vocational providers offering Diplomas in counselling. My host in Singapore was Dr Jeffery Po the inaugural President of APACS. I spent some time with Dr Po discussing the counselling scene in Singapore and its progression.

I was also fortunate to spend some time in Sabah, Malaysia with the current President of APACS, Dr Prem Kumar, where he is the CEO of a Drug and Alcohol Rehabilitation Centre. I spent some quality with the staff of the Centre discussing the special requirements of supervision in such a setting particularly the multi-cultural background of the clientele who come from all around the world. The therapist need to be very sensitive of the needs of each client not only from a therapeutical perspective but also culturally. It was interesting to note the therapists also came from varied backgrounds and cultures.

One of the rehabilitation counsellors at the Centre was an Australian and member of ACA, it was gratifying to find out she had secured the position after ACA had advertised it earlier this year in its Ezine. This outcome was one of my other primary objectives whilst in Asia, to promote cross border employment opportunities for ACA members in Asia. One of the purposes of ACA outreach work is to create a cross border situation whereas ACA membership and registration can be transportable within our region allowing ACA members to apply for employment positions within Asia on the basis of their ACA registration. I was surprised to actually meet several ACA members in Indonesia, Malaysia and Singapore who told me that membership to ACA had greatly helped them in securing employment.

Letter of thanks

In response to the 2013 Bundaberg floods, ACA ran a mobile counselling and information service in and around Bundaberg immediately after the flood waters receded. We recently received a letter of appreciation from the office of the Mayor.

I would like to express my sincere gratitude to you for your participation in the Human and Social Recovery Group and the process of the recovery after the 2013 foods.

Since the floods we have seen an outstanding recovery effort with the community showing exceptional resilience to fight back, resume their normal lives and ensure our region returns to full productivity.

I hope that as a community we do not have to experience another disaster of this magnitude and I can be confident in the knowledge that, should another event occur, we will be prepared to face those challenges.

Thank you once again for your valuable assistance.

CR MAL FORMAN
Mayor, Bundaberg Regional Council

Second Frankfurt Policy Statement on Counselling 15.02.2012

The DGVT specialists group Forum Counselling has issued a new "Frankfurt Position Paper on Counselling" and, just as we did ten years ago, we would like to stimulate discussion about counselling[1] among practitioners and academic specialists.

Ten years ago, the Forum Counselling of the German society for behaviour therapy – Deutsche Gesellschaft für Verhaltenstherapie (DGVT) – raised the question of the future of counselling in its first position paper on counselling (www.forum-beratung-dgvt.de) and called for a new discourse about counselling. A decade later our forum is assessing the situation and taking a look at current counselling questions that still require answers. Our goal is once again to stimulate discussion about counselling among practitioners as well as academic specialists. We would like to have a debate that may also be controversial and we want to set forth our own position.

A world undergoing change has a need for counselling, but it requires a type of counselling that takes this change into account!

This thematic statement of the **first frankfurt position paper** continues to be equally valid today. Professional counselling operates under social and cultural conditions that have not changed fundamentally in the last ten years. However, counselling has become more independent and has begun to receive more public attention: the counselling discourse has been enriched by a multiplicity of relevant publications. Counselling is increasingly being taught at universities and political positions on counselling have found their place in new counselling associations.

Counselling has also become a fixed component of online media over the last ten years. Within these online media forms of information, help and advisory have come into being that did not exist before in this form, and through these new developments, counselling – online as offline – will also continue to be influenced in the future.

But our everyday experience continues to be permeated by counselling offers: by good as well as bad ones – in response to questions for which we must all continually search for satisfactory and, at least temporarily practicable, answers. Thus counselling is also subject to change: types of counselling offers, services, content, institutional associations, as well as social challenges and tasks are also undergoing change. Every counselling process is caught up within the tension between creating decision options and forcing decisions. It is in this way that the emphasis on information and knowledge in our society 'produces' as its flip side further ignorance, insecurity, questioning, and even loss of orientation. This has consequences for counselling. There might be the danger that in counselling processes quick and simple solutions suggest certainty where reflections and careful considerations would be more appropriate. Often it is the case that counselling is put into play as forced decision-making, as expertise, as a quick solution, without thinking through the possible consequences and side effects. Concerning this we, Forum Counselling, think, that counselling that is only offered as a commercial product for the solution to orientation, decision-making and planning problems carries with it the danger of becoming divorced from its proper helpful, problem-solving function.

Thus our first conclusion is:

Counselling in our everyday reality – from both academic and political points of view – has never been as relevant and multifaceted as it is today. But, at the same time, it has never been so much in danger of becoming too diffuse.

A differentiated palette of counselling offers doubtless has considerable advantages for all of us, but it also has disadvantages that should not be overlooked. There is a great danger that counselling in the process of diversification will lose its defined profile and become an empty term used to designate quite different things. Counselling that loses its 'core meaning' in this sense would endanger a range of professional counselling services (including those online) that have been established with high standards of quality in social, psychosocial, pedagogical, education-orientated and health-related fields of activity.

On the other hand, in the current opening-up and enlargement of the fields of application for counselling, there are also opportunities for change, new developments and contemporary adaptation. Thus we have to ask ourselves whether our 'old' concepts, approaches and perspectives are still applicable and whether they are valid to the same extent for all those fields in which counselling is being practiced. So we need to ask: are we – counselling practitioners and counselling academic – working with concepts that have lost their significance and must be newly reformulated or made more precise? Generally speaking:

Where is there a danger that counselling could lose its (well-founded) meaning

and where is it necessary to develop new criteria, concepts and approaches?

From our, Forum Counselling, perspective, there are nine areas that currently and for the future demand critical attention.

1. Counselling requires free will

It is precisely because counselling as a form of intervention has been so successful in the past 30 years, that it is commonly encountered in such areas as social work, child care, education and health care, where a high degree of administrative power is exercised and where frequently and almost imperceptibly a shift from forms of communication that lend an admonitory or punitive character to 'counselling' takes place. Thereby one of the most basic and most strongly emphasized standards in the discourse of counselling, namely 'free will', is called into question if punitive sanctions are to be expected when socially undesirable decisions or decisions that deviate from organisational or sponsoring institutional interests are made. In such situations, a form of coercion underlies the counselling conversation that may have threatening consequences for the person being counselled.

Nowadays we use terms like 'coercive counselling' to refer to those counselling conversations which are supposed to meet all of the criteria for a counselling process – open-ended results, inclusion of emotional-affective factors, orientation towards real life experience – but, as in such cases as pregnancy conflict counselling, or student advising with respect to the timely completion of studies, or counselling with respect to eligibility for unemployment benefits, are initiated under some type of legal coercion. The problems connected with these situations today are not, however, limited to these institutional contexts. Such 'coercive counselling' also takes place more or less explicitly in other areas.

If we remain committed to the defined goal of counselling communication, that is, to being psychosocially, communicatively and situationally appropriate in our approach and offering the client a new orientation with respect to personal conflicts, disturbances and developmental desires, then a coercive context is an obstacle to counselling. It is only with the precondition that counselling should be open-ended with respect to results and should follow the decision-making efforts and orientation needs of the one seeking advice without any coercive pressure that a confidential and trusting counselling relationship can come into being. Only such a relationship can set the counsellor free to be empathetic and understanding and set the client free to be open to suggestions, new information, possible confrontation and emotional intervention.

Although the questions are becoming more complex with respect to the meaning of internal and external forms of coercion, we continue, as before, to be concerned with 'free will', but this is not sufficient to specify or clarify the questions. A counselling label that would here falsely signal possibilities of choice would not relieve theoreticians and practitioners of the task of developing suitable forms of support for people in coercive contexts. What we need here is a framework for discussing counselling with a view to old as well as new coercive contexts and to work out the specialised methodological bases for counselling under both negative and positive coercive pressure.

However, conversations that take place under the guise of counselling, but that are covertly forms of steering, are explicitly to be criticised and – with orientation towards the standards of professional counselling – to be clearly rejected. Working out the conditions under which there is not a good basis for counselling does not mean that we cannot act at all in coercive contexts. Rather, it is much more the case that we must throw open the question of what qualified form intervention can and should take if the preconditions for counselling are not present. Nevertheless, freedom of choice and free will remain methodological and ethical postulates for counselling, even when these are not empirical facts of the situation.

2. Counselling is not a commodity

The privatsation of publicly financed social services is proceeding at a rapid pace. Private enterprises are thus taking over the counselling market. From a conceptual perspective, this need not necessarily lead to a loss of quality in counselling services being offered as long as professional and ethical standards are preserved. It becomes problematic, however, when under private conditions, not only fees are charged for counselling, but it is also offered as a commercial product with orientation towards profit and it appears as something to be passively consumed. 'Commodification' describes the consequent alteration that can be observed in counselling when it is marketed as a product. Counselling has already become a commodity in many situations where it is on offer in competition with other providers and products and is supposed to be consumed by counselling 'customers'. It is not only counselling in business enterprises that is being marketed, other forms of counselling are also involved in attracting customers. Counsellors present themselves as competent service providers and guarantees of success are given. Counselling quality is replaced by effect-producing facades. Critical perspectives are eliminated since they might potentially be bad for business.

For counselling as a professionally valuable and academic research-orientated service within public and non-profit institutions that came into being through a multiplicity of social and anti-consumerist movements as well as humanistic welfare-orientated perspectives, the move towards privatised, profit-orientated service providers carries with it the danger of replacing professional content with superficially attractive appearances.

If counselling is now only foregrounded as a marketable and profit-orientated product, clients with their various life experiences only play the role of 'consumer' and counsellors become sales representatives. Examples of this type of development can be observed in various fields ranging from the financial sector to educational and health-related areas. Counselling must put up resistance here. It must be dedicated to the interests of the help-seekers, and remain within the framework of its professionalism as fundamentally orientated towards client and subject empowerment, whether this is in private or publicly funded settings. Counselling cannot be reduced to a cheap product exclusively within the realm

of business logic. In the final analysis, counselling services, like educational services, are a valuable sociocultural entity.

3. Counselling requires navigation through an overwhelming array of data, information, and advice

Thanks to the internet, practically any type of information is now accessible to everyone at any time and from any place. The latest generation of smartphones makes it possible for a user to have at his/her fingertips articles on particular topics or even to download whole books. However, this easy accessibility and large amount of information does not always lead to accurate information or to being better informed. Clients and counsellors are at the mercy of this flood of information and are not always able to filter out the most important details or to make a reliable assessment of what they encounter. Improved information access does not necessarily lead to an improvement in being well-informed.

People seeking help today often come to counselling already furnished with information and with the desire for assistance in dealing with aspects that may appear ambiguous or questionable. Counselling is increasingly becoming a kind of information processing with the goal of transforming information that appears to be divorced from any context (not only on the internet) into knowledge that relates to individual real-life experience and is relevant to their personal behaviour.

It is not only a question of "what" – which information is usable and which is not. Just as important is to reflect on "how", "when," and "how much". In using online information we all must be aware of how reliable information appears to be. Does it have the status of what is merely an assumption or are facts being communicated? Is it presented as one option among many or as the only relevant point?

To be client-oriented in dealing with information also means determining whether right now is the best moment to communicate certain information. Can additional information be accepted and tolerated by the client or is he/she at the limit of what can be taken in? Or would it be better to encourage an independent search by the client and/or provide him or her with some research skills? Establishing confidence in counselling requires a thoughtful handling of information and a sensitive approach to information processing.

4. Counselling has developed a new presence on the internet

In recent years, counselling on the internet has become an independent and expected part of the contemporary counselling landscape. From data-driven information and social networking to professional counselling media websites – everything is open to public participation – whether the goal is to seek information, to obtain counselling or just the desire to be entertained.

Counselling has long had a full-fledged internet presence: In 'web 1.0' it was established in its professional form in a fixed, reliable, and many-faceted institution-related position. In 'web 2.0' there is also 'counselling 2.0' in the sense of counselling forms that are directly relevant to everyday life of whatever kind (this includes: counselling blogs, counselling networks, etc.). In addition to professional counselling, everyday counselling has also taken on its own web media presence in social networks.

Alongside professional counselling practice, online counselling has recently given rise to its own academic-interdisciplinary discourse. Counselling has thus become more diverse, more mobile and more flexible; but it has also become open to misuse in both its form and content. It seems to be a particular feature of German-language online offers that they can profit from the high quality of a wide range of offers from institutional service providers. These providers have frequently expanded their offers with online variants and thus have ensured a high quality and reliable service. Transparency, trustworthiness, security, and professional competence continue to be the foundation of counselling offers that users can have confidence in. But this does not apply to everything that appears on the internet under the heading of counselling. In multimedia social networks without institutional connections, not only is everyday counselling offered, but frequently there are also hidden commercial motives and thus a subtle form of misuse of information occurs.

5. Counselling can no longer be adequately described with the categories of 'old' counselling approaches ('old schools') that are taken for granted

With the rapid and radical social changes and frequently ambiguous information that we all have to deal with, difficulties with orientation, prediction and planning increase; being in possession of more information does not necessarily make decisions any easier. At the same time, public institutions and organisations increasingly delegate risky orientation, planning and decision-making tasks to the individual and withdraw themselves from social responsibility for safety and security. Counselling services should accompany the individual in all areas of his/her life and support him/her in these tasks. When clients looking for help find themselves facing ambivalent and paradoxical challenges and when their ability – if they have any – to make prognosis is restricted only to short-term, many traditional counselling approaches reach their limit. In particular, individual-centered, rationalistic counselling models in apparently 'objective' fields (such as career counselling, counselling in health care, organisational counselling, etc.) based on strict, no-frills, autonomous decision and planning competences are in need of fundamental revision. Counselling must always and everywhere provide for the integration of intuition and creativity in decision-making, planning and behavioral assistance and must always and everywhere reflect the incorporation of these individual processes into personal relationships and social networks.

Counselling as an academic discipline is thus required to develop new and alternative theories and practices. What are needed are concepts that help to secure an identity within social integration and that also support personal and social empowerment processes. At the same time, these concepts must also enhance a positive approach to uncertainty and insecurity. Counselling can and must incorporate intuition and emotion alongside rationality and, even in the face of ambiguous and contradictory challenges, reinforce a sense of coherence and optimism about meeting and overcoming these challenges. Attempts at social construction and counselling models of 'positive uncertainty', 'planned

happenstance' and 'serendipity' offer new theoretical and practical perspectives. Persons looking for help thereby take on the role of 'self-motivating' constructors of their world and are thus supported in developing personal identities within social communities and in becoming (co-) creators and self-conscious actors in their own life stories and their futures.

6. Counselling should not be professionalised according to the legal pattern set up for psychotherapy.

The legal situation of psychotherapy is not a model for a more formal and justifiable regulation of the practice of counselling. First of all, counselling is not practiced in only one social arena, nor is it possible to designate just one goal category – in contrast to 'healing', 'orientation' is concerned with various thematic areas and forms of life experience. On the other hand, in connection with the legal situation of psychotherapy, there have been consequences for the content of the therapy, as well as for the professional and financial situation that should not be repeated for the field of counselling (narrow limitation to just a few preparatory disciplines and procedures, getting stuck in medical models of treatment and healing, establishing more and more individual practices with accompanying lengthening of patient waiting time for treatment, minimal concern with prevention, cooperation and crisis intervention, etc.).

Such efforts in the direction of strict formal or politically-orientated limitations of counselling would also not necessarily lead to better quality, if they are only in favor of professional associations and training institutions. They also do not make accessibility and availability of counselling services any easier, particularly for those population groups who are especially in need of support or are disadvantaged. In addition, they devalue a variety of informal and semi-professional counselling services that are of great significance in a wide range of everyday settings.

The quality of counselling and counselling competence is less a product of formalized regulations and certifications concerning who, for whom, how and with what additional qualifications someone is allowed to engage in counselling. More important are: academic and research-based efforts to establish qualified training within appropriate university degree-programs and further education settings; improving existing counselling services with stronger life experience and resource-orientation; a stronger connection between counselling and everyday organised help and self-help efforts as well as community engagement. In this context, counselling in less formal and informal everyday settings should be valued and expanded.

7. In every sphere in which it operates, counselling must continually come to terms with questions of diversity.

Although counselling as form of professional intervention is fundamentally conceived of as open-ended with respect to results, client-centered and relevant to real-world experience, regional requirements as well as the necessity of creating structures within institutions and training programs nevertheless lead to narrowing perspectives. A particular spectrum of concerns becomes the central theme. Diagnoses and the interpretation of case studies construct types of clients. This does not do justice to the diversity of themes, problems and counselling concerns that arise from social differentiation and societal developments.

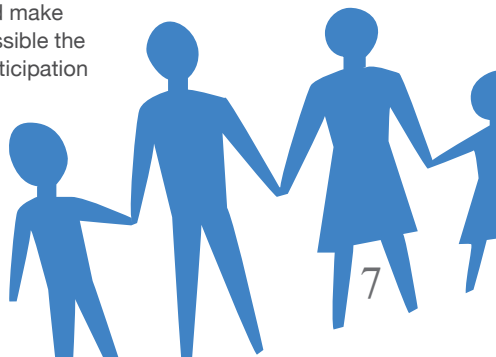
In what languages should we spread information about counselling services? What information pools should be provided? Should we try out new working procedures or arrange special services for particular groups of clients? Do we need to rethink the ease of access to counselling services? Is counselling in its present form really open to immigrants, gays, lesbians, transgendered people, the young and the old, and the undocumented and/or those living in extreme poverty…? Questions of this type are not theoretical questions for specialised institutions, but are, rather, a continual accompaniment to every professional counselling practice.

8. Counselling should not be evaluated according to one-dimensional efficiency criteria.

The tightening of resources for publicly-funded social services and the tendency towards privatisation among the associated 'service-providers' have led to a new strictness with respect to success-evaluation in counselling. Many sponsors are now demanding documented evidence of the positive effects of counselling in child-rearing, education, psychosocial work and healthcare services. To demand carefulness in handling public resources and the documentation of effective use is certainly not unreasonable. However, a simplistic case-specific proof of success is not possible for what are usually complex counselling processes. The importance of that type of help which counselling offers (as distinct from information services, training or teaching) lies precisely in being able to empathise with individual goals, constellations of values and forms of emotional processing peculiar to particular clients.

Openness in counselling is thus a pre-condition for achieving such goals as discovering personal resources and the broadening of individual behavioral options – an operationalised measurement of pre-established goals to be reached by fixed times is therefore inadequate. In addition, the basic need to ensure the confidentiality of all communications within counselling makes this form of evaluation problematic. Precisely in contrast to administration in employment, social work and healthcare, as well as in comparison with sponsors who are primarily interested in demonstrating achievement and efficiency, the guarantee of protected confidentiality in counselling is especially important.

It is our position that counselling requires appropriate procedures for evaluation and to determine its effectiveness: activity reports (numbers of cases and case summaries) document working procedures and the scope of an individual institution. Quality controls (case conferences, further education, supervision) ensure the capacity for development. Specialised evaluation procedures by experts determine the perception, acceptance and judgment of counselling processes and make possible the participation



of the users. Independent effectiveness research analyses frameworks, concepts, and methods of counselling as well as features of counsellor behavior and context-related studies document the influence of counselling services on the surrounding cultures and milieus and also reveal unintended effects and/or 'counselling-damages'.

9. Counselling quality is also guaranteed by counselling research.

Counselling research is counselling research – not therapy research. It must be further developed as an independent branch of research – beyond claiming to be the only representative of the experimental-statistical paradigm and not focused on a list of modularised interventions. Methods of counselling are not patent medicines and counselling is not the prescription of medicine.

Research in the field of counselling starts from the assumption that quantitative and qualitative research plans and procedures, reconstructive and narrative descriptions, practice-evaluations and field studies are all desirable as central elements of research. It is not merely hypothesis-testing that is the central focus, but rather exploratory studies and an empirically-based theory development that are essential. Most important is that the relationship between theory and practice is not understood as prescriptive or instructional; it is more the case that the research stimulates the practice and engages in dialogue with it (for example, in behavioral research projects).

The potential to support and encourage resources and health lies at the centre of our concerns, much more so than reducing deficits and problems. The essential qualities of counselling are: multiple perspectives, an interdisciplinary and multi-professional outlook, emphasis on free will and open-ended results, confidentiality and services provided without cost. These contexts and counselling dimensions are also central to counselling research. Participatory research taking into account the varying perspectives and relevance of all the parties involved must become a part of the accepted ordinary research approach. Diversity is not to be treated as problematic variable in investigations, but rather considered as a value in itself and one of the most important current research concerns. The criteria for judging 'outcome' should not be merely the greater 'efficiency' of counselling services in the sense of 'keeping in check' social problems, rather the focus should be primarily on the significance and usefulness for the client. Research for the purpose of legitimation is not the appropriate future for counselling research.

How can you participate in further politically–based discussion of counselling?

We also regard this **second frankfurt position paper** as a call to stimulate discussion among a circle of colleagues. We have formulated what we regard as the currently significant fundamental issues. Perhaps you see many aspects in a similar light or you might also view the situation in a completely different way. Let us talk about it and thereby continue to secure and improve the quality of counselling.

For the Forum Counselling of the DGVT, Frankfurt, January 2012: Vera Bamler, Frank Engel, Ruth Großmaß, Albert Lenz, Frank Nestmann, Ingeborg Schürmann, Ursel Sickendiek, Jillian Werner, Daniel Wilhelm.

NOTES

1. In comparison to the term 'counselling' the German term 'Beratung' is more comprehensive including guidance, advice giving, consultation etc.
2. Arbeitslosengeld II (ALG II)

Child drowning support

I am delighted to announce that I have finally completed my doctorate at UQ entitled *The psycho-social Impact of Child Drowning in Queensland and the Availability and Use of Support*.

I interviewed bereaved parents and a range of service providers who were involved in bereavement support (Including the ACA). Of significance to the ACA is the fact that whilst there was some experiences of positive familial and professional support, almost all parent participants commented on the lack of appropriate support they received from various professional and community organisations and services, as well indicating disappointment with family and friends. Many service providers also commented on their frustration with not being able to offer optimum support to families bereaved following a fatal child drowning.

It became clear that this was obviously not through intent but often through lack of funding and also lack of appropriate training and awareness. These families experienced unintended sudden child death and most reported that the professionals to whom they were referred were often unable to provide the appropriate support and/or referral to an appropriate support agency. Sadly, a number stated that at times the experience did more harm than good, often due to inappropriate use of language, service restrictions and time lapses between support opportunities.

Amongst my many recommendations I have suggested a review of school and workplace support for bereaved families. In addition, a review of professional training, for doctors, psychologists and counsellors in regard to supporting people through disenfranchised grief and unexpected loss is suggested. This is different to other types of grief.

You may ask yourself at this point – how capable do you feel in offering this support, do you know what the difference is and who would you refer clients to in this situation?

2015 is going to be an interesting year.

Dr Dawn Macintyre (Spinks)
BH (hons) Education and Psychology (London); MPH (Curtin); PhD (UQ).
www.nothingchangesifnothingchanges.com.au
0417 633 977

Identity Care Australia & New Zealand

National Identity Theft Case Management Centre

www.idcare.org

About iDcare

iDcare has been established by public and private sector leaders as the trans-Tasman national response to identity theft and misuse impacting members of the community. It is a registered Australian charity and not-for-profit. Its Board consists of business and government representatives from both sides of the Tasman that drive its charitable services to directly support individuals that need to respond to risks to their personal information.

Importance

Recent research undertaken by the Commonwealth Government, backed by iDcare's own expert research, tells us that:

- over a million Australians and New Zealanders each year are impacted by identity theft and misuse;
- less than 2% of organisations have information about what to do when a customer's identifying information and credentials have been compromised;
- at least a third of individuals experience mental health impacts following an identity theft and misuse event; and
- children, the elderly and small business are amongst the highest at risk groups in our community.

Meeting Needs

Think of how many organisations you have represented in your purse or wallet. If that was stolen or lost, each of those credentials can put your identity at risk. iDcare provides a toll-free national hotline to work with clients individually to develop tailored response plans to their given circumstances.

Our Services

Tailored response plans for clients can have both online and physical world aspects. The advice is generally quite specific and actionable and is focused on immediate requirements as well as longer-term mitigation strategies.

Member organisations across government and industry (micro to large) receive quarterly reports. These reports capture trends in identity theft and misuse events, customer experiences, and enhancement opportunities. Monthly alerts and bulletins are also a key part of our services to communicate with members evolving methods and key trends impacting organisations. Finally, our significant knowledge of identity theft and misuse has placed us in the best position to develop and test a Code of Practice that assesses organisations in their capacity to prevent and respond to identity theft and misuse. Accreditation with iDcare is a great way to promote how organisations care about the personal information of their customers.

Working with iDcare

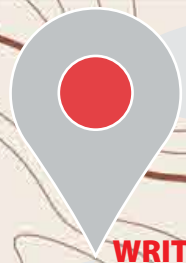
iDcare runs an active clinical placement and research program. We host behavioural science placements and work with researchers to ensure the community benefits from leading edge thinking. Our staff have Blue Cards and are experienced counsellors, educators and psychologists. We undertake an enormous amount of community presentations and engagement to raise awareness.

What we don't do

- Charge for our individual client services
- Collect personal information
- Provide legal advice
- Reveal the identity of our clients to government or business (we don't collect personal information)

Rules of engagement: A 'mud map' for healthy therapeutic relationships

PEER REVIEWED ARTICLE



by David (Bhakti) Gotlieb,
supervisor, conference presenter, counsellor

How a counsellor develops a relationship with a client is the very basis for whatever effective work they are going to do with each other. There are some key issues that, when dealt with well, make navigating the inner work much easier and more effective. In my 30 years of counselling, but particularly the 15 years of experience offering supervision, a few useful tidbits have emerged that make a difference in maximising the likelihood of a healthy, sustainable relationship and minimising the likelihood of unexpected challenges with clients.

The seven points that I have noticed that make a big difference when they are addressed adequately are: written guidelines; checking for desired outcomes; co-creating a therapeutic alliance; making every attempt to ensure comfort; following content signals; following process signals; and asking for feedback.

Written guidelines

I have found it of mutual benefit to both client and counsellor to have a written set of guidelines that outline how you work, when you work, what your boundaries are, what your fees are, what your cancellation policy is, what your confidentiality includes and excludes and anything else that would be good for them to know before they start.

There are many reasons for this, the most important of which is your professionalism and clarity from a legal perspective. There are many pro formas for you to base a personalised version on (one good example can be found on page 34 of 'The Practice of Clinical Supervision' - Pelling, Barletta and Armstrong 2010). I have found that clients come in with many assumptions about counselling either based on their own previous experiences or from hearsay. Unless these are teased out and addressed they will remain the basis of what they project on to the therapeutic relationship. Setting things out clearly may seem a little formal and forward at the beginning but it will save a lot of heartache in the long run.

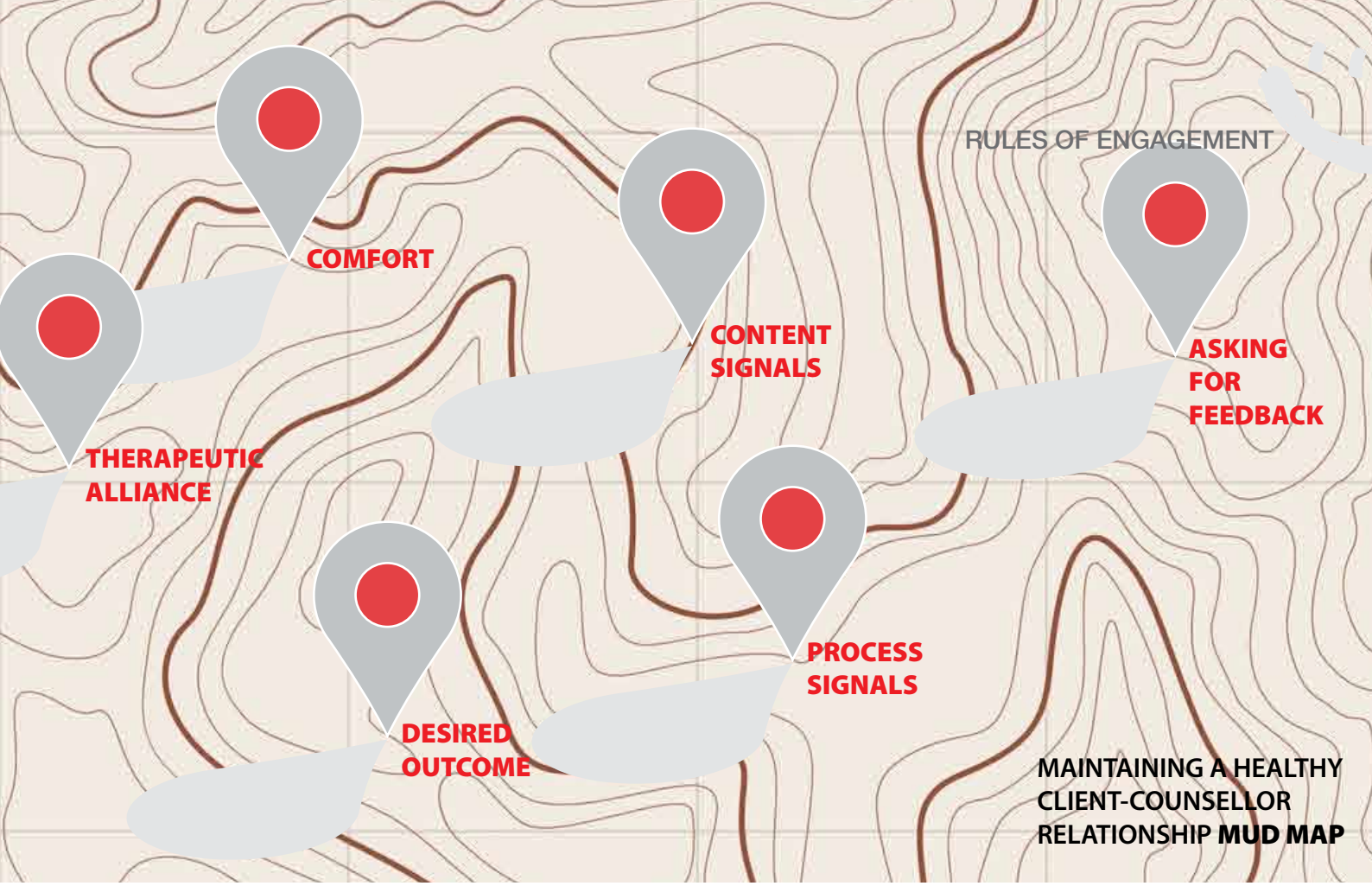
Make sure you go through the salient points with them, especially around confidentiality relating to legal and safety issues. Outlining supervision is important as many clients do not know what it is and need to understand the confidentiality of supervision, and this is best dealt with upfront. Similarly, talking about cancellation policies is advisable as there is a tendency for that to become ugly later if it hasn't been made very clear. I've never had anyone baulk at it yet, when it's adequately explained. My guidelines tell them a little of how I operate and especially explain my focus on comfort so that even in the waiting room they are given a sense that they will be dealt with sensitively.

Desired outcome

It never ceases to amaze me in supervision sessions how often we know all about our clients presenting issues, we have a pretty good idea of what sort of diagnosis they might have, and we have a very clear idea of what we think they need in the way of intervention, *however*, we haven't directly asked the client what 'their' desired outcome is. It isn't necessarily what it seems. In fact, I would go further and say that looks are very often deceiving, for example, consider the amount of times that couples come in for counselling vowing undying commitment only to find that one of them has left the relationship before the beginning of the second session.

First of all, it's important not to assume that everyone has a desired outcome. Helping them establish whether or not they have one is critical to successful therapeutic alliance. Without it the team is like a rudderless boat, possibly having a wonderful time but simply bobbing about not going anywhere in particular.

Some people just want to talk, vent or cry on your shoulder, however, it is essential to check whether that is all they are after. Otherwise they will have talked, vented or cried and still feel unsatisfied at the end of their session/s because they



didn't get what they came for. It is also very useful to unpack or make sure you are fully understanding the words they are using and translating them into tangible outcomes that you both agree on, for example, "I just want to get less angry." Is it that they want to get less angry or is it that they want to stop yelling at their children. Similarly, "I want to be more confident," or could that be better translated as wanting to be able to speak up in social situations. It is essential to make sure you know what behaviour they are after, if in fact it is a behaviour they want.

While it may be easy to ask the question " What outcome/s would you like from our time together?" it may be helpful to assure the client that it may not be so easy to answer it. However, it is worth taking the time to gain clarity as it will maximise the likelihood of them getting what they want. This will help you both get an idea of the scope of the work you are doing together and, more importantly, gain a reasonably clear idea of how you'll know when you will be finished. Given that some modalities such as analysis have an open-ended relationship to time, it can be relieving to develop clarity on the parameters of the work being undertaken.

Another important aspect of desired outcomes is to offer the truth when what they are desiring as an outcome is either not possible, or not within your own expertise or ability. A classic example of this is where a husband or wife comes in and one of their desired outcomes is that their partner stop smoking or become less violent. It is highly recommended to let them know what you can and can't offer, for example "I can't change your partner (short of a straight jacket) but I can help you learn how to set and enforce limits around their smoking or violence." You may be able to help their partner with their smoking or violence but you wouldn't want them to be relying on that. Being clear on what the desired outcome is helps build a therapeutic alliance where it's relatively clear what you're doing together and how you're going to do it.

One other tricky area is where clients come in with glaring issues, like eating disorders but they have no intention or desire to even broach that subject. It can be a real challenge for us, as counsellors, to stick to their desired outcomes unless or until they change their minds.

Therapeutic alliance

A therapeutic alliance is the platform on which the desired outcome gets worked on or moved towards. It is a big phrase that simply means that ideally you and the client are a team and hopefully *feel* like you're a team. The reason for making the therapeutic alliance an entity that can be talked about is so that later on when and if something changes and it seems like the client is not so comfortable anymore then it's highly likely that they are no longer 'on board' with the therapeutic alliance. If your client is standing on a different platform to you or has diverged on to a different track, the change must be addressed in order to get back to a therapeutic alliance where you are both on the same page, travelling in the same direction. This is the biggest reason why clients 'mysteriously' don't come back.

Each of you need to be able to let the other know if they feel that the direction being taken doesn't look like it's moving in the direction of the desired outcome. Collectively, you need to take stock of the situation and come up with a new plan that you both feel comfortable with.

The key things in a therapeutic alliance are:

- Who's in the team? (for example, the two of you, the whole family or the three of you with a couple)
- What are the desired outcomes?
- By what agreed upon methods will we attempt to get there?
- How will we know when we're finished?

One of the best ways of monitoring the therapeutic alliance is by rigorously following the client's signals. I go into this

in more detail when I cover content and process signals.

Comfort

Given that, in the end, comfort is usually the state that the client is wanting to get to, making comfort the highest priority at the beginning is fundamental. As Ghandi said, "The means *is* the end." It is also beneficial, when bringing this intention, to pace out the usual cultural norm, which is to put on a brave face and pretend everything is fine, especially when it's not. The 'great Australian battler' mentality translates, in a counselling context, to a notion of "Let's get this job done, no matter how uncomfortable it might be!" This will work with modalities that help people override their disturbing processes but mostly only temporarily as the 'core issue' (or 'healing trying to happen', see Healing Inner Conflict, HIC) of the disturbance will almost always come back in order to attempt to force attention towards that which needs healing.

It can be useful to get them to check in with whatever level of comfort/discomfort they are feeling, giving them lots of permission to mention discomforts. Reminding them of the likelihoods of feeling levels of discomfort by being in an unfamiliar room, with a person they don't know well yet and subject matter that is likely to be challenging. Subsequently, to let them know that if they start to feel less comfortable than they are at that time, that something is probably going wrong and to bring it up so that it can be addressed in order to get back to a direction leading to more comfort. This doesn't mean that you never address issues that may trigger discomfort, it simply means that you use the therapeutic alliance to ameliorate the clients worst fears. As discussed under 'signal work', the use of addressing process signals can be extremely helpful.

I find it useful to include the importance of comfort in my written guidelines, saying something like, "It is very important to me that you feel comfortable and whenever possible to indicate when you are not, unless you are choosing to explore an area that is uncomfortable and, therefore, wish to do so." When we begin to work I elaborate in order that they understand how important it is not to ignore signals of discomfort as they arise in order to try to 'get somewhere'. This is like arriving in Paris for a family holiday only to find that one of the children is still at home and hasn't made it past the front door. If the work that is being intended to be done is going to be sustainable, then all the different aspects of their inner life, especially the ones that feel the most uncomfortable, need to be interacted with in an understanding and compassionate way.

I use the notion of 'sensitivity' as way to help clients notice their tendencies to ignore their own discomfort. Asking them whether they would want their own children to deal with themselves in that way, often wakes them up to their own internal insensitivity. This then becomes a basis on which to begin the process of moving towards more sensitivity, more comfort and therefore a more sustainable outcome.

Signal work – content signals

These are the pieces of information that become evident as you follow the signals of the clients presenting issues or disturbances. As their story unfolds you get a sense of the pieces of the jigsaw puzzle that need to be taken out of the box so that piece by piece the total picture comes to awareness. The responses the client has to the information, as they get the pieces out, or turn them over, are 'process signals'. It is just as important to follow 'content signals' or 'information signals' as it is to follow process signals or 'response to information signals'. The disturbances and desired outcomes are a springboard for allowing us to begin sorting out the mechanics of the inner processes limiting their ability to become effective in these arenas. Disturbances are somewhat representative of inner children. They are all important and bother us in order to get their needs met. Our job is to meet their needs one at a time, in order of priority, by listening and attending to content and process signals.

Content signals tend to be easier to follow as they tend to follow a linear, rational or logical path. Process signals, on the other hand, tend to circumvent the usual thought processes, which is why it is so important to follow them. They tend to be less sophisticated and therefore more close to the essential truth of an individual's momentary experience.

Signal work – process signals

As soon as you begin to focus on the aspects of the desired outcome that are challenging for the client, everything that you or your client notice, internally or externally, is information about the process. There will be very specific reasons for these signals that are very contextual for the client. They may be a high-flying CEO able to wheel and deal on an international stage and yet still have certain contexts where they struggle to get out of bed in the morning.

Once you begin to get close to these aspects of themselves, defence mechanisms that have been maintaining a status quo for many years are likely to show themselves. These signals are most often not noticeable to the client due to them being so familiar. It is our job to help them navigate them effectively and sensitively. As one of my great teachers once said, " It's like they're trapped in a box, but unfortunately the instructions on how to get out of the box are on the outside of the box!"

These process signals can include a constant chatter, blankness, flooding of information or feelings, nausea, agitation, tiredness, anger, vacant staring, changing the subject, an urgent need to toilet, lack of desire to continue the work, shaking, or anything noticeable. These are all signals being conveyed to them by aspects of their inner landscape attempting to project pieces of information on to the screen of their being – what they feel and sense in their body and mind. It can be summed up by the metaphor of someone imprisoned in a castle dungeon sending out messages in a bottle across the moat, asking for help. Someone has to be looking for the bottle and that's our job in relation to process signals. The client is not being triggered by the external reality of the room or the moment they are in now, therefore these must be signals from parts of them connected to the disturbances you are exploring. Try to help them develop a curiosity and ability to welcome any signals, however challenging or seemingly irrational they may seem.

Encourage them to think in terms of an internal communication that goes something like, "Thank you for showing me information about the way I have been kept out of the loop (dissociated) previously, so that I could get on with the job of surviving whatever needed surviving. Let me know more because I am older and more resourceful now. What would you need to be able to allow these issues to see the light of day, even if only within myself? In what context is, or was it important that we not be aware of these aspects of ourself?"

When people become aware of what their process signals mean they can then begin to put the whole jigsaw puzzle together in a meaningful and often extremely healing way.

Asking for feedback

The biggest reason we, as counsellors, have a tendency not to actively ask for feedback is because, like most people, we

are human and fear criticism. However, no matter how challenging that might be for us, it is often doubly so for our clients. Actively seeking their feedback and making sure you ask for both positive *and* negative feedback move the therapeutic alliance in a direction way beyond their usual relationship with authority figures like parents, teachers and so on, where you're meant to 'put up and shut up'. I will be writing another article solely on the issue of power dynamics in the therapeutic alliance but suffice it to say for now, it is important to actively encourage the client to be in the driver's seat of the therapeutic process. The second biggest reason we don't solicit feedback is that we often just don't think about it regularly because we're busy getting on with the job at hand.

I try to ask for feedback at the end of each session wherever at all possible, however, with some exceptions, such as not straight after a very deep process. I also offer them the option of dropping me a line on an email or giving me feedback at the next session. It's a really good way of maximising the possibility of keeping the therapeutic relationship as clean as possible. If your clients are telling you what they find challenging, difficult or uncomfortable, as well as what they find beneficial about what or how you are doing things, then you know that you have a very healthy therapeutic alliance.

When used in combination, these seven ways of addressing the client/counsellor relationship offer a helpful handrail that usually leads to very effective outcomes.

David (Bhakti) Gotlieb MAppSci Crit Psych, Grad Dip Social Ecology, ACA College of Supervision, is a supervisor, counsellor, and facilitator. He presents workshops at ACA and other conferences and in his private counselling and supervision practices in Crows Nest, Sydney and Bowral, NSW. He has trained with Dr Richard Alpert (Ram Dass) Dr Arnold Mindell (Process Oriented Psychology) Helena Cornelius (Conflict Resolution Network) and many others.

He has written articles and an e-book on his modality, healing inner conflict (HIC), which are freely available at healinginnerconflict.com.au.

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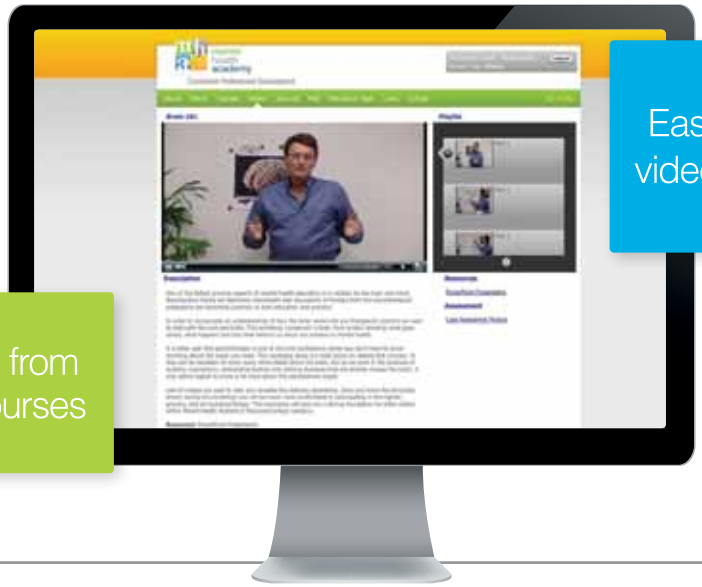

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Boundaries in client-counsellor relationships

In this essay I examine the role of the boundary in client-counsellor relationships. In particular the reasons therapeutic boundaries are created and maintained. The paper will argue that maintaining good boundaries and understanding the psychological role of boundaries, is necessary for successful therapeutic work. In considering the complexity of boundaries in client-counsellor relationships it is important to think about boundaries, psychologically and in relation to the frame they provide. I aim to differentiate between boundary crossings and boundary violations and discuss how disruptions to the frame, may have either beneficial or detrimental effects on therapeutic outcomes. I hope to present in this essay the strong evidence towards the argument that some boundary crossings can further the therapeutic work when done with mindful reflection and in the best interests of the client.

A definition and overview of boundaries

The *Webster Comprehensive Dictionary* (1992, p.158) defines boundaries as limiting or dividing lines or marks, or something that serves to either indicate a limit, or to confine. Brown and Stodart (2008, p.xiii) speak of boundaries acting as barriers or delineators; that they can keep in or keep out, and they can hinder or enable safe passage from one place to another. This aspect of enabling safe passage is central to the role boundaries play in clinical practice.

In clinical work boundaries define what we consider as the edge of appropriate behaviour. Gutheil and Gabbard (1998, p.410) assert that this edge however, is not easy to define because of the diversity of psychotherapeutic approaches and treatment strategies.

This difficulty in defining boundaries is echoed by Zur and Nordmarken (2011) when they say that in the field of psychotherapy, there is not an agreement or a single definition about what constitute clinically and ethically appropriate boundaries between therapists and clients. They affirm that although they may be difficult to define, boundaries in therapy

tend to be focused around issues related to physical touch; self-disclosure by the therapist; where and how long sessions are conducted; activities taking place outside the office; exchanges of gifts; bartering; social and other forms of non-therapeutic contact; and various forms of dual relationships.

However difficult it may be to define boundaries we can explore their function and purpose. The true function of a boundary is its role in creating the necessary framework of trust and safety for therapy to be effective. They are not there simply to protect the therapist from litigation but to enable successful therapeutic engagement and positive outcomes. "Boundaries in the therapeutic relationship are essential to provide a safe forum for deep emotional engagement with a therapeutic purpose" (Bridges, 2005, p.1). How therapists translate this into practice is something that they must reflect on and decide for themselves.

Gutheil and Brodsky (2008, p.8) state that boundary issues are first and foremost, clinical issues, secondly they are ethical issues and then finally, legal issues. Therefore, to ethically and legally defend and negotiate the boundaries between client and therapist there must be a grounding and understanding of the clinical process.

The evolution of boundaries began with Freud's understanding of the power of transference – i.e. the unconscious relationship between client and therapist. Jung expanded this into an understanding of the effect a patient may have upon the therapist, which he called countertransference (Brown & Stodart, 2008, pp.1-2). The history of our changing understanding of boundaries is explored by Corey, Corey and Callanan (2011). They describe how concerns about therapeutic boundaries began to emerge in the 1960s and 1970s, as we became more aware of the exploitation of clients due to a prevalent lack of any sense of boundaries by mental health professionals. Therapists were then advised to avoid dual relationships and not to enter into sexual relationships with clients. The 1980s saw increased sanctions against boundary crossings and greater emphasis on risk management. Then in the 1990s a change in thinking about psychotherapeutic boundaries began to emerge. There was increasing acknowledgement that some boundary crossings, such as therapist self-disclosure and non-sexual touch, could be clinically valuable. Professional organisations began to rewrite their ethical codes to also acknowledge that nonsexual,

dual relationships were unavoidable in some situations (p.274).

All current professional bodies governing therapists are expected to have a code of ethics that outlines and clarifies the ethical basis of the therapy relationship. While these codes do not necessarily define boundaries they may outline the ethical principles underpinning the therapy relationship. For example the Psychotherapy and Counselling Federation of Australia (PACFA) code (see appendix A) has a statement listing six ethical principles to be upheld by therapists. They are:

- fidelity (honouring the trust placed in the practitioner);
- autonomy (respect for the client's right to be self-governing);
- beneficence (a commitment to promoting the client's well-being);
- non-maleficence (a commitment to avoiding harm to the client);
- justice (the fair and impartial treatment of all clients and the provision of adequate services); and
- self-respect (fostering the practitioner's self-knowledge and care for self).

How these are translated into clinical practice is left to the member organisations of the PACFA to define for their members. This may take the form of specific boundary rules and codes of conduct. The Australian Counselling Association (ACA) outlines explicit boundary rules and regulations for their members in their code of practice (see appendix B).

Gutheil and Brodsky (2008) define boundaries as "the edge of appropriate behaviour at a given moment, in the relationship between a patient and therapist, as governed by the therapeutic context and contract" (p.18). From this, we can postulate that boundaries are therefore not hard-and-fast. In fact they are movable and context-dependent.

Gutheil and Brodsky (ibid.) go on to assert that we must examine the nature and significance of boundaries in clinical practice if we hope to gain a clearer understanding of both the flexibility of boundaries and the limits of that flexibility. It is only then, that we might be better equipped to make appropriate clinical and ethical decisions concerning boundaries, which we face with every client in each consultation.

Bridges' (2005, p.5) view is that the fiduciary principle, that is, that the needs of the client come first, is the crucial concept that all treatment and treatment relationships should be based on. Codes of ethics dictate this ethos of professional care. Privileging the client's needs ensures the development of trust, which is essential for therapeutic work to take place. Without a commitment to this principle, a therapist may abuse therapeutic power and use clients for their own needs, causing suffering and harm.

Necessary boundaries – creating the therapeutic frame

Continuing on from this notion, Bridges (2005) goes on to say that clear, consistent, predictable boundaries aim at creating a safe place and frame for the treatment relationship. Therapy requires a frame that clearly defines the purpose and meaning of the relationship between the client and therapist. It must also define and articulate the therapeutic work to be done. She says "clarity regarding treatment boundaries

allows the therapeutic work to move safely to an intimate affective and relational edge" (ibid.,p.1).

Brown and Stobart (2008, p.xiii) make the point that boundaries are also necessary to create a distinction between the therapeutic space and the outside world.

To someone new to therapy, the boundaries of the therapeutic relationship may seem artificial and strange – sometimes downright annoying and frustrating or just silly! It is only as we explore and understand the deeper rationale for them that we can appreciate the important role boundaries play in the therapeutic relationship and the work being done, within this safely contained and held space.

Brown and Stobart (ibid.) add that the process taking place in this therapeutic space needs both the protection and containment that is very similar to maternal containment. Gutheil and Gabbard (1998) liken this to Winnicott's notion of the holding environment which addresses similar concepts (p.410).

When powerful emotions are being addressed, or are as yet in the background, a secure container for those feelings is essential. A familiar routine provides a safe and reliable environment in which to experience "that which is not safe and reliable, that which might be new, shaky or perhaps even explosive" (Brown & Stobart, 2008, p.3).

Boundaries and containment encourage trust, which in turn provides a better situation for the exploration of the parts of our psyches that are hidden or difficult to face. Brown and Stobart (ibid., p.7) see this as particularly important because much of what is difficult to face is related to either a breakdown of trust or to trust not having been established in the first place.

While the boundaries spoken of so far are for effective treatment outcomes they are not just for the needs of the client. Drawing once again on the guidance of Brown and Stobart (ibid,. p.10) they cite another aspect of the function and purpose of boundaries. That is, to assist the therapist in their work, not just to prevent litigation! Boundaries help the therapist to feel safe and contained, so they are then able to hold and contain the client.

> A warm, comfortable, quiet and uninterrupted space, and the boundaries that maintain this, are a vital protection for the therapist's capacity to keep their mind available for the therapeutic encounter. Even if a client does not notice a boundary being out of place it still might affect the therapist's ability to function in a containing manner, and the client might notice or be affected by this change in the therapist's demeanour (Brown & Stobart, 2008, p.11).

Boundaries are in place to remind both parties that, although the therapeutic relationship is intimate and personal, the potent feelings that can be stirred, for both client and the therapist, must not be acted upon. An example of this is given by Brown and Stobart (ibid.) saying that at times it can be difficult for a client to make a distinction between adult sexual feelings and powerful infantile attachment to a parent. If the therapist in this situation has their own unresolved issues, and does not have good supervision, the feelings may be acted upon.

There is one final aspect to boundaries that I would like to mention. A great deal of emphasis is placed on building trust and security. However, Brown and Stobart (ibid., p.10) remind us, that sometimes in the work, it is in the experience of frustration, as clients come up against a boundary that feels harsh or unwelcoming, that insight is gained.

I will use the words of Brown and Stobart (2008) to sum up the importance of boundaries in clinical practice:

> They create a safe and secure container for the work. They help to illuminate what Jung called the 'shadow' – our unknown side. They help to highlight what might otherwise be difficult to see unless it is thrown into relief and magnified. They facilitate confidentiality and trust. They encourage 'the opposites' to emerge. They promote thought and enhanced ego-functioning through an increasing ability to tolerate frustration. They contribute to a necessary sense of security for the practitioner who in turn can be more containing for the patient. They are finally, a protection for both patient and therapist against acting out (p.12).

In the next section I examine some aspects of a few particular boundary issues in clinical practice and how they might impact the therapeutic work and the client-counsellor relationship.

Boundaries in action

When we look at boundaries more closely we see how different aspects of boundaries allow for therapeutic change. How a client responds to boundaries set in the therapeutic relationship will vary depending on many factors. For example, their history of attachment, trauma, relationships, cultural and family background, and personality type will have an influence.

Boundary issues typically revolve around things like confidentiality, timing and duration of appointments, predictability, therapist self-disclosure, payment, and the physical space that the sessions take place in. It is not just the way that consistency and stability can create a sense of safety and build trust, it is the meaning our clients make from the boundaries that is very important.

Brown and Stodart (2008, p.6) explain how the therapeutic work is facilitated by

the fact that the boundaries are ordinarily in place and so the impact of any change is usually noticeable. However carefully therapists maintain boundaries there are times when the unexpected happens e.g. the counsellor is unexpectedly delayed. These breaks of the boundary, if explored, can form bridges to important aspects of the work. It may bring to the surface times that boundaries were broken in childhood (such as betrayal by an important carer) or issues of distrust in the client's current life. When their containing function 'fails' boundaries become the focus of feeling. Brown and Stodart (ibid.) describe it as "putting a magnifying glass" to a previously invisible part of the psyche.

Let's look at a few common boundaries in clinical practice and explore what their role might be therapeutically. What might our clients gain or learn by the boundaries being maintained and how do they work to progress the process of therapy.

Confidentiality is considered fundamental to counselling due to the intimate nature of client disclosure. It can only take place in a relationship based on trust. If therapy is to be effective it requires confidentiality. When clients know that what they say is held in confidence it allows them to speak of things that can't be contained anywhere else. However, it can be enormously important to understand how long it may take an individual to disclose what is painful or shameful to them even though the subject of confidentiality has been discussed. How a therapist introduces the issues of clinical supervision, their notes, and their training status, are all potential triggers for clients and the material arising in these areas may need to be explored in some depth.

Responses and reactions to the **time and duration of appointments** can also reveal much about our clients. Brown and Stodart (2008, p.6) use the example of the client who brings up something new and significant just at the end of the session. Counsellors might be tempted to extend the time in order to explore it. However, if the client is familiar with the length of the sessions, they may be counting on the counsellor to hold the boundary around duration of appointments, to protect them from getting into more than they could manage. Consciously or unconsciously, they may be relying on an unchanging setting to guard their psychological safety.

Could this disclosure be a test of other things, for example, whether their material is 'too much' for the therapist or to protect the therapist from their emotional self. Being able to understand the 'acting out' around the boundary may be useful. We can reflect on things like, how the client enters and leaves – are they early or waiting; making us wait and worry. What might we make of the client who arrives with only 15 minutes of session to go or the client who doesn't want to leave?

A regular pattern of appointment times might be secure in the sense that it is consistent but for some clients it will feel inflexible and/or withholding. An example of this 'coming up against a boundary' and how it can be therapeutically beneficial is given, again, by Brown and Stodart (2008): A client felt intolerable rage toward his caring therapist, due to the 'rigid' session times. Eventually he mentioned that he had been a 'Truby King baby', which meant as a baby, he had been fed at regular and prescribed times that did not coincide with his hunger. He was then able to connect to childhood memories and feelings of frustration toward his mother about this. The obvious, but until then unconscious, link was made and the client was able to let the rage go (pp.9-10).

The limiting of **therapist self-disclosure** ensures clients don't feel burdened by knowledge of what is happening for their therapist or take on responsibility for caretaking them – unconsciously or consciously – which may re-create childhood patterns.

Predictability allows safety and trust to be built. For someone who has experienced chaos in their early history or current life, the new sense of stability and security offered by the therapist can be healing – emotionally and developmentally.

And then there are the **financial matters**. The issue of the exchange of money for counselling in itself stirs many significant psychological issues, often from passive aggression to overt rage.

Talking about boundaries with clients will also involve the discussion of contact, like **phone calls and text messages**, outside of hours and **holidays** taken by the therapist.

The client who rails at the therapist may be confronting their feelings towards siblings or the others 'chosen' or favoured in particular relationships. The steadiness of the boundaries allows safety for feelings of emotional burden, of love and hate, distrust and trust, lust and disgust, satisfaction and disappointment, hope and loss.

Boundary issues typically revolve around things like confidentiality, timing and duration of appointments, predictability, therapist self-disclosure, payment, and the physical space that the sessions take place in. It is not just the way that consistency and stability can create a sense of safety and build trust, it is the meaning our clients make from the boundaries that is very important.

The frame is a symbolic container for dynamic change and development and as such it is very important to understand the way its limits (taboos) evoke, reactivate, and reveal problems in a client's psychological development and relationship history. Through understanding a client's responses to a firm frame we can understand their defences and their past trauma. The frame helps the client understand his/her destructiveness. That is, their capacity to destroy the good relationships, and a lot of disturbed behaviour that could include dissociation, fragmentation, and re-traumatisation.

Boundary crossings and boundary violations

Bridges (2005, p.26) defines boundary transgressions as any action that disrupts the treatment frame and the therapeutic relationship. It is largely accepted that boundary crossings or transgressions may or may not be harmful to the therapeutic process. In fact they may indeed be very helpful and as stated previously, aid the development of trust and a deeper

therapeutic alliance; expose previously hidden material; and lead to greater insight.

Gutheil and Brodsky (2008, p.1) remind us that dilemmas concerning the boundaries of the therapist-patient relationship are common, and well-intentioned clinicians at all levels of training and experience struggle with them daily. They go on to speak of how clinicians must make subtle determinations about questions of boundaries, day by day and moment by moment.

Bridges (2005, p.32) helps us to understand how easy it is for otherwise competent clinicians to commit damaging boundary violations. She says that this is often the result of a therapist's inability to identify and contain arousing and destabilising affects and disowned psychic material. She warns us that we are all vulnerable to these situations and capable of distorting, denying, or rationalising conduct with particular clients when we are in these altered states.

Generally speaking though, we can divide boundary transgressions into two broad categories. One would be **boundary crossings**, where the deviation from what is customary, is used to advance the therapy in a constructive way and does not harm the client (Gutheil & Gabbard, 1998, p.410).

The second category would be the **boundary violations**, where the breach is clearly harmful to, or exploitive, of the client. In contrast to the boundary crossings, the boundary violations are often not discussed by the therapist and client. The harm may range from wasting time and therapeutic opportunity to inflicting severe trauma (ibid.).

In contrast to boundary violations, boundary crossings can form an integral part of well-formulated treatment plans or be central to a particular therapeutic approach. Lazarus and Zur (2002, citied in Zur and Nordmarken, 2011) give us some examples: a Reichian or Bioenergetics therapist whose hands-on techniques are part of the modality; handshakes, an appropriate pat on the back, handholding or a non-sexual hug are all also legitimate and often helpful boundary crossings at appropriate times; making a home visit to a bed-ridden or immobile elderly client; or when a behavioural therapist, as part of systematic desensitisation, flies on an airplane with a client who suffers from a fear of flying.

While professional ethics boards ultimately decide what is ethical conduct, Bridges (2005, p.29) argues that it is the intrapsychic meaning to the patient, that determines whether an interaction has been a boundary violation or not.

It is clear that therapists often have to navigate their way through difficult and tricky situations involving boundary issues. Brown and Stobart (2008, p.11) suggest having sufficient supervision and personal therapy as part of the safety net that helps the therapist to contain the material in the session and to continue to understand it symbolically. They also remind us of Jung's words about understanding the potential for the therapeutic process to affect and transform both participants which led him to emphasise the necessity for the practitioner's own personal therapy.

Boundaries exist on a continuum and are constantly shifting to meet the needs of the particular client and therapist in a given moment. Navigating this shifting and often subtle territory is one of our greatest challenges as therapists.

Barnett (2007, cited in Corey, Corey & Callanan, 2011, p.271) counsels that even well-intentioned clinicians need to engage in thoughtful reflection to determine whether crossing a boundary will result in a boundary violation. He advises that we need to practice in accordance with industry standards and take into account other variables such as the client's diagnosis, history, values and culture, to determine if our actions may result in harm to our clients.

Barnett (ibid.) sums this perspective up in the following quote: "One person's intended crossing may be another's perceived violation." He recommends wherever possible, talking openly with clients before engaging in actions that may be misinterpreted or misconstrued. Barnett is also of the opinion, expressed by many others, that crossing boundaries can be appropriate and that to avoid crossing some boundaries would work against the goals of the therapeutic relationship (ibid.).

What happens when we as therapists recognise that we have crossed a boundary? It is important that we take responsibility for both the breach and for repairing the relationship. Bridges (2005, p.28) advises that if the incident is not able to be discussed by the client and therapist it will be difficult to repair or even determine what is the extent of the injury.

As a framework for attending to this repair work, Bridges cites Epstein's multistep process:

> First the therapist attends to the patient's experience including thoughts, feelings and fantasies to elicit conscious and unconscious reactions to the therapist behaviour. Next, the therapist acknowledges her contribution to the incident and finally, the therapist helps the patient metabolize the psychological and emotional aftermath of any injury (cited in Bridges, 2005, pp.28-29).

The risk of rigidity

The widespread and differing ideas about boundaries and how to define them, leads to much controversy around boundary issues. As previously stated, there has been a progressive raising of consciousness about boundary issues by mental health professionals. Amid this admirable heightening of awareness, Gutheil and Gabbard (1998, p.409) report what they say is an overreaction to boundary concerns and has led to a misapplication of the principles underlying boundaries and the role they play therapeutically.

There is now a great deal of debate over not only what constitute good boundaries and where the line or edge is, but the potential risk of boundaries becoming barriers, and the harm that may inadvertently come from rigidity. Barnett and Johnson (2010, cited in Corey, Corey & Callanan 2011) claim "rigid adherence to boundaries may be just as harmful to a client and the therapeutic relationship as a boundary violation" (p.276).

On the same note Lazarus (1994a, 2001, 2006, cited in Corey, Corey & Callanan, 2011, p.275) contends that some well-intentioned ethical standards can be transformed into artificial boundaries that result in destructive prohibitions and ultimately undermine clinical efficacy.

This viewpoint is also discussed by Gutheil and Brodsky (2008, pp.7-8).

They speak of the dangers of being too fixated on avoiding boundary violations, inadvertently creating other forms of substandard or unethical practice, such as failing to maintain an effective therapeutic alliance or being disrespectful to a client.

Gutheil and Brodsky (2008, pp.7-8) attribute some responsibility for this rigid preoccupation with boundaries, to the professional associations and a few leading figures in the field. They are concerned that practitioners and trainees are being given an overly restrictive and liability-driven message that emphasises 'don'ts' at the expense of 'dos'. They contend that this focus does not allow for valid variations in treatment methods, inhibiting therapists from exercising appropriate flexibility and creativity in the client's best interest.

This is further expanded by Gutheil and Gabbard (1998) when they state "… the perversion of boundary theory may place professionals at risk for underserved sanctions and may potentially harm patients themselves by frightening the professionals into rigidity in therapeutic interactions" (p.409).

Rather than a rigid and inflexible stance, Gutheil and Gabbard, (ibid.) emphasise that context is critical and must be considered whenever a boundary problem has been alleged, and that boundaries must be viewed as flexible standards of good practice rather than lists of generically forbidden behaviour.

In a recent article, published in the *Psychotherapy In Australia* journal, Elisabeth Shaw (2014, pp.48-49) offers some thought provoking observations on the potential dangers for practitioners in private practice, who she fears are more prone to boundary violations.

She suggests how factors, such as anxiety and ego, may influence the decisions self-employed practitioners make concerning boundary issues. In the article she cites Keith-Spiegel (2014), who says:

> It can be too easy to rationalise the acceptance of a boundary crossing or deviation from contemporary practices as related to one's own clinical judgement, special circumstances, or even client responsiveness, when it may be that self-interest or ethical fading are in play (p.49).

There is a great deal of emphasis and focus on the negative outcomes of boundary crossings. As Corey, Corey and Callanan (2011, p.278) say, the prevailing attitude seems to be that without ethical rules and regulations all practitioners would be violating their clients! They are in agreement that this negative focus can be detrimental for our clients and the therapeutic work. They use Greenspan's (1994, cited in Corey, Corey & Callanan, 2011) words to summarise this perspective. He states: "The standard of care itself conspires against the genuine meeting of persons that is the real sine qua non of healing. It keeps patient and professional separate even when they do not wish to be. It makes authenticity feel like a bad and dangerous thing" (p.278).

Corey, Corey and Callanan (2011, p.278) urge us to consider our client population's when deciding on the kinds of boundaries to need to be sensitive to. Age, diagnosis, experiences of abuse, life history and culture all need to be taken into account when we establish boundaries with our clients. An important contribution to the discussion on boundaries is added when they stress that we as therapists, need to consider our own character, and values in relation to boundaries. They say that our personal experiences and attitudes to boundaries, have more influence than training and therapeutic orientation. Therefore, exploring our own history and relationship to boundaries, both in our family of origin and personal lives becomes relevant to our professional stance. If we establish and maintain appropriate boundaries in our personal lives it is unlikely that in our professional lives we will ignore or be indifferent to boundary issues.

Conclusion

Boundaries are clearly a vital aspect of clinical work. They play a central role in creating a safe and containing frame as well as the therapy itself. It is important that we as clinicians have some understanding of their role therapeutically and how boundaries are a meaningful part of the work itself.

Each clinician will have their own perspective on boundaries, depending on their therapeutic orientation, personal history and culture. Different modalities will place differing degrees of meaning and psychological relevance to boundaries and the frame and how they used and related to therapeutically.

As emphasised in this essay, many boundary crossings have the potential to be constructive, in that meaning can be explored, and the therapeutic work, moved forward. A boundary violation on the other hand has the likely outcome of destructiveness, putting an end to the healing potential of the work.

Boundaries exist on a continuum and are constantly shifting to meet the needs of the particular client and therapist in a given moment. Navigating this shifting and often subtle territory is one of our greatest challenges as therapists. To do this in the service of best therapeutic outcomes requires us to consider boundary questions from their true purpose and meaning and within the therapeutic context this all takes place in.

It is imperative that the therapist consider the therapeutic implications and meanings, be they literal, metaphoric or symbolic, for the client, for all boundary crossings or changes to the boundaries. This intra-psychic meaning must be explored and respected.

See page 26 for references and appendices.

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Appendix A

Excerpts from the PACFA Code of Ethics:

3.1 Values of Counselling and Psychotherapy

- Respecting human rights and dignity
- Ensuring the integrity of practitioner-client relationships
- Enhancing the quality of professional knowledge and its application
- Alleviating symptoms of personal distress and suffering
- Facilitating a sense of self that is meaningful to the person(s) concerned within their personal and cultural context
- Increasing personal effectiveness
- Enhancing the quality of relationships between people
- Appreciating the variety of human experience and culture
- Striving for the fair and adequate provision of Counselling and Psychotherapy services

3.2 Ethical principles of Counselling and Psychotherapy

- Fidelity: honouring the trust placed in the practitioner
- Autonomy: respect for the client's right to be self-governing
- Beneficence: a commitment to promoting the client's well-being
- Non-maleficence: a commitment to avoiding harm to the client
- Justice: the fair and impartial treatment of all clients and the provision of adequate services
- Self-respect: fostering the practitioner's self-knowledge and care for self

3.3 Personal moral qualities

- Empathy: the ability to communicate understanding of another person's experience from that person's perspective.
- Sincerity: a personal commitment to consistency between what is professed and what is done.
- Integrity: commitment to being moral in dealings with others, personal straightforwardness, honesty and coherence.
- Authenticity: the capacity to be true to self and relating truthfully to others.

Appendix B

Excerpt from ACA Code of Ethics and Practice

3.9 Boundaries

(a) With Clients

i. Counsellors are responsible for setting and monitoring boundaries throughout the counselling sessions and will make explicit to clients that counselling is a formal and contracted relationship and nothing else.

ii. The counselling relationship must not be concurrent with a supervisory, training or other form of relationship (sexual or non-sexual).

(b) With Former Clients

i. Counsellors remain accountable for relationships with former clients and must exercise caution over entering into friendships, business relationships, training, supervising and other relationships. Any changes in relationships must be discussed in counselling supervision. The decision about any change(s) in relationships with former clients should take into account whether the issues and power dynamics presented during the counselling relationship have been resolved.

ii. Counsellors are prohibited from sexual activity with all current and former clients for a minimum of two years from cessation of counselling.

3.11 The Counselling Environment

There are two environmental factors to be considered:

- physical factors
- emotional factors

because of this,

(a) ideally the counselling room should:

- be well lit and ventilated, and preferably have window(s)
- have a temperature that is set at a comfortable level for both counsellor and client
- have the exit easily accessible to the client should they choose to avail themselves of it
- provide for confidentiality while allowing the client to feel safe
- have within it a comfortable open space between the counsellor and the client, insofar as the work environment allows.

(b) In terms of ethics, a failure to provide such an environment could be seen as leading to a breach of:

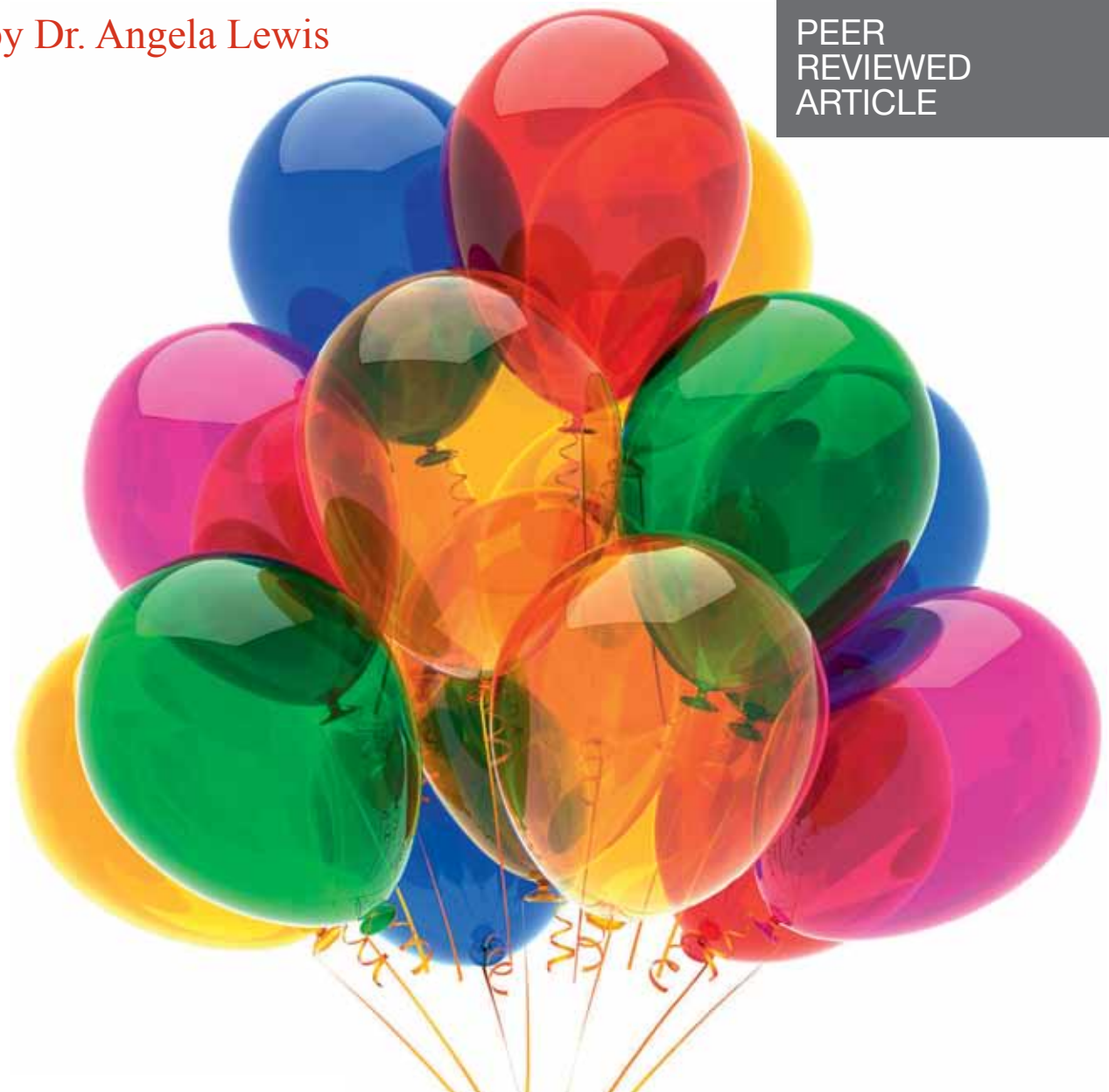
3.2 (a) i "Counsellors must take all reasonable steps to ensure that the client does not suffer physical, emotional or psychological harm during counselling sessions."

depending upon the effect of the counselling environment both physically and emotionally upon the client.

Blown up and ready to pop: a global survey of balloon fetishism

by Dr. Angela Lewis

PEER REVIEWED ARTICLE



Kris is a neuroscientist and PhD candidate in her twenties; Andy is a long-haul trucker, married with two lovely little girls and Tom is an economics teacher nearing his fortieth birthday, which he will celebrate by taking a motorbike trip around South America. They are three ordinary, happy, healthy and, by all accounts, well-adjusted members of society. On the surface they appear to have nothing in common – aside from their passion for balloons. By balloons I mean those that you can buy in stores everywhere that are used at celebrations, parties and events all over the world. To balloon lovers (who refer to themselves as Looners), balloons are more than decorations, holding a special place in their hearts, their minds and frequently their sex lives. This is their story.

Overview

In the early part of 2014 I ran a large-scale survey of the balloon-loving community, with the intention of gathering data on people who are erotically attracted to balloons. It was a repeated and expanded

version of a survey I had run in 2011, which had had a very low response rate. On speaking with the community, I found that this hesitancy could largely be attributed to male Looners being reluctant to publicly admit their passion because of the common misconception that a sexual interest in balloons equated an unnatural or unhealthy interest in children.

The latest 2014 survey had a far healthier response rate, with 298 respondents, of whom 259 identified as male. The results are broken down below; and while there is no 'typical' profile for a balloon lover, this survey found them to be overwhelmingly male, mostly in the 18–25 age bracket, in some type of relationship, Caucasian, and well educated. Their interest in balloons usually began in early life, and for many coincided with their sexual development. Just over a quarter said they could not give up balloons if asked to do so by their partner.

What constitutes a balloon fetish?

Basically it is what the name implies: having a passion or strong interest in interactions with latex balloons, which often extends to a sexual element. How people interact with balloons varies, but can include simple pleasures such as blowing up as many balloons as possible, having them around to touch and play with, stuffing them in their clothes, riding or masturbating on and with them, popping them, or watching others interact with balloons. It has become such a common interest that there are a number of adult speciality sites targeted specifically at erotic balloon play, and a number of online outlets selling large and robust balloons which can withstand adult handling.

Data breakdown

Those aged 18–25 years old were most represented at 30.6%, followed by 21.4% aged 31–39 and 21.4% aged 26–30. Numbers declined as age increased, with only 2% of balloon lovers aged sixty-plus registering in this survey.

As is the case with many alternative sexual interests, the self-identified gender of respondents was overwhelmingly male; however, in terms of the options presented, I did not use the category Transgender as I believe that allowing individuals to identify their preferred gender categorisation is more respectful.

Male/man	86.9%
Female/woman	11.1%
Do not wish to disclose	1.5%
Androgynous	0.5%

Respondents' self-reported sexuality was predominantly heterosexual, with the breakdown as follows:

Heterosexual	80.6%
Bisexual	8.2%
Gay	5.6%
Prefer not to answer	3.1%
Asexual	1.5%
Lesbian	1.0%

The category of asexual is taken to mean having no desire for a sexual relationship with men or women. While 1.5% people identifying as asexual is not a significant, it is slightly higher than one of the few available studies which found that 1% of the British population reported as asexual (Bogaert 2004). Kris (the neuroscientist in her twenties), also considers herself asexual, but added the rider 'but questioning,' as she still has a sexual attraction—just not to a person. Similar comments were made that asexuality was specifically in relation to people:

> I consider myself asexual in regard to women and I am totally fine with that, as my greatest love and lust is for reserved for my balloons.

While the respondents came from all over the world, the majority, 30%, were from the United States. This was followed by 12% from the United Kingdom, then 7% equally from The Netherlands and Australia. The remaining nationalities were diverse and included most countries in Europe as well as Japan, South America and India.

Balloon enthusiasts identified as generally well educated, with 47.9% reporting they had attended college or university, and a further 12.6% having completed graduate studies of some type.

Postgraduate studies, e.g. MBA, PhD	12.6%
Completed college/university degree	33.3%
Some college/university	26.8%

In the course of research in previous years, I have routinely found that the people participating in non-mainstream practices are mostly well educated. My theory is that being educated means they have opened their minds to a broader outlook on life which allows them to experiment, and to have experiences that are challenging, if they choose to do so. While I did not ask about earning and wage capacity, being well educated usually indicates the ability to earn well (Blanden, Gregg, Machin 2002) and allows people to more easily meet many of their primary needs. This in turn allows them to self-actualise (see Maslow's hierarchy of needs, 1943), and explore other dimensions of self and ego.

Respondents were scattered over various industry types, with the highest proportion of 25% reporting employment in the white collar/private industry sector. Students were at equal second place, making up 17.3%, which fits into 30% being in the 18–25 year old group.

White collar (private industry)	25.0%
Retail/sales/customer service	17.3%
Student	17.3%
Other	9.7%
Manufacturing	7.1%
Education /Academia	6.6%
White collar (government)	6.1%
Blue collar (trades: plumbing, building etc.)	5.1%
Unemployed	5.1%
Retired	0.5%

Relationships

At 26%, the majority of Looners were married. If this figure is combined with the number in a relationship, the percentage of partnered people at the time of this survey was around 69.4%. Just over a quarter (26.7%), were single and not dating. This correlates with the number of those who reported play alone or utilising the Internet for balloon activities. There were no widowed respondents recorded.

A majority of 62.6% reported enjoying their passion for balloons in both real life and online. When interacting with balloons in real life, 33.8% played alone and 27.5% enjoyed it as part of their regular relationships.

Both online and in real-life	62.6%
Solo (I play alone)	33.8%
A regular part of my relationships	27.5%
Online fantasy only	18.3%
Online if partner is not interested	13.7%

If those who were partnered chose to play alone, this was not necessarily based on the partner's lack of interest but was sometimes a specific choice. On reflection

I was remiss not to include an option for 'partnered but choose to play solo', as a number of respondents made the point that they were in a relationship but it was their preference to play with balloons alone – either with their partner's knowledge or in secret:

> My relationship with my partner does not depend on her sharing my interest for balloons. I can get sexual arousal and gratification with her alone. Balloon play is something that I greatly enjoy alone and on its own merits.

On the other hand, a number of men and women commented that their relationship with balloons was exclusive and specifically precluded other people:

> I've never had sex with women; my only sex life is with my balloons.

> I've chosen for balloons to replace a human relationship and I honestly, I can't see that ever changing.

> I will always choose balloons over men, they are my only passion.

In answer to a question on how their current partner (or previous partner, if currently single), felt about balloon play, the results were as follows:

Partner is not interested but will participate in balloon play with me occasionally	30.5%
I have never broached it	29.0%
Partner was not interested at first, but now enjoys it	17.6%
Partner is not interested but does not stop me from interacting with balloons alone	10.7%
Partner is also a balloon enthusiast and we play with balloons together.	7.6%
Have broached it but partner hates the idea so I play in secret	4.6%

A number of positive comments were made (by male Looners in particular), with regard to both partner participation and acceptance towards balloon play in the bedroom, even when female partners did not share the interest:

> My current girlfriend is actually afraid of balloons, but still pops them for me during sex occasionally.

> She does it to satisfy me and while she isn't into it, she doesn't mind if we do it and I love her for it.

While the majority of those surveyed were currently in a relationship, 64.9% of participants said they would not give up their balloon play if asked by a partner, 28.9% said it depended on the person, and 6.9% said they would do so, albeit reluctantly, as it was such a big part of their lives.

A number of comments indicated that respondents would not give up their balloon play but would be satisfied with a compromise which respected their life choices:

> I believe everyone has the right to consensually express their sexuality in the best way fitting to themselves and the partner – with the obvious caveat for the exploitation of animals and children. If a partner did not want to participate, I would hold the expectation that the expression of my sexuality in my private time would still be respected, as I would respect my partner's.

For others, it was sufficient that they be given the space or peace to enjoy balloons as a solo interest, with comments such as "I'd just have a sneaky play anyway" indicating they would get around a partner's caveats surreptitiously. However at 64.9%, the majority considered it a deal breaker when a partner would not respect what they considered an integral part of their identity. There were also a number of comments indicating that for some it was about acknowledging that this was an addiction they had tried to quit but had now accepted:

> I always put my wife first and she knows that, but we both also know that I attempted unsuccessfully to give it up before I learned to accept it and now she accepts it too.

> Already tried numerous times to give it up thinking it was a phase. Every time I go without for a week or so the urges comes back stronger than ever.

> Long story short: it would probably be a deal breaker for the other person – not me, because they are the one who can't accept my behaviours.

Excluding their primary relationship (when they had one), just over half those surveyed (55.7%) did not divulge their interest to family, friends or those outside the balloon community. When they shared their interest, reactions were reported as fairly neutral, with 12.2% saying others found it harmless and 10.7% finding people weren't that bothered, typified by this comment:

> Friends know and don't care. People are too wrapped up in their own issues to devote much energy or attention to other people's fetishes. In my experience they find it briefly fascinating for the duration of a short conversation over a glass of wine and that's the end of it.

A small number of respondents (3.8%) reported being met with humour when they shared their love of balloons. As one male Looner described it, "while some thought it was a bit strange, most had a laugh after I told them and all thought it was harmless".

Only a very small number at 2.3% experienced a negative response from others:

> I used to pop balloons with friends as a child for fun. My parents were quite frankly appalled when they found out that the balloon popping was actually a sexual activity later in life.

Early awakenings

Everyone with a fetish or interest in something that is not mainstream has to battle the "why/how did this start" question. And of course I also asked whether respondents could pinpoint an age when they became of aware of their interest in balloons. For most Looners it is simply part of who they are, and while they generally have an idea or memory of when it began, they can't answer why. A number of respondents to this survey remarked that it coincided with the imprinting of sexual preferences acquired through exposure to particular stimuli during a specific period, usually at the time of puberty/sexual awakening. There is very little empirical data to confirm or refute this, and much of what is known is based on anecdotes and hearsay; but it was a common response in this survey. The breakdown below shows there was fairly uniform pattern of identifying their interest at a young age:

- 43% recall being between 11 and 16 years old
- 18% recall being between 2 and 10 years old
- 12% could not recall an exact age, but said it was in puberty
- 11% had no memory of when it began
- 8% were between 17 and 21 years old
- 8% say they have always known it to be part of who they were.

Looner style and play

There are two acknowledged types of

Looners, poppers and non-poppers, depending on whether they enjoy popping a balloon or not. For the popper the allure is focused on the lead up to, then the moment the balloon pops, which coincides with the peak of their excitement and release. For some poppers the pop is actually feared, but in that delicious, risk-taking way where they dread it but enjoy the adrenaline rush surrounding the moment when and if the balloon pops. This is similar to other activities such as sky diving, white water rafting, swimming with sharks or other activities that might be deemed risky but sought-after. Popular methods of popping are sitting, bouncing, riding, squeezing or stomping on the balloon; and for some it can extend to using sharp devices, long fingernails or cigarettes. The theory of counterphobic behaviour would explain the fear of popping in these types, as a type of defence mechanism:

> It often happens that a person shows a preference for the very situation of which he is apparently afraid. And even more frequently he will later develop a preference for the situations which he formerly feared (Fenichel, 1946, p. 264).

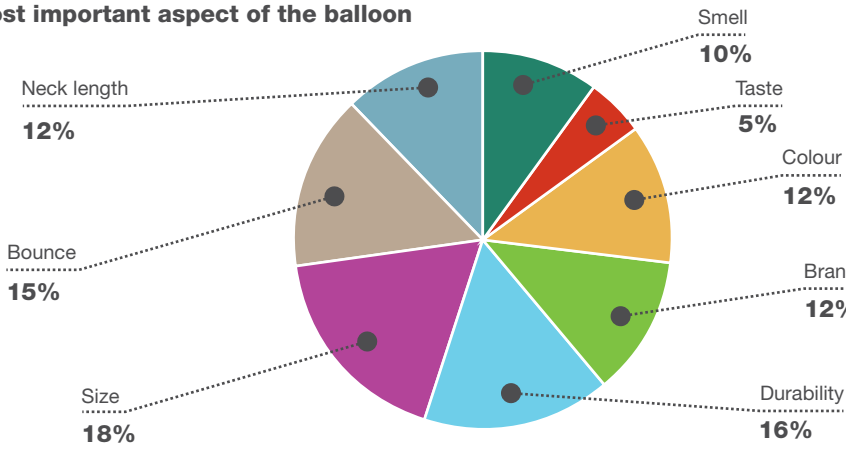
The poppers' diametric opposites are the non-poppers, who will take great care never to pop or damage a balloon. They are generally gentler with their balloons while enjoying similar forms of play such as sitting, stroking, squeezing or stuffing them in clothing – they just take great care not to damage the balloon.

Popper	21.4%
Non-popper	26.0%
I enjoy both	52.7%

It was my initial assumption that people would be black-and-white in identifying as either a popper or non-popper; however more than half of the respondents reported enjoyed both activities, depending on mood, circumstance and play partner. While there is very little research on this community, much of what is published points to a definite dividing line between poppers and non-poppers. As to whether my results are more reliable or accurate than common perception remains to be seen, as I can only share the results as they were self-reported in this survey.

Despite the main distinction between popper and non-popper, there are many more ways to enjoy balloons and respondents nominated the following in order of importance:

Most important aspect of the balloon



- Sexual interaction (masturbation, rubbing or riding to climax)
- Watching women play with balloons
- Inflation
- Including balloons in couple play
- Popping
- Sitting, bouncing, riding
- Cuddling, hugging or otherwise touching
- Stuffing into clothing

I did an extended interview with Kris earlier this year and this is how she described her ideal balloon play session:

> First I start with some 'balloon foreplay'. This involves blowing up a few balloons. I then squeeze them into the ground/bed and watch them distort. I imagine how good it would feel to sit on it. I squeeze the balloon in various ways using different body parts. I might lie on it, but avoiding contact with my genitals. The idea is to do this until I can't stand it anymore. When this happens, I 'ride' the balloon. As the name implies in a sexual context, this means straddling the balloon, putting your weight on it and bouncing/grinding on it. My favourite way is putting the balloon on an armchair or that type of support rather than a flat surface. It allows me to put more weight onto the balloon. While doing this, I'll also attempt to pop some balloons by hand or pop the balloon under me (depending on its size). A pop can bring me close to orgasm if I'm aroused enough. Also, the more aroused, the more 'brave' I am with popping the balloon, so it becomes a positive feedback loop. Eventually I get to a stage where the sexual pleasure totally overwhelms the fear and all I want to do is pop that balloon. I won't last long in this stage as I'll have an orgasm.

The allure of the balloon

There are many aspects of balloons that make them attractive, some of which a non-Looner might never consider. Respondents were asked to rate various attributes including colour, size, durability and brand.

While a non-Looner might assume colour would be one of the important attributes of a balloon, qualities related to handling were more important, with the top three considerations its size, durability and bounce. Some of the reasons that balloon fetishists express a preference for larger, more durable balloons are that they can be enjoyed for longer in play before popping, that they are easier to ride or lie on (as they can take the weight of a human body), that there is more to hold on to and enjoy – and, for those who enjoy popping, larger balloons make a louder bang.

Although I did not ask about shape (thinking only in terms of round balloons), there were a number of comments indicating a preference for zeppelin or airship shapes as they align nicely with the body; the types GL500/GL700 were mentioned by a number of people in the question on brand preference.

A preference regarding neck length is related to how easy it is to insert a penis into the neck, as having an intimate experience with a balloon is an important consideration for some Looners. Smell was not high on the preference list, although those who find it an important aspect are generally attracted to latex in other forms, because of the same distinctive smell.

Specific size preferences were as follows. I did not include an option for 14- or 24-inch, and these are the two sizes specified in the 'other' category.

16–20 inch	42%
12-inch	16%
Other	14%
36-inch	13%
Biggest available	11%
No size preference	5%

I also asked how many balloons people had blown up in one sitting, and while there was a wide range of numbers – from a single one because the Looner "preferred quality play over quantity" – to 46% reported blowing up over 100 at one time, 30% between 11-99 balloons and 24% blowing up under 10 at one time. When the number of balloons inflated is high, they are generally also the smaller 12 inch size. Many of those inflating low numbers in a sitting explained this was because they were blowing up large or extra-large balloons. When blowing up between 50-70 balloons, 16-20 inch was the most common size. This number is often used as it works well to fill a balloon room (might be a room in the house specifically designated for this activity).

Colour came in at the lower end of the spectrum and at 12% was equal with brand and neck length. The top 10 favourite colours are shown below. After some enquiries, the reason that 'clear' was second favourite was revealed as the ability to see a woman's body when the balloon was pressed against her. Yellow is favoured because of its nostalgic association with rubber kitchen gloves, wearing yellow raincoats as a child and the ubiquitous yellow rubber ducky played with in the bath –for many, these occasions were when they first identified pleasure with latex.

red	16%
clear	12%
yellow	11%
blue	9%
purple	8%
crystals	6%
black	5%
pink	4%
green	4%
orange	4%
no favourite	4%

Other colours were mentioned in lower numbers and included teal, burgundy red, jewel tones, white and prints.

One of the comments I received was a plea not to publicise the balloon fetish 'because people don't understand'. But that is the very reason I undertake these articles, so we can all learn and hopefully understand a little more. If you are interested in delving a little deeper into the world of Looners there are many interest groups and forums online, however, if you choose to investigate further please respect their privacy and their right to enjoy their lives in the way they choose. As well, the data from the 2011 survey and the interview with Kris are both available on my website, simply type 'balloons' in the search field.

A huge thank you goes to everyone who a participated in this survey and had the patience to wait for me to collate all of the results. It has taken me some time, but I hope I have done this gentle and delightful community justice in what I have produced.

www.myotherself.com.au

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Book review

Full Esteem Ahead

Helen Harrison

Published: March 2014
Publisher: Power of Change Counselling & Coaching
Where to buy: www.powerofchange.com.au/mybook/
Price: $20 inc postage for Australia, or use the link to Amazon

Full Esteem Ahead is a must-have book in the toolkit of women starting out on a journey of self-development through exploring spirituality. Helen Harrison, a private practice counsellor and life coach at Power of Change Counselling & Coaching, Redlands City, Queensland, has written a well thought out and logical approach for readers on their journey of developing a healthy self-esteem. *Full Esteem Ahead* is a tool book that can be used by readers as self-help book or in conjunction with the workshop of the same name offered at Power of Change Counselling & Coaching.

The book has spiritual overtones and may not appeal to everyone with reference made to the universe and other alternative concepts. However, there is a niche for this type of approach aimed at women ready to embark on a spiritual journey of self-love and self-acceptance. Harrison's approach to the topic adopts the analogy of using a train as a metaphor with each carriage being a separate chapter on the journey of self-discovery in working through self-esteem issues.

I like the inspirational quotes by other authors scattered throughout the book as this provides a point of reflection for the reader. Another strength that the book has is asking the reader questions and setting self-reflective exercises to encourage the reader to release limiting and self-defeating patterns. There is some over generalisation and one weakness the book has is not including a warning about journaling as a tool. In my opinion this is an area most authors neglect to mention when suggesting using journaling to help clear issues. I think every author suggesting journaling as a tool needs to add a warning of the potential embarrassment and damage that can be done by having personal journals read by someone else or used in a public arena to discredit the journal writer.

Overall, *Full Esteem Ahead* is a well written contribution to the self-help industry targeted at women on a spiritual journey wanting to improve their self-esteem. I'm happy to recommend the book to clients and have bought a copy for my own reference library.

by Jacinta Hodnett

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Contact	**Suburb**	**Phone Number**	**SUP PP Hourly**	**Medium**
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Karen Rendall	Barton	0431 083 847	Upon Enquiry	FTF
Brenda Searle	Canberra Region	02 6241 2765 or 0406 376 302	$100 to $130	FTF
Hun Kim	Downer	02 6255 4597	Upon Enquiry	FTF
Mijin Seo - Kim	Downer	02 6255 4597	Upon Enquiry	FTF
NEW SOUTH WALES				
Yvonne Aldred	Albury	02 6041 1941	Upon Enquiry	FTF
Elizabeth Allmand	Queanbeyan	0488 363 129	$120	FTF/WEB/PH
Penny Bell	Cumbi Umbi	0416 043 884	Upon Enquiry	FTF/GRP/PH/WEB
Sandra Bowden	Lysterfield	0438 291 874	Upon Enquiry	FTF
Patriciah Catley	Narellan	02 9606 4390	Upon Enquiry	FTF
Michael Morris Cohn	North Bondi	0413 947 582	$120	FTF/GRP/PH/WEB
Leon Cowen	Lindfield	02 9415 6500	Upon Enquiry	FTF/GRP/PH/WEB
Lorraine Dailey	Maroota	0416 081 882	Upon Enquiry	FTF
Karen Davey-Phillip	Lake Munmorah	0418 216 836	Upon Enquiry	FTF
Brian Edwards	Forresters Beach	0412 912 288	Upon Enquiry	FTF
Linda Elsey	Wyee	02 4359 1976	Upon Enquiry	FTF
Wendy Gibson	Koolewong	02 4342 6746	Upon Enquiry	FTF
Kim Michelle Hansen	Putney	02 9809 5989 or 0412 606 727	Upon Enquiry	FTF
John Harradine	Cremone	0419 953 389	FTF & WEB $160; GRP $120	FTF/GRP/WEB
Brian Lamb	Newcastle/Lake Macquarie	0412 736 240	$120 (contact for sliding scales)	FTF/GRP/PH
Anne Larcombe	Wagga Wagga	02 6921 22 95 or 0448 212 295	Upon Enquiry	FTF/GRP/PH/WEB
Gwenyth Lavis	Albury	0428 440 677	$95	FTF/PH
Dr Dawn Macintyre	Clunes	0417 633 977	Upon Enquiry	FTF
Heide McConkey	Bondi Junction	02 9386 5656	Upon Enquiry	FTF
Karen Morris	Newcastle/Hunter Valley	0417 233 752	$100	FTF/GRP/PH/WEB
Kathryn Quayle	Hornsby	0414 322 428	$90	FTF/WEB/PH
Judith Reader	Stockton	02 4928 4880	Upon Enquiry	FTF
Deborah Rollings	Grays Point/Cronulla	02 9525 6292 or 0404 884 895	Upon Enquiry	FTF
Veronica Sandall	Mullumbimby	0420 436 460	Upon Enquiry	FTF/GRP/PH/WEB
Megan Shiell	Tweed Heads	0417 084 846	Upon Enquiry	FTF
Grahame Smith	Singleton	0428 218 808	$66	FTF/GRP/PH/WEB
Rhondda Stewart	Leichhardt	0419 698 650	Upon Enquiry	FTF
Carol Stuart	Bondi Junction	0293 877 752	$80 pp - % rate $ 50 for early graduates	FTF/GRP/PH/WEB
David Edwin Warner	Peakhurst	0418 283 519	Upon Enquiry	FTF
Kevin Garth Webb	Belmont	02 6964 4927	Upon Enquiry	FTF
Michella Wherrett	Lake Macquarie/Newcastle	0414 624 513	$80	FTF/PH
Jennifer Blundell	Austinmer	0416 291 760	Upon Enquiry	FTF
Katrina Christou	Earlwood	0412 246 416	Upon Enquiry	FTF
Lyndall Briggs	Kingsgrove	02 9024 5182	Upon Enquiry	FTF
Patricia Cheetham	Kensington	1300 552 659	Upon Enquiry	FTF

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David Gotlieb	Bowral	0421 762 236	Upon Enquiry	FTF
Vicki Johnston	Eastlakes	02 9667 4664	Upon Enquiry	FTF
Kirilly Smitheram	Newtown	0411 550 980	Upon Enquiry	FTF
NORTHERN TERRITORY				
Margaret Lambert	Darwin	08 8945 9588 or 0414 459 585	Upon Enquiry	FTF/GRP/PH/WEB
Rian Rombouts	Millner	0439 768 648	Upon Enquiry	FTF
QUEENSLAND				
Lynette Baird	Maroochydore/Sunshine Coast	07 5451 0555	Grp $30 or Indiv $90	FTF/GRP
Maartje (Boyo) Barter	Wakerley	0421 575 446	Upon Enquiry	FTF
Christine Boulter	Coolum Beach	0417 602 448	Upon Enquiry	FTF
Judy Boyland	Springwood	0413 358 234	$100	FTF/GRP/PH/WEB
Rev. Dr. Apichart Branjerdporn	Kenmore	0411 866 663	GRP $100 Indv $80	FTF/GRP/PH
Jennifer Bye	Victoria Point	0418 880 460	Upon Enquiry	FTF
Myra Cummings	Inala	0412 537 647	$66	FTF/PH
Catherine Dodemont	Grange	0413 623 162	$40 Grp; $100 indiv	FTF/GRP/PH/WEB
Patricia Fernandes	Emerald/Sunshine Coast	0421 545 994	$30-$60	FTF/PH
Rev Peter Gee	Eastern Heights/Ipswich	0403 563 467	$65	FTF/GRP/PH/WEB
Nancy Grand	Surfers Paradise	0408 450 045	Upon Enquiry	FTF
Valerie Holden	Peregian Springs	0403 292 885	Upon Enquiry	FTF
Beverley Howarth	Mitchelton	0409 619 107	Upon Enquiry	FTF
David Kliese	Sippy Downs/Sunshine Coast]	07 5476 8122	$80	FTF/GRP/PH
Kaye Laemmle	Helensvale	0410 618 330	Upon Enquiry	FTF
Sharron Mackison	Caboolture	07 5497 4610	Upon Enquiry	FTF
Neil Roger Mellor	Pelican Waters	0409 338 427	Upon Enquiry	FTF
Ann Moir-Bussy	Sippy Downs	07 5476 9625 or 0400 474 425	Upon Enquiry	FTF/GRP/PH/WEB
Judith Morgan	Toowoomba	07 4635 1303	Upon Enquiry	FTF
Diane Newman	Bundaberg West	0410 397 816	Upon Enquiry	FTF
Christine Perry	Beerwah	0412 604 701	Upon Enquiry	FTF
Brenda Purse	Sunshine Coast	0402 069 827	Upon Enquiry	FTF
Yildiz Sethi	Hamilton	07 3268 6016	$45 Grp Or $90 Ind	FTF/GRP/PH/WEB
Frances Taylor	Redland Bay	0415 959 267 or 07 3206 7855	Upon Enquiry	FTF
Pamela Thiel-Paul	Bundall/Gold Coast	0411 610 242	Upon Enquiry	FTF
David Hamilton	Beenleigh	07 3807 7355 or 0430 512 060	Upon Enquiry	FTF
Stacey Lloyd	Mount Gravatt	07 3420 4127	Upon Enquiry	FTF
Laura Banks	Broadbeach	0431 713 732	Upon Enquiry	FTF
Kim King	Yeppoon	0434 889 946	Upon Enquiry	FTF
SOUTH AUSTRALIA				
Adrienne Jeffries	Stonyfell	08 8332 5407	Upon Enquiry	FTF
Pamela Mitchell	Waterfall Gully	0418 835 7867	Upon Enquiry	FTF

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Carol Moore	Old Reynella	08 8297 511 bus hrs or SMS 0419 859 844	Grp $35, Indiv $99	FTF/GRP/PH
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David Hayden	Howrah North	0417 581 699	Upon Enquiry	FTF
VICTORIA				
Joanne Ablett	Phillip Island	0417 078 792	$100	FTF/GRP/PH/WEB
Danielle Aitken	Kilcunda	0409 332 052	Grp $50, Indiv $80	FTF/GRP/PH/WEB
Anna Atkin	Chetlenham	0403 174 390	Upon Enquiry	FTF
Judith Ayre	Bentleigh	0417 105 444	Upon Enquiry	FTF
Nyrelle Bade	Geelong	0402 423 532	Upon Enquiry	FTF
Marie Bajada	Ballart	0409 954 703	Upon Enquiry	FTF
Zohar Berchik	South Yarra	0425 851 188	Upon Enquiry	FTF
Kathleen Brennan	Narre Warren	0417 038 983	$35 Grp, $60 Indiv	FTF/GRP/PH/WEB
Sheryl Brosnan	Carlton North/Melbourne	03 8319 0975 or 0419 884 793	Upon Enquiry	FTF/GRP/PH/WEB
Sandra Brown	Frankston/Mount Eliza	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Molly Carlile	Inverloch	0419 579 960	Upon Enquiry	FTF
Tim Connelly	Healesville	0418 336 522	Upon Enquiry	FTF
Roselyn (Lyn) Ruth Crooks	Brookfield	0406 500 410	$60	FTF
Debra Darbyshire	Berwick/Somerville	0437 735 807	$60 discounted rates applied	FTF/GRP/PH/WEB
Patricia Dawson	Mooroolbark	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
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Sara Edwards	Dingley	0407 774 663	Upon Enquiry	FTF
Jenni Harris	Kew	0406 943 526	$90 per 3 hr session Small group only	FTF
Melissa Harte	Pakenham/South Yarra	0407 427 172	$132 to $143	FTF
Paul Huxford	Yarraville	0432 046 515	Upon Enquiry	FTF
Beverley Kuster	Narre Warren	0409 938 397	Upon Enquiry	FTF
Keren Ludski	Malvern	03 9500 8381 or 0418 897 894	Upon Enquiry	FTF/PH/WEB
Barbara Matheson	Melbourne	03 9703 2920	Upon Enquiry	FTF
Peter Mauger	Bairnsdale	0412 141 340	Upon Enquiry	FTF
Robert McInnes	Glen Waverley	0408 579 312	Upon Enquiry	FTF
Patricia Reilly	Mount Martha/Gardenvale	0401 963 099	Upon Enquiry	FTF
Graeme John Riley	Gladstone Park	03 9338 6271 or 0423 194 985	$85	FTF/WEB
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Kenneth Robert Scott	Bunyip	03 5629 5775	Upon Enquiry	FTF
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Cheryl Taylor	Port Melbourne	0421 261 050	Upon Enquiry	FTF
Suzanne Vidler	Newport	0411 576 573	$110	FTF/PH
Helen Wayland	St Kilda	0412 443 899	Upon Enquiry	FTF
Cas Willow	Turalgan	03 9327 2293 or 0428 655 270	Upon Enquiry	FTF/PH/WEB

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Joan Wray	(Mobile Service)	0418 574 098	Upon Enquiry	FTF
John Dunn	Colac/Mt Gambier	03 5232 2918	Upon Enquiry	FTF
Sharon Vivian Blake	Fremantle	0424 951 670	Upon Enquiry	FTF/PH/GRP/WEB
Eva Lenz	South Fremantle	0409 405 585	Upon Enquiry	FTF
Salome Mazikana-Mbenjele	South Headland	08 9138 3000 or 08 9172 2212	Upon Enquiry	FTF
Carolyn Midwood	Duncraig	08 9448 3210	Grp $44, Indiv $110	FTF/GRO/PH/WEB
Dr. Patricia Sherwood	Boyanup	08 9726 1505	Upon Enquiry	FTF
Lillian Wolfinger	Yokine	08 9345 0387 or 0401 555 140	Upon Enquiry	FTF/PH/WEB
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Fiona Man Yan Chang		+852 9198 4363	Upon Enquiry	FTF
Polina Cheng		+852 9760 8132	Upon Enquiry	FTF
Viviana Cheng		N/A	Upon Enquiry	FTF
Eugnice Yiu Sum Chiu		+852 2116 3733	Upon Enquiry	FTF
Wing Wah Hui		+852 6028 5833	Upon Enquiry	FTF
Cary Hung		+852 2176 1451	Upon Enquiry	FTF
Giovanni Ka Wong Lam		+852 9200 0075	Upon Enquiry	FTF
Frank King Wai Leung		+852 3762 2255	Upon Enquiry	FTF
Mei Han Leung		N/A	Upon Enquiry	FTF
Lap Kwan Tse		N/A	Upon Enquiry	FTF
Barbara Whitehead		+852 2813 4540	Upon Enquiry	FTF
Yat Chor Wun		+852 264 35347	Upon Enquiry	FTF
Pui Kuen Chang		N/A	Upon Enquiry	FTF
Winnie Wing Ying Lee		N/A	Upon Enquiry	FTF
SINGAPORE				
Deborah Cameron		+65 91868952	$100	FTF/GRP/PH/WEB
Eugene Chong		+65 6397 1547	Upon Enquiry	FTF
David Kan Kum Fatt		+65 9770 3568	Upon Enquiry	FTF
Gan Su Keng		+65 6289 6679	Upon Enquiry	FTF
Ellis Lee		N/A	Upon Enquiry	FTF
Jeffrey Gim Tee Po		+65 9618 8153	$100.00	FTF/GRP/PH/WEB
Nadia Rahimtoola		+65 9647 1864	Upon Enquiry	FTF
Prem Kumar Shanmugam		N/A	Upon Enquiry	FTF

SUBMISSION GUIDELINES

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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 be published in the next cycle.

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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

ACCEPTANCE & COMMITMENT THERAPY WORKSHOPS 2014

LIMITED SPACES PER EVENT

Designed for **psychologists, counsellors, social workers, occupational therapists & other mental health professionals**

WHAT IS ACCEPTANCE & COMMITMENT THERAPY?

Acceptance and Commitment Therapy (ACT) is a growing discipline within psychology utilising mindfulness-based strategies while encouraging value-driven action and acceptance. ACT therapy offers a simple and effective approach to facilitating mindfulness practice, enhancing acceptance and connecting with values, helping clients live a richer and more meaningful life.

ACT has been widely researched and holds empirical support for effective use with a wide range of psychological conditions such as depression, anxiety, trauma, post-traumatic stress disorder, chronic pain and personality disorders and can be used when working with individuals, couples and groups.

INTRODUCTORY WORKSHOP

The two-day introductory workshop is for psychologists, counsellors, social workers, occupational therapists and other mental health professionals who want to learn about, or may be lacking in confidence when using ACT. This workshop has been developed to support clinicians to understand the core principles within the ACT framework and to begin integrating ACT processes such as mindfulness, values clarification and cognitive defusion into their practice.

This is an experiential workshop where you will be given an opportunity to participate in the 6 core processes of ACT and in turn understand the fundamental attributes to delivering ACT. This practical hands-on training will give you a broad understanding of ACT and the confidence to begin using the core processes with clients.

ADVANCED WORKSHOP

The two-day advanced workshop is for clinicians with a basic understanding of ACT looking to flexibly apply the 6 core processes of the therapy model in different scenarios of everyday practice.

In this advanced workshop you will learn practical tools to getting unstuck as a clinician when dealing with challenging clients and situations. This workshop will provide you with an opportunity to see live ACT role plays ranging from introducing ACT for the first time to a client and obtaining client consent through to working within complex client presentations and how to balance values, mindfulness and committed action. You will learn troubleshooting strategies and most importantly how to deal with tough situations when clients get stuck and no longer respond to the basic ACT approach.

If you are looking for advanced applications of ACT over a wide range of psychopathology including depression, anxiety, trauma and personality disorders, this workshop is for you.

WHAT ELSE YOU WILL GET

Prior to both the introductory and advanced training you will receive short pre-workshop readings and resources. Although not necessary, these resources will help you in understanding the history and development of ACT.

On completion of the workshops you will also receive questions and answers to test your knowledge which comply with industry active CPD requirements.

PRESENTED BY

Nesh Nikolic (BA Psych, Grad Dip App Psych, M Clin Psych, MAPS, MACCP) is a Clinical Psychologist and ACT trainer with over 8,000 hours of one-on-one therapy experience.

Nesh has practiced ACT within a number of therapeutic contexts including individual therapy, couples counselling and family therapy. He has also worked with the Canberra Raiders and other athletes on increasing sporting performance using ACT.

Nesh runs a busy private psychology practice and has applied ACT to a wide range of mental health difficulties including depression, anxiety, trauma, personality disorders, eating disorders and pain management.

INTRODUCTORY WORKSHOPS

12 CPD HOURS

SYDNEY

MELBOURNE

BRISBANE

ADELAIDE

PERTH

CANBERRA

GOLD COAST

ADVANCED WORKSHOPS

12 CPD HOURS

MELBOURNE

SYDNEY

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