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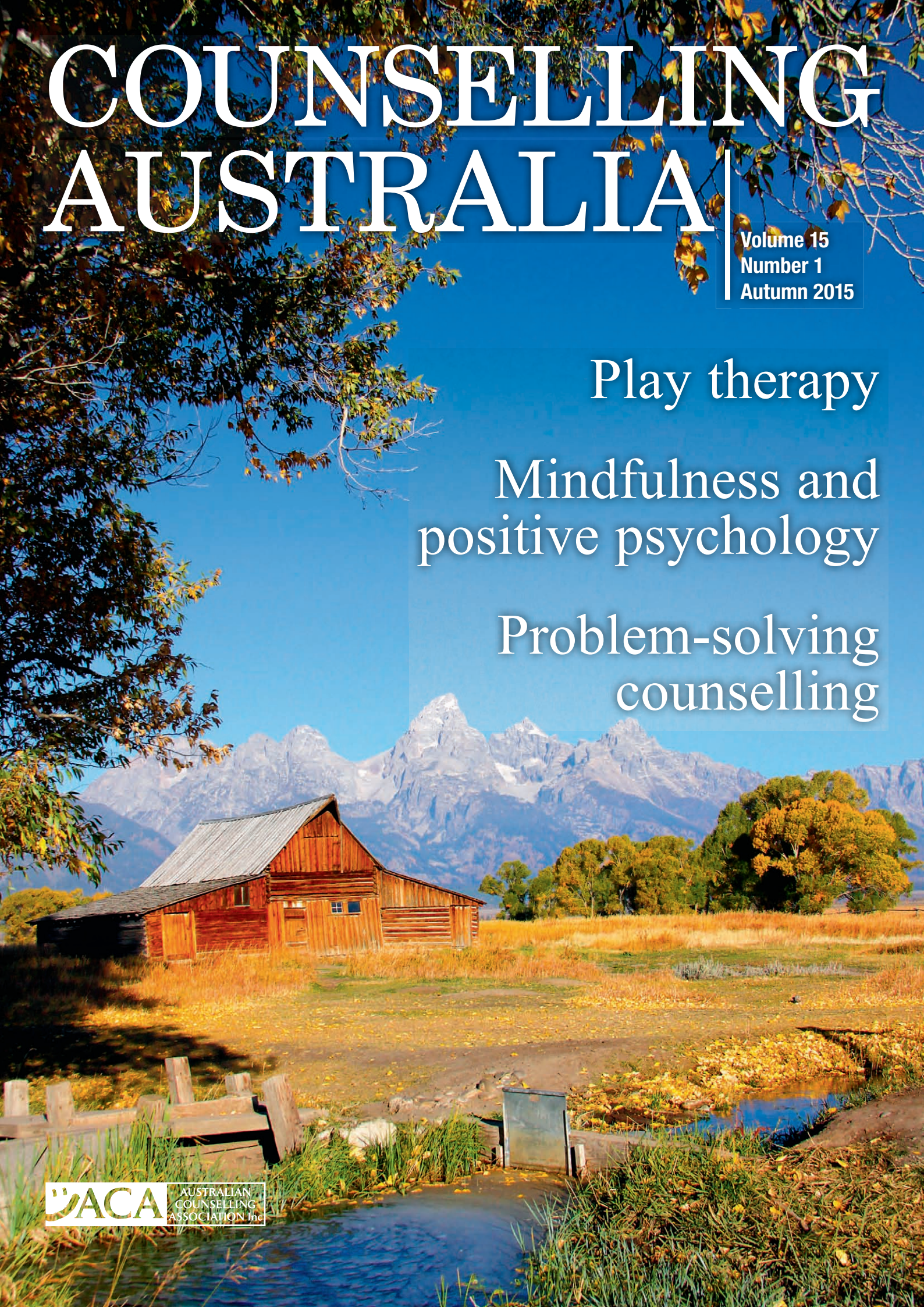
Play therapy

Mindfulness and positive psychology

Problem-solving counselling



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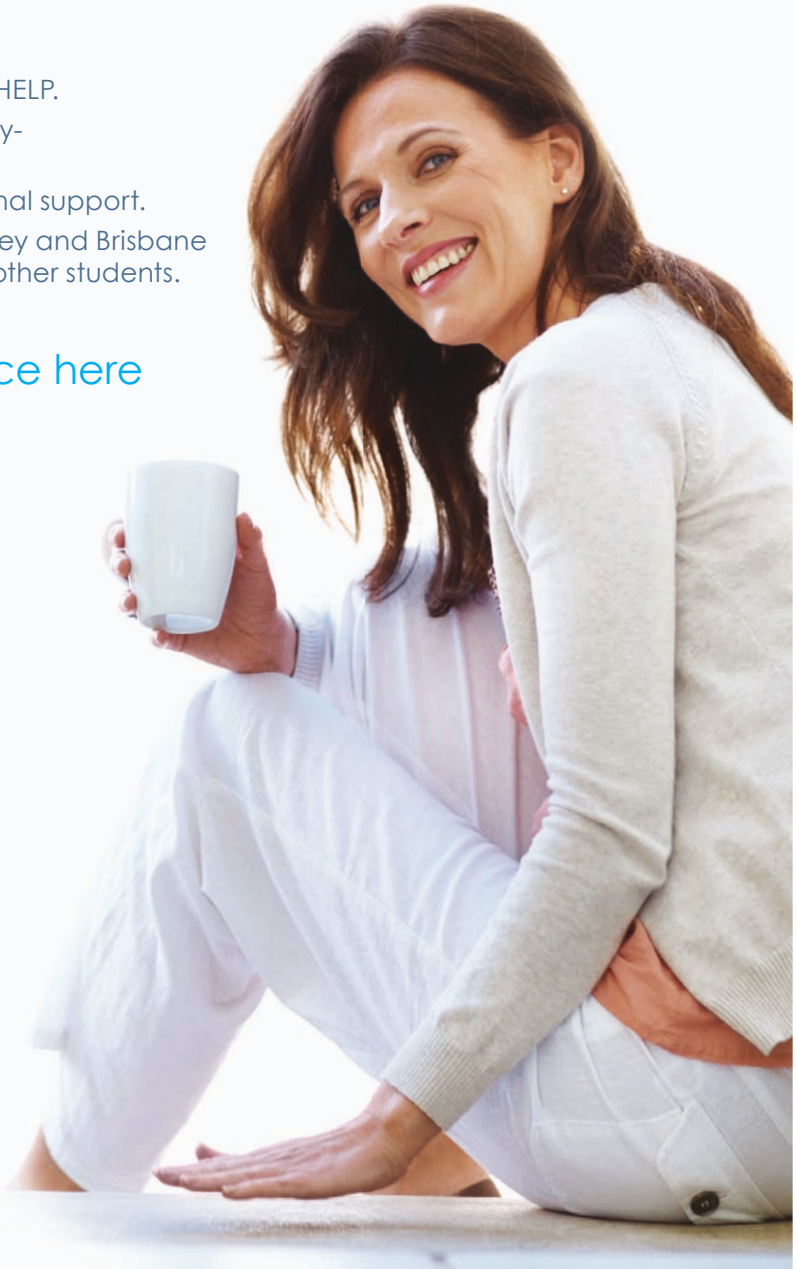

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REGULARS

Letters to the editor should be clearly marked and be a maximum of 250 words.
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By Philip Armstrong

Spotlight to shine on qualifications and accreditation

This year is potentially going to be a landmark year in relation to counselling/psychotherapy and employment opportunities. ACA last year commissioned an investigation into WorkCover and Employee Assistance Programs (EAP) which will be published shortly. We have also had significant discussions with the government and other potential employment groups, the one issue that was consistent in all these discussions was that of standards and qualification. This has now bought to a head the issue of overseas qualifications and the accuracy of members curriculum vitaes and websites. In the last 12 months four ACA members have been investigated for making claims of misrepresentation by either claiming to hold qualifications they don't actually have or not accurately reflecting the qualification/s they do have. This is a breach of the ACA Code of Ethics and the consequences can be significant particularly beyond any action taken by ACA. Insurance policies are clear in this regard that should your stated qualifications (as per websites, not just CVs) be misrepresented or found to be non-existent then your policy is most likely redundant and will not protect you or pay for legal fees. If you are in New South Wales or South Australia you are also likely to have legal action taken against you by the Health Complaints Commission, which is a legislative body. The potential consequences for clients, and these may include supervisees, can be catastrophic. This all impacts on how the industry is viewed: is it safe, is it well regulated by the peak bodies and are peak bodies being diligent when assessing memberships or simply taking the money and rubber stamping applications?

ACA has always prided itself on a comprehensive quality accreditation process for qualifications; unfortunately this process cannot be applied to overseas qualifications. Therefore ACA has spoken with many similar overseas associations such as the American Counseling Association, British Association for Psychotherapy and Counselling and other similar Australian peak bodies such as the APS in relation to what constitutes equivalency in qualifications. One constant in all these conversations is that qualifications from the USA that do not meet the Council for Higher Education Accreditation are not recognised. This is because in the USA education is not regulated as it is in Australia whereas only registered higher education providers can deliver and award degrees and post graduate qualifications such as Masters degrees and PhDs. Unfortunately those looking for a fast tracked PhD or Masters who are prepared to pay thousands of dollars can, after undertaking some very basic course work, have themselves presented with a qualification albeit one not recognised from a Diploma Mill. The attraction for most is the simple application process, which does not require you to meet the pre-requisites required of registered Universities nor is there a legitimate review process of research or thesis. Simply pay the fees and you are guaranteed within a short period of time with some work at a level usually far below that required from an Australian provider and bingo suddenly you have a PhD. One that falls far short of an equivalent Australian PhD which is why it is not recognised by government, employers or peak bodies. Unfortunately it is not illegal to undertake these courses, however, if you are registered with a peak body such as ACA, APS or AASW then you are unlikely to be able to refer to these qualifications which includes using the title Dr or post nominal PhD. The fact that an Australian counsellor can undertake a PhD for free with the correct pre-requisites through an Australian University begs the question, why would they chose to spend thousands of dollars on an overseas qualification that does not meet any legitimate standards?

In the case of making claims to hold qualifications you simply do not have, you are in clear breach of the Code of Ethics and the HCCC, possibly ASIC, ACCC and potentially some industrial laws. Any insurance you may hold is also quite likely to be invalid. It is possible for a member to make a typo when entering data onto a website or form, however, when this occurs continuously over a period time and not in isolation ACA can not see it as anything less than an intentional attempt to mislead and/or gain advantage by deception. There is no place for people like this in ACA or the mental health industry. It is in every member's own interest to continuously check their web pages, including ACA profile and also any networking sites such as LinkedIn. It is a good idea to google yourself and/or the name of your company to see if any other sites have copied your information across on to their pages. This is quite common of networking sites and they quite often don't inform you, so if you have any incorrect data that will be copied across as well.

The following policy has been put in place by ACA so members can be clear on what is acceptable and what is not in relation to non-Australian qualifications. ACA is happy to receive feedback on this policy.

Non Australian Doctor of Philosophy (PhD) and Doctorates in Counselling/Psychotherapy

The following only applies to PhDs and/or Doctorates in Counselling, Psychotherapy, Family Therapy, Clinical Supervision, School Guidance or Counselling Psychology. PhDs or Doctorates completed through research or course work that cover other similar subjects will need to be assessed individually for relevance prior to being assessed against the following criteria.

The completion of a PhD/Doctorate is a significant achievement in anyone's life and one that should not be minimised through the recognition of overseas PhDs that are not equivalent in content or assessment. Unfortunately the proliferation of non registered training organisations overseas,

particularly in the USA, has seen training providers, commonly called Diploma Mills, offering PhDs that are not equivalent to Australian standards. In many cases these qualifications are determined more by the student's ability to pay than for the work done.

When considering that undertaking a PhD in Australia is free it is curious as to why an Australian citizen would choose to study a non accredited PhD or Doctorate through a web based course provider from overseas for tens of thousands of dollars. Most of these courses have no pre-requisites, are completed in a short period of time, they may not require submitted work to be referenced and articles and research are not published in recognised journals or peer reviewed. Possibly this is the attraction.

In Australia only registered Universities and higher education providers can legally award PhDs and/or Doctorates. This ensures high standards are maintained in relation to Australian qualifications and there is consistency in relation to how the qualification is delivered and assessed. Therefore this policy is not relevant for Australian delivered PhDs or Doctorates.

ACA is accountable for academic standards and public accountability in relation to qualifications it accepts for the registration of counsellors and psychotherapists. The public expects ACA to be diligent when assessing the creditability of qualifications and the training providers who deliver the qualifications. It is only through a rigorous auditing process of transcripts of training and course providers registration with appropriate government departments that ACA can maintain its high reputation as a peak body to government, employer groups and the Australian public. ACA has adopted the following policy to enable the public, employers and ACA members to determine what constitutes an ACA recognised PhD or Doctorate that has been completed outside of Australia. The criteria set by ACA is consistent with other similar peak bodies within Australia.

Currently only registered Universities and Higher Education providers are able to legally deliver PhDs in Australia. Therefore any PhD completed through an Australian University or registered Higher Education Provider that is relevant to counselling/psychotherapy will be recognised by ACA.

Non Australian PhD/Doctorate

The number of years spent studying is not necessarily indicative of the level of comparability. As part of the assessment process ACA takes into consideration the accreditation requirements within the country the qualification was completed and whether the training provider was formally registered and recognised through the Department of Education within that country.

USA

To meet ACA recognition requirements qualifications gained in the United States of America (USA) that are accredited by the Council for Higher Education Accreditation (CHEA) will most likely meet Australian equivalency. PhDs completed in the USA that are delivered by a CHEA accredited Institution are automatically eligible for assessment by ACA. CHEA accredited institutions can be found on the CHEA website http://www.chea.org. A PhD that is gained from a non CHEA accredited institution may be submitted for recognition by ACA if it meets all of the following criteria:

a. Has a prerequisite requirement of the student holding a recognised bachelor degree with Honours or equivalent (a stand-alone graduate Diploma is not considered equivalent) or a recognised Master's degree in counselling, psychotherapy, psychology, mental health, clinical social work or other that is relevant to counselling.
b. The training provider has a physical campus, where they deliver face to face training in the State where they deliver the qualification.
c. Markers and reviewers hold a PhD in counselling, psychology, psychotherapy or clinical social work and all lecturers/tutors hold a minimum Master's degree in counselling, psychology, clinical social work or similar relevant to counselling.
d. The final thesis is reviewed by a minimum of 3 x PhD qualified experts in the field of research that the thesis is in.
e. If a publication and/or book is submitted for recognition towards the PhD it must be a fully referenced text that is published by a recognised publisher of tertiary texts and not be a self-published non referenced publication.
f. PhD must be completed over a period of no less than 3 years full time or 5 years part time.

Europe

A PhD from any country in Europe must be gained from a University or higher education provider that is fully registered and recognised by the Department of Education (or its equivalent) within that country to be recognised by ACA. A PhD gained from a University or higher education provider that is not registered as such within the country it operates must meet the following requirements before it will be assessed by ACA for recognition or otherwise.

a. Has a prerequisite requirement of the student holding a recognised bachelor degree with Honours or equivalent (a stand-alone graduate Diploma is not considered equivalent) or a recognised Master's degree in counselling, psychotherapy, psychology or clinical social work.
b. The training provider has a physical campus (not a shop front or office) where they deliver face to face training.
c. Markers and reviewers hold a PhD in counselling/psychology or clinical social work and all lecturers/tutors hold a minimum Master's degree in counselling, psychology or clinical social work.
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e. If a publication and/or book is submitted for recognition towards the PhD it must be a fully referenced text that is published by a recognised publisher of tertiary texts and not be a self-published non referenced publication.
f. PhD must be completed over a period of no less than 3 years full time or 5 years part time.

Using the title Doctor (Dr) or post nominal PhD: A counsellor/psychotherapist who holds a PhD or Doctorate

EDITORIAL continued …

By Philip Armstrong

in another field eg; administration, engineering, nursing, teaching etc is not to refer to themselves as Doctor or use the post nominal PhD when putting themselves forward as a counsellor/psychotherapist. This includes in social media, the web, documents. marketing material or any other form of communication. In general the public will assume if the title of Doctor or post nominal PhD is used when someone puts themselves forward as a counsellor/psychotherapist that the title would be referring to qualifications awarded in the field of counselling and/or psychotherapy. To intentionally use the title of doctor in such cases would be misleading and could be seen as intentionally attempting to gain an advantage through deception.

Counsellors/psychotherapist's who hold a recognised PhD or Doctorate in another field are encouraged to reflect their well-earned title when not presenting as a counsellor or psychotherapist. Should a holder of a PhD or Doctorate be in a position where they are not directly presenting as a counsellor or psychotherapist such as a website, public meeting etc however it is known they are a practicing counsellor or psychotherapist they must be transparent in what field their PhD or Doctorate is held. Academics are exempt from this policy whilst working within academia however outside of academia they need to be transparent in relation to what field the award of their PhD or Doctorate is in.

Counsellors/psychotherapists who have completed a non accredited PhD or Doctorate as outlined in this document should not refer to themselves as Doctor or use the post nominal PhD at any time whilst in Australia. Prior to using the title Doctor or post nominal PhD overseas you should seek clarification from an appropriate peak body within that country to ascertain whether the qualification thus the titles can be legitimately used.

ACA members who ignore this policy may find themselves placed under an administrative investigation for breaching the ACA code of conduct 3.2(d)i.

Notice: ACA would like to apologise to Karen Daniel for not including her name in her Peer Reviewed article titled 'Boundaries in client-counsellor relationships' which was published in Counselling Australia Volume 14 Number 4 Summer 2014.

TECHNOLOGY UPDATE

With Technology Advisor Dr Angela Lewis

Apps

As we have discussed previously the term 'app' is an abbreviation of the word application and an app is simply a piece of software. While an app can be run on a computer, the term is most commonly used for the software that is loaded onto your smart phone or other electronic device such as an iPad.

Photo editing and digital slimming

The photo editing apps are becoming extremely popular as people them to edit their selfies (photos of themselves) to erase blemishes and wrinkles or to even artificially thin waistlines! Some are free while others may cost a few dollars and most of these types of apps can be downloaded either online or through iTunes. Here's a few that you can explore, or do a Google search for more using terms such as thinify app, beauty editing app or selfie editor app.

- **Perfect365**
- **Facetune**
- **Avairy**
- **Photowonder**
- **Skinny Camera**
- **SkinneePix**

Medicare claim app

Finally a way to avoid going to the Medicare office when you need to make a claim! I haven't downloaded my copy of the app yet, but I'm excited to go ahead and do so! Medicare has launched an app called **Express Plus Medicare**, which is downloaded from iTunes. You need to first create a myGov account at my.gov.au then you can use this ID to set up a pin and starting using the app, which allows you to do most things relating to your Medicare account including claiming benefits (by taking a photo of the bill to be claimed), updating history and requesting duplicate or replacement cards.

Anonymous messaging and secret sharing sites

Anonymous messaging websites or apps allow users to send anonymous emails of their choosing to others. This might be a compliment, a confession of love or lust or something just plain nasty or mean. One of the newest and most popular is called **Leak**, however a quick Google search of 'anonymous emailing' will yield a huge list of websites offering this service.

Secret sharing sites do just that, allowing people to off-load their secrets and confessions into a public forum. The longest secret sharing site is **PostSecret**, which started as an art project in 2005 when it invited people to send an anonymous postcard with a written secret which was then uploaded online. Others include **PenCourage** and **Whisper**.

What is an e-signature?

Said simply, an e-signature is your signature on a digital document. It can come in the form of an image of your signature, your name typed out, or increasingly common, your name signed with your mouse or even your finger on your device's screen.

PowerPoint and Pechauchka

While this might sound like one of the Pokemon characters, **Pechakucha** is a Japanese term meaning 'chit-chat' (pronounced petch-a-koo-cha). It was developed into a presentation methodology by a couple of architects and is based around the concept of a PowerPoint presentation being limited to 20 slides, with each being displayed for only 20 seconds each (so 6 minutes and 40 seconds in total). The slides should be based on an image and the facilitator or speaker narrates or speaks to the image, rather than reading off notes or off the slide itself. Anyone that has read my previous articles on good PowerPoint presentations published previously in the journal, will recognise some of the basic tenants of Pechauchka are inherent to the basic rules of a good presentation. These include not reading off the slide, keeping text to a minimum and using imagery to deliver the message. I personally find the Pechauchka methodology (if followed to the letter) to be far too limiting on the presentor, and I believe it should be used conceptually rather than rigidly. For more on how to create a PechaKucha presentation, just do a search on Google.

For more tips, hints and reference material on technology and social media, visit me at www.angelalewis.com.au

Terms

Fitspo
Selfies of fit bodies for 'fit inspiration'.

Healthy selfie
Selfies posted of healthy foods or activities.

Thinify
Using an app to make you appear thinner in pictures.

Problem-solving counselling

By Michael Neenan

PEER REVIEWED ARTICLE

Problem-solving counselling programmes, designed to teach individuals social, workplace or interpersonal skills, have increased in the last 30 years. Here Michael Neenan and Stephan Palmer describe an approach which tackles both the emotional and practical aspects of a problem.

Problem-solving is a structured and systematic method of teaching clients to identify current problems or stressors in their lives and then learn a series of graduated steps or skills in order to tackle these difficulties. Programmes designed to teach individuals social, workplace or interpersonal problem-solving skills have increased in the last three decades (e.g. D'Zurilla and Golfried, 1971; D'Zurilla, 1986; Palmer; 1997). These problem-solving approaches have in common a number of sequential steps that include problem definition, generation of alternative problem definition, generation of alternative problem-solving methods, decision-making and evaluation of the chosen course(s) of action.

The problem-solving counselling we describe here is a double-headed or dual systems approach, i.e. tackling the emotional and practical aspects of a problem. As Walen, et al (1992, p. 52) observe: "Dealing with the emotional problems gets rid of emotional disturbance; dealing with practical problems leads to self-actualisation and improvements in the patient's quality of life. Both are important."

The emotional problem is tackled first as clients are not usually effective practical problem-solvers when they are emotionally disturbed. For example, a man who is depressed (emotional problem) about his lack of friends (practical problem) fails to develop a social network. This is because his view of himself as unlikeable and unattractive militates against making any successful social overtures. By helping him to challenge and change his negative self-image and depressagenic thinking, he is then able to focus his restored energies on initiating the necessary practical measures (e.g. joining a singles group, adventure weekends) in order to provide opportunities to find a suitable partner.

The dual systems approach to problem-solving we practice is essentially a cognitive-behavioural one because it emphasises the significant impact our thinking has on our emotions and behaviour. The specific cognitive-behavioural model we employ for emotional problem-solving is Ellis' (1994) rational emotive behaviour therapy (REBT); the model for practical problem-solving is the one proposed by Wasik (1984). The ultimate aim of this dual systems approach is to teach clients to become their own counsellors or problem solvers.

Emotional problem solving

The cornerstone of REBT rests on the assumption that individuals are not so much disturbed by events as by the views they take of these events (Ellis and Bernard, 1985). For example, two people fail the same job interview: the first person is disappointed but realises that nobody has to give him a job and thereby dips on applying for other ones; the second person becomes depressed and angry because he believes he absolutely should have got the job and the interview panel have revealed his worthlessness by not appointing him – he now concludes that it is futile to apply for any more jobs.

The ABCDE model of emotional disturbance and change presents clients with a means of understanding and tackling their emotional problems:

A = activating event (past, present or future, internal or external)

Being passed over for promotion

B = beliefs in the form of rigid and absolute musts, shoulds, have-tos, got-tos, oughts

'I absolutely should have been promoted, its not fair.'

C = emotional and behavioural consequences

Hurt and withdrawal ('sulking') leading to both decreased productivity and interpersonal contact at work

D = disputing the client's rigid beliefs that produce her emotional and behavioural reactions at C

'Just because I very much wanted the promotion there is no reason why I have to get it.. Too bad that I didn't. I'd better

stop moping about and get on with the job I have got.'

E = a new and effective rational outlook based on flexible thinking which reverses the workplace decline and ameliorates the disturbed feelings noted at C.

From the REBT viewpoint it is B rather than A that determines C (though it is important to emphasise the significant contribution that A brings to C). This is known as emotional responsibility, whereby the individual accepts that her emotional problems are largely determined by her rigid beliefs. In order to achieve E, the client usually has a lot of hard work (homework) to carry out through the disputing (D) process. This is known as therapeutic responsibility. The use of the ABCDE model is illustrated in the following case study.

John – a case study

John had been referred by his GP for anxiety and stress. He was a 32-year-old single man who lived in a block of flats. He worked part-time in a local supermarket and described his life as 'quiet and uneventful' with few friends and little social life. However, his 'quiet' life was frequently shattered by the couple in the next flat who played their music loudly and for long periods. He described himself as 'always being on edge' when at home and felt ashamed that he was not able to confront the couple in the next flat. The therapist was keen to find out what prevented him form doing this:

Client: I'd get anxious if I went next door.

Therapist: Because....?

Client: They wouldn't pay any attention to me. They'd laugh at me or tell me to 'get lost'.

Therapist: And if they said or did those things, what then?

Client: Well, all the sneering and horrible looks I'd get from them on the stairs, meeting them in the hallway or in the car-park outside. I did once ask them to turn the music down and that's how they responded.

Therapist: And what are you anxious about if they do behave like that.

Client: I'd feel very uncomfortable knowing how much they dislike me or that they're laughing at me. I don't want to feel like that. I try to avoid any arguments or unpleasantness in my dealings with other people.

Therapist: Is that what you are most anxious about: that you wouldn't be able to cope with the intense personal discomfort you would experience if you confronted them?

Client: Yes, that's it. I just want a quiet life.

Therapist: That seems to be precisely what you're not getting at the moment.

The therapist has located the reason John's anxiety (C) blocks him form taking any effective action with his noisy neighbours (A) – his avoidance of interpersonal tensions or conflict. In REBT, this is hypothesised as low frustration tolerance (LFT) or discomfort anxiety, i.e. the worry individuals experience when anticipating pain, discomfort, agitation, unpleasantness, etc.

Implicit or explicit in this anxiety is a demand that the anticipated discomfort must not be too great, otherwise it will be unbearable. This point of view is offered to the client:

Client: That sounds a lot like me. I'm always trying to avoid unpleasantness in my life because I believe I can't cope with it but avoidance doesn't make me any happier.

Therapist: So how would you state your belief in precise terms so we are both clear what it is that you what to change?

Client: I must avoid at all costs any unpleasantness or conflict with other people because I just can't cope with it (B).

Therapist: In the case of your noisy neighbours, would you be interested in working with me to lower your anxiety and increase your ability to cope with this difficult situation by challenging and changing that belief?

Client: I suppose I need to do something about this situation but I just can't go round there now and have it out with them.

Therapist: I'm not asking you to do that. Let's first deal with the ideas that drive your anxiety because they prevent you from taking effective action with the couple next door.

Client: OK, I've got nothing to lose but my mind if that music doesn't stop.

During subsequent sessions John agreed to undertake a variety of homework or self-help assignments in order to weaken his disturbance-producing beliefs and strengthen his newly emerging emotional problem-solving beliefs ('I don't like these unpleasant situations or feelings but I can learn to deal with them better):

Cognitive tasks compiling a list of the advantages and disadvantages of not tackling his problem and then revisiting the advantages to examine whether they were genuinely advantageous; reading a self-help book which encourages individuals to court and tolerate discomfort in order to achieve their goals (Dryden and Gordon, 1993).

Behavioural tasks undertaking a series of 'stay-in there' exercises (Grieger and Boyd, 1980) which consisted of remaining in situations he usually avoided in order to work through his disturbed thoughts and feelings, e.g. visiting his parents who nearly always criticised him for not 'getting on in life', going to the dentist for a much delayed check-up.

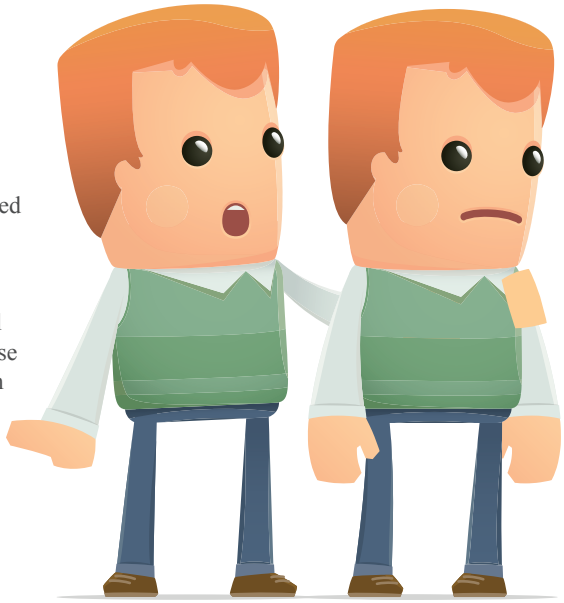
Emotive tasks engaging in shame-attacking exercises (Ellis, 1969). As John said he felt ashamed of himself – 'I'm weak and pathetic for not standing up to them'. These exercises teach clients to expose themselves for their perceived defects and to distinguish between criticising a behaviour or trait but not condemning themselves on the basis of it. Exercises that he carried out included asking directions to the local railway station while standing outside it and walking down the road with an umbrella open when it was not raining. After eight sessions of tackling successfully the emotional aspects of his problem, John then focused on its practical aspects.

Practical problem solving

He said that he wasn't always sure what to do when he had practical problems to deal with and this often meant he ended up with more rather than fewer problems. The model taught to him was Wasik's (1984) seven-step problem-solving approach which includes self-questioning:

1. Problem identification *What is the concern?*

2. Goal selection *What do I want?*



3. Generation of alternatives *What can I do?*
4. Consideration of consequences *What might happen?*
5. Decision making *What is my decision?*
6. Implementation *Now do it!*
7. Evaluation *Did it work?*

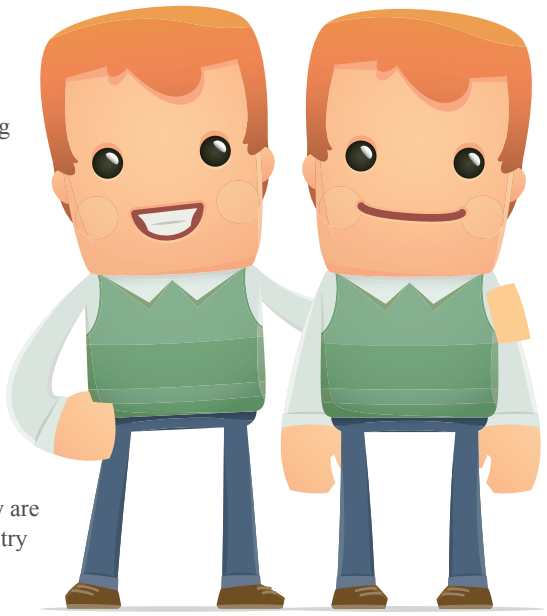
Step 1 John's obvious problem was his noisy neighbours who made his home life unpleasant. This was the biggest current problem in his life (if he had a multitude of difficulties to be addressed then a problem list would have been drawn up).
Step 2 His goal was to find some means of influencing his neighbours to reduce their music playing to a more tolerable level – 'so that I no longer feel I'm living in the same flat as them'.
Step 3 Here John was encouraged to come up with as many possible solutions to his problem no matter how ludicrous or unrealistic some of them initially appeared; in other words, to brainstorm. At first, he had trouble suggesting solutions, so the therapist offered some as a means of prompting him and then he produced these:

a. Ask the council for a transfer.
b. Let their car tyres down.
c. Knock on their door every time they play their music too loud and ask them to turn it down. Be persistent.
d. Find out the council's rules and regulations regarding the playing music and what enforcement powers they have.
e. Ask the other neighbours if they are upset over the music levels and try to get up a petition.
f. Blast them out with music!
g. Let the noisy couple know what my plan of action will be if they ignore me.

Step 4 This involved John considering the advantages and disadvantages of each solution produced from the brainstorming session. The client may wish to rate the plausibility of each possible solution on a scale of 0-10: where 0 is the least plausible and 10 the most plausible:

a. 'It's running, or literally, moving away from the problem. I've done too much of that in my life.' (1)
b. 'Too childish and may make the situation worse.' (1)
c. 'This sounds more like it. It will be hard for me to do that but if I don't, I'm never going to get any peace. Stand up and be counted.' (8)
d. 'This is a very sensible step and I will contact them if the couple don't turn down their music.' (7)
e. 'If there are other people in the block who are also fed up with the music, then force of numbers either through a petition or knocking on their door might prevail.' (6)
f . 'A non-starter then I'll get a double dose of loud noise.' (0)
g. 'I'll certainly use this tactic if I get no satisfaction from them.' (6)

Step 5 John now chose which solution to pursue based upon the calculus of probable success decided in the previous step: 'I'll start with c, and fall back on d, e and g if the going gets really tough'.
Step 6 This involved role-play: the therapist took on the role of one of the neighbours while John made repeated requests to him to turn the music down. John's voice faltered at times and he often looked down at the floor. Coming out of the role-play, the therapist commented upon John's indecisive manner and changes were made in his inter-actional approach. John then practised the new behaviour in the session as well as agreeing to act it out in imagery for a homework task. The therapist can also prompt the client to suggest ways of handling the situation if setbacks occur (they usually do).



Step 7 At the next session, which is after the client has carried out the agreed solution, therapist and client evaluated its outcome:
Therapist: How did you get on?
Client: They're still playing their music too loud but the good news is that every time they do that I've been straight round there to complain.
Therapist: And how did they respond?
Client: As expected: rude, slammed the door in my face sometimes and, at other times, didn't even bother answering it.
Therapist: Any threats of physical violence?
Client: No, but if there are, I will immediately call the police which I didn't put on last week's list.
Therapist: Were there any moments or times when you wanted to forget the whole thing?
Client: On several occasions. The old ideas came back.
Therapist: Such as....?
Client: 'I can't stand all this unpleasantness. Why won't it go away? I just want a quiet, uneventful life.'
Therapist: How did you deal with those ideas?
Client: As you taught me in the earlier part of therapy – vigorously dispute them.
Therapist: Did it work?
Client: Yes, it did. I told myself to stop running away when things become unpleasant or difficult in my life and see the problem through to the bitter end. I think I'm beginning to get some backbone.
Therapist: It's good to hear you're making progress. So what's the next step with the noisy neighbours?
Client: Well, I told them yesterday that I've had enough and I'm officially complaining to the council and demanding that action be taken. I'll also be seeking the views of other residents.
Therapist: How does it feel to be doing all that?
Client: To be honest, I feel quite proud of myself. At last I'm really carrying something through.

In the following weeks, John reported that the music level of these neighbours had dropped appreciably. 'They still give me icy stares when they see me but I can live with that.' Another benefit he enjoyed was that he finally got to know and became friendly with other residents in the block of flats: 'We were strangers until I knocked on their doors.'

The practical problem-solving section of counselling had lasted for five sessions. To return to step 7, if the proposed solution(s) has been successful, the client can then pick another problem from his list and follow steps 1-6 again.

Ending

Now that he had success in one area of his life, John said he had experienced a

'sea change' in his outlook and wanted to do more with his life such as leaving his part-time job in the supermarket and pursuing 'a career that will be interesting and challenging for me in ways which the supermarket has never been'. He also wanted a more exciting social life and now felt he had the confidence to meet people and make more friends. Follow-up appointments were arranged for three, six and 12 months to monitor his progress in maintaining his therapeutic gains as well as finding out about the other developments in his life.

In conclusion

Problem-solving counselling is a psychoeducational approach that teaches clients how to remediate their present problems and prevent or reduce the occurrence of future ones. It is an approach that can be used in a variety of clinical settings (e.g. schools, colleges, industry). Problem-solving counselling is ideally suited to brief therapy regimes used in, for example, employee assistance programmes and general practice. Whether the emphasis is on emotional problem-solving or practical problem-solving or both, we believe that this approach has a great potential for helping individuals to accelerate the process of change in their lives and adapt more effectively to the increasing demands of a complex society.

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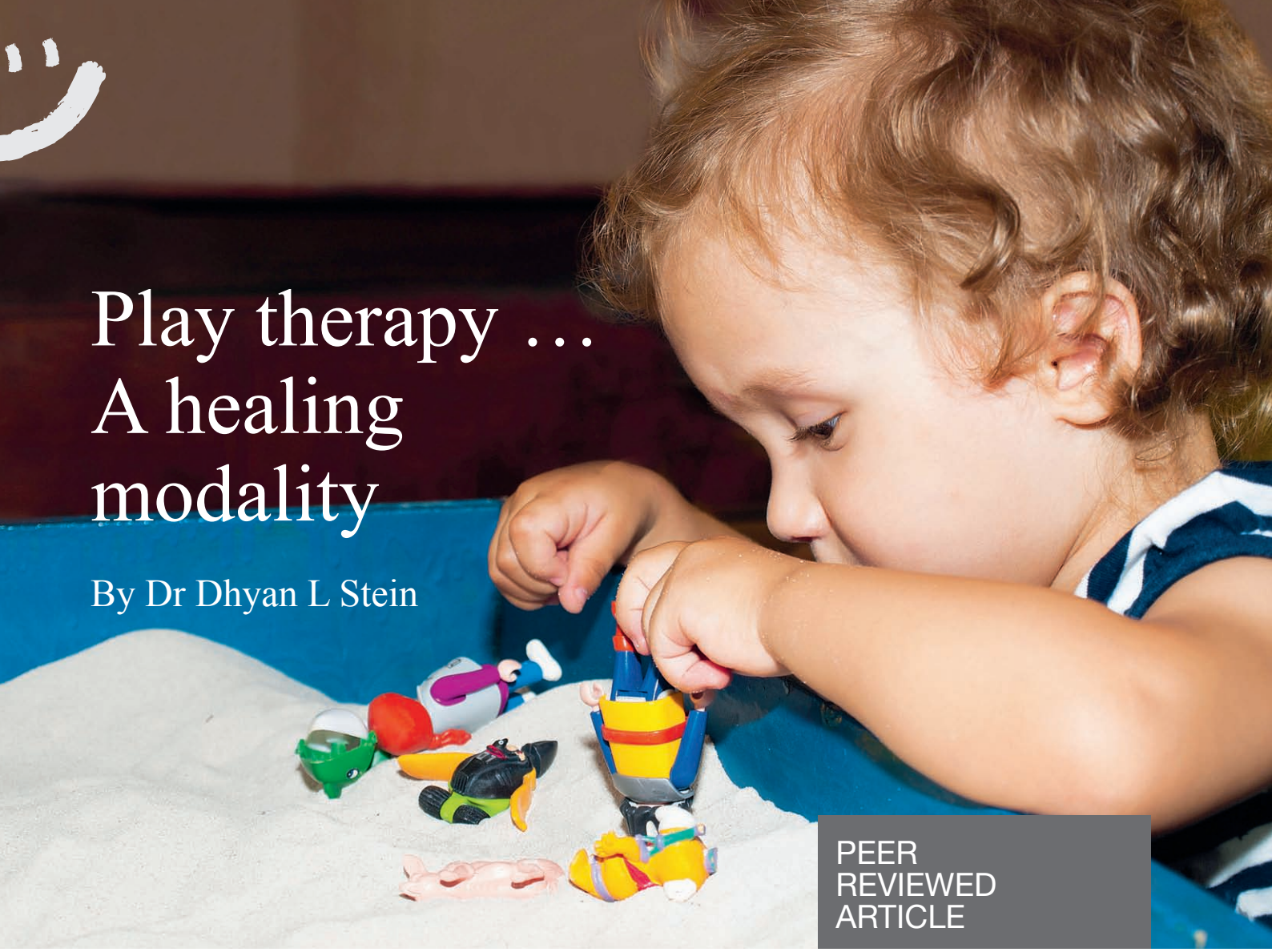

Play therapy … A healing modality

By Dr Dhyan L Stein

PEER REVIEWED ARTICLE

Introduction

This article constitutes an introduction to the precepts of play therapy, an evidenced-based effective intervention used for a wide range of childhood emotional, behavioural, social and psychological difficulties (Reddy, Files-Hall & Schaefer, 2005). Initially, the importance of play as immutable to child development is discussed. Additionally the role of play as a therapeutic modality is explored, highlighting its rationale. Definitional notions articulated by international organisations committed to regulating the practice of play therapy are also reviewed. A history of trends in play therapy that indicates its nexus with diverse mental health modalities is presented. Finally, commonalities and differences in approaches are examined based on whether the therapist assumes a directive or non-directive role.

Importance of play

Professional interest in play therapy as a healing modality has grown steadily over the past decade, driven in part by the recognition that children between the age of three and twelve increasingly require substantive mental health support (Homeyer & Morrison, 2008). Indeed it is suggested that the therapeutic needs of children in this domain are approaching crisis level. Statistics espoused by the World Health Organisation (2005) contend that twenty per cent of children suffer from disabling mental health problems (Bratton, Ray, Rhine, & Jones, 2005).

In response to this trend the United Nations High Commissioner for Human Rights identifies play as an inalienable right of all children that is required for optimum growth (1989). This position supports key developmental theorists such as Piaget (1962), Erikson (1963) and Vygotsky (1978) who assert that the human trajectory is critically mediated by caregivers relating to children through the medium of play (Eccles & Templeton, 2002). Moreover recent developments in neuroscience suggest that children with few opportunities to engage in play restrict the neural connectivity, plasticity and pathway development within the brain which is essential for learning (Sutton-Smith 1997, p. 17).

In terms of informed commentary, there is general agreement that children use play to develop imagination, dexterity as well as physical, cognitive and emotional strength (Ginsburg, 2007). Significantly, Freud (1945, p.45) postulates that a child at play behaves "like an imaginative writer that creates a world of his own, or more truly, arranges this world and orders it in a new way that pleases him better". Frank (1982) concludes that play is how children learn what no one can teach them … expressing their emotions and thoughts in play … rehearsing their behaviours in play … exerting their will in play … moving through developmental stages with play … and learning with play.

Esteemed contemporary play therapists such as Landreth and Homeyer (1998) argue that play constitutes the singular, central activity of childhood that occurs at all times and in all places. Additionally, Woltmann (1964) contends that play furnishes children with multiple opportunities to 'act out' situations that are disturbing, conflicting, and confusing.

Thus given that play is viewed as central to human development, a growing number of mental health professionals contend that this activity embodies a valuable resource to be utilised for healing purposes (Gil & Drewes, 2005). Whilst a detailed discussion of this notion is beyond

the parameters of this article, a brief review of the rationale underpinning this contention follows.

Rationale for play therapy

Landreth (2002) argues that the therapeutic use of play has the potential to expand child self-expression, self-knowledge, self-actualisation and self-efficacy. Schaefer (1993) maintains play therapy relieves stress and boredom, stimulates interpersonal connection, creative thinking and internal and exploration. Gil (1991) emphasises therapists utilise play strategically to help children express thoughts and feelings as their language facility is limited. Moreover, a positive relationship between therapist and child implementing play therapy may provide a corrective emotional experience that is curative (Moustakas, 1997). O'Connor and Schaefer (1983) also posit that play therapy promotes cognitive development, insight, and conflict resolution.

Nevertheless, despite this broad applicability, it is important to recognise that play therapy is a structured modality that implements a large number of treatment methods. This is based on the premise that play therapists are trained mental health professionals who use children's play as the basis of different kinds of therapeutic interaction. As the history of play therapy parallels the development of the mental health field, this practice reflects a broad and diverse domain of directive and non-directive praxis that is subject to ongoing change. Whilst full details tracing its development are beyond the scope of this discussion, a brief historic overview points to its reliance on varied trends within the domain of mental health (Bratton & Ferebee. 1999).

In the early twentieth century, Freud (1928) and Klein (1932) applied psychoanalysis to children whilst Lowenfeld (1935) developed sand play therapy to enhance understandings of the child's phenomenological world. Axline (1947), Guerney (1983) and Landreth (2002) popularised child-centred play whilst Moustakas (1959) extended their ideas to introduce relationship play therapy. In addition, Allan (1988) initiated Jungian-based play therapy and Oaklander (1988) developed its gestalt-based equivalent. Contemporarily, Knell (1993) honed cognitive behavioral play therapy whilst Kottman (2003) brought Adlerian psychology to play therapy. Dynamic family play therapy stems from the efforts of Harvey (2006) whilst Jernberg's (1979) Theraplay and O'Connor's (1997) ecosystemic play therapy have received recent critical acclaim.

Significantly, this surfeit of therapeutic methods is paralleled by a plethora of definitional notions that attempt to capture the meaning of play therapy. As an understanding of this construct constitutes the major focus of this article, a review of these definitions forms the next task of this review.

Definitional notions

There is general agreement that play therapy is a form of counselling used to ameliorate the social, emotional and behavioural problems of children. Furthermore it is commonly accepted that play therapy enables children to use toys, art supplies and sensory media to communicate their thoughts and feelings through action rather than words. The views of associations that regulate play therapy praxis are instructive on how this is achieved (Bratton, Ray, Rhine, & Jones, 2005).

The website of the Australian Play Therapy Association (APTA, 2015) states that play is the child's natural medium of self-expression and an "opportunity to 'play out' feelings and problems." This is achieved through the specialised skills of a trained play therapist who enables the child "to enter into a therapeutic relationship wherein the child can safely express, explore and make sense of their difficult and sometimes painful life experiences."

Alternatively in the United States, the Association for Play Therapy (APT, 2015) website defines play therapy as:

> "the systematic use of a theoretical model to establish an interpersonal process wherein trained play therapists use the therapeutic powers of play to help clients prevent or resolve psychosocial difficulties and achieve optimal growth and development."

In a more detailed explication the British Association of Play Therapists (BAPT, 1996) defines play therapy as:

> "the dynamic process between child and play therapist in which the child explores at his or her own pace and with his or her own agenda those issues, past and current, conscious and unconscious, that are effecting the child's life in the present. The child's inner resources are enabled by the therapeutic alliance to bring about growth and change. Play Therapy is child-centred, in which play is the primary

medium and speech is the secondary medium. Play Therapy encompasses many approaches but the foundation of all approaches is child-centred."

Commonalities in client-centred approaches

Although these explications of play therapy processes appear dissimilar, they share common features. Specifically, all these statements privilege the therapeutic relationship and the process of play as informants of therapeutic change. Play is constructed as a way of being with the child that honors their uniqueness in the context of their developmental stage (Landreth, 2002). Additionally, these models are heavily influenced by Rogers' (1989) client centred humanism significantly refined by Axeline (1964) and Landreth. As this approach views play as a metaphor, it acknowledges that the subtleties of verbal communication are beyond the reach of children.

This perspective also maintains the symbolism of play and avoids challenging it or interpreting it. It also recognises that children straddle their internal and external worlds through bridging the perceptual and the imaginary. Thus the play therapist attunes to children's communication by engaging with their creativity through enactment and projective play. This empowers children to find meaning and resilience through the expression of difficult feelings in a contained, safe therapeutic space. Over time this process leads children to gain enhanced understandings of themselves and others (Schaefer, 1993).

However, these commonalities exemplify a non-directive approach to play therapy extensively articulated by Axline (1947). She proposes that the therapist develops a warm, friendly relationship with the child and accepts the child exactly as they are. This facilitates free expression of feelings by establishing a sense of permissiveness that encourages the development of insight by reflecting the child's feelings. Additionally, the therapist respects the child's ability to solve their problems, make choices, and institute change. The therapist refrains from directing the child's actions or conversation and allows therapy to be a gradual, unhurried process. The therapist also establishes only those limitations that are necessary to anchor the therapy to the real world and encourage the child to be responsible in the therapeutic relationship (Schaefer & Carey, 1994).

Differences in directive play therapy approaches

By way of contrast, directive play therapy is guided by the belief that instructions guiding the child through play generate more rapid change than nondirective approaches. The therapist plays a bigger role in this context, implementing several techniques to engage the child. This might include playing with the child themselves or suggesting new topics instead of letting the child direct the conversation. Stories read by directive therapists are more likely to have an underlying purpose. Such therapists are also more likely to create interpretations of stories that children tell. In directive therapy, games are chosen for children who are given themes and character profiles when engaging in doll or puppet activities. Although this way of working still leaves room for children's free expression, it is more structured than nondirective play therapy. Moreover different techniques are used in directive play therapy, including sand tray therapy and cognitive behavioral play therapy (Bratton, Ray, Rhine, & Jones, 2005).

Conclusion

This paper portrays play therapy as a dynamic, growing field that seeks to meet the mental health needs of children. The evolution of national professional play therapy associations is a feature of this trend. These focus on the development of adequately trained play therapists and the establishment of minimum training standards (Wilson & Ryan, 2001). Thus the meaning of play therapy, its rationale and definitional notions as well as the commonalities and differences between models are the subject of ongoing debate. It is hoped that members of the Australian Counselling Association will contribute to this discourse.

Dr Dhyan Stein PhD (Psychology) is a mental health clinician of more than fifteen years standing. Although she has extensive experience working with adults as a counsellor and psychotherapist, in recent years she has begun to work therapeutically with children, adolescents and families. Although Dhyan is currently employed as a senior social worker with the West Australian Child and Adolescent Mental Health Service, she also works in her private practice as a child centred play therapist. Although Dhyan primarily views herself as a mental health practitioner, she also has an ongoing commitment to lifelong learning evidenced in her diverse postgraduate education and research interests.

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Adolescent grief: the forgotten ones

By Ainsley Brennan

PEER REVIEWED ARTICLE

Dealing with grief is like trying to live with an amputation. You do heal, but you are never the same' (Kendrick, 2011). A journal article by Lenhardt (2000) titled 'Adolescent unresolved grief in response to the death of a mother,' highlights that adolescent grievers are 'the forgotten ones.' This occurs as adolescents are often grouped with younger children or adults, while their own unique grieving style goes unrecognised (Kubler-Ross as cited in Lenhardt, 2000). Grief for an adolescent is different to that of children and adults. For example, Noppe (2004) posits that it would be wrong to assume an adolescent's concept of death is the same as adults. Adults view death through the lens of wisdom and life experience. Furthermore, teens think abstractly like adults but do not have the same emotional maturity; therefore their grief response is very different from adults (Backlund, 1991). Moreover, adolescents are especially vulnerable to loss since their ego is still evolving and their range of coping skills are not fully developed (Backlund, 1991). Indeed, to treat adolescents like adults or children may actually hinder their grieving process (Noppe, 2004).

Adolescent development and psychosocial stage

Adolescence is known as the transitional period between childhood and adulthood, between the ages of 12-20 (Rider, 2012). According to Erikson (1963), individuation and separation are the primary developmental tasks of adolescence (as cited in Hooyman, 2006). Early adolescence is characterised by a mix of pulling away from the family, rebelling and wanting to be "cool" and hanging out with friends. This stage also includes intense emotional outbursts, alternating between expressing love and hatred towards parents (Hooyman, 2006). Bacho (1995), states that the adolescent self in transition is vulnerable confused and conflicted.

Erikson's psychosocial theory focuses on eight major conflict stages of personality development. Each stage is characterised by a different conflict that must be resolved by the individual (Cramer, 1997). Only when each crisis is resolved does the person have sufficient strength to deal with the next stage (Cramer, 1997). Erikson uses the word 'crisis' to describe a series of internal conflicts that are linked to developmental stages (Oswalt, 2013). The way a person resolves the 'crisis' will determine their personal identity and future development (Oswalt, 2013). Moreover, if a person is unable to resolve a conflict at a particular stage, they will confront and struggle with it later on in life (Cramer, 1997). Stage five of Erikson's (1963) psychosocial developmental stage for adolescence is called 'identity versus role confusion' (as cited in Rider, 2012). This is a time when an adolescent is trying to forge an independent identity separate from that of their parents (as cited in Rider, 2012). However, Erikson explains that while an adolescent is asserting their independence, it is imperative that they have the stability and security of their parents to return to (as cited in Lenhardt, 2000). However, a parent's death makes that separation complete, final and irreversible (Hooyman, 2006). Consequently, a parent's death can often interfere with the adolescent's inner search for identity and complicate their grieving process making it possible for the adolescent to become 'stuck' in a development 'crisis' (Oswalt, A. 2013).

Adolescent grieving style

Adolescent grief is complex and can be presented in short outbursts followed by the use of withdrawal, denial and avoidance to self-protect. According to Lenhardt (2000), adolescents are a distinct group with very specific developmental needs that complicate the normal grieving process. Sussilo (2005) concedes that "the untimely death of a parent is experienced as an incomprehensible and overwhelming assault that strikes at the core of the adolescent's intra-psychic and external world" (p.499). Also reported, was more anger at the deceased, sleep disturbances, dream activity and irritability than the adults (Geldard & Geldard, 1999).

Ways an adolescent may attempt to cope with their overwhelming grief may be through the use of drugs or alcohol, self harming or risk taking behaviour. It is not uncommon for the grieving adolescent female to desperately yearn for that re-attachment of unconditional love and therefore find themselves pregnant in late adolescence.

Adolescent issues that hinder the grieving process and the consequences

Adolescents have four main issues that can hinder their grieving process and result in them being 'stuck' in grief.

1. Firstly, adolescents want to be accepted and have a strong need to belong and not be different from their peers (Dalton, 2006). As a result, many teens do not want people to feel sorry for them or to be treated differently from their friends. For some, to grieve publicly in front of their friends only reinforces that they are different and have become 'that kid' whose mother or father has died. Subsequently, the adolescent grieving 'style' of denying and avoiding their grief may also result in becoming 'stuck' in a developmental crisis or result in complicated grief (Dalton, 2006). Indeed, this form of grieving behaviour may result in delinquent or depressive behaviour (Dalton, 2006). Consequently the adolescent will struggle to develop into an emotionally mature adult and may have mental health issues later on in life (Oswalt, 2013). Cramer (1997) concedes that if a person is unable to resolve a conflict at a particular stage, they will confront and struggle with it later on in life (Cramer, 1997).
2. In addition to the adolescent wanting to 'appear normal' in front of their friends they may also be dealing with guilt and shame. Often during adolescence the teen is rebelling and often as stated by Hooyman (2006), is expressing hatred towards their parents. Once the parent has died, this can make the bereaved teen feel incredibly guilty for the way they

have treated their parent prior to their death. Teens are often not aware that their adolescent behaviour is normal for their developmental stage and therefore are filled with incredible guilt and shame for the way that they treated the now deceased parent. According to a recent study it was reported that many adolescents felt that their "...bereavement process was hindered by intrusive thoughts and feelings of guilt and shame" (Hooyman, 2006, p.174). This guilt can present itself through depression, anger and nightmares.

3. Another aspect to be aware of is that often after a parent has died, the teen is expected to step into the role of the parent who has died. For daughters whose mothers have died, they are sometimes expected to cook, clean and look after younger siblings. For sons whose fathers have died they are expected to be the man of the house, to provide for the family and undertake manly chores. This can further amplify the already confused adolescent as they search for meaning and identity.

4. According to mid-life adults who had lost a parent during adolescence, they found transitioning into early adulthood difficult. This often coincides with the adolescent getting married and starting a family of their own. This can often 'trigger' a fear that the same thing will happen again. Also once the adolescent becomes a parent themselves this can often bring up feelings of loss at not having the missing parent at their wedding or the birth of their first child. This is also a time when the adolescent has now matured and sees their peers enjoying a close relationship and friendship with their parents. In addition, throughout their life cycle, other traumas or grief can re-trigger the trauma of the early adolescent loss, often presenting itself as anxiety or depression.

A programme evaluation conducted by Shaffer (2007) on the success of a programme entitled 'growing through loss' focused on 300 incarcerated teenagers in California who had experienced a recent loss. This study revealed that 98% of the adolescents who completed the 12 session programme showed a reduction in depressive symptoms and greater integration of their loss into their lives. The study by Shaffer (2007) also revealed that unless the adolescent is given proper attention and grief support that the loss may affect them later in life. Hooyman (2006) concedes that the lack of support from peers and adults can complicate an adolescent's grief process. In addition, Hooyman (2006) further explains that counsellors need to understand the distinctive developmental tasks so they can support and understand the distinctive ways an adolescent expresses their grief (Hooyman, 2006). Finally Shaffer (2007) posits that little support and very few resources are available for grieving adolescents.

An Australian study conducted by Cubis and colleagues (1990) revealed the impact parental loss had on the social and emotional development of an adolescent. The data revealed a pattern of poorer adjustment of adolescents who had lost a parent, as well as lower self esteem. The data also revealed more emotional problems and higher rates of mental health concerns in teens that had lost a parent (Cubis et al., 1990). Furthermore, this study demonstrated that parental death did impact on adolescent development (Cubis et al., 1990). In addition, Noppe (2004) states that bereaved adolescents may follow a life-long developmental trajectory and continue to feel the loss throughout their lifespan. A further study by Speisman (2006) suggests that unsupported childhood grief can lead to adulthood depressive symptoms. According to Kivalae (2006), the psychological and emotional trauma that develops due to an early parental loss are directly related to depression in adults (as cited in Speisman, 2006). These studies are limited in the fact that they relate to early childhood bereavement and fail to take into account the specific adolescent age group.

Research by Hurd (1999) on adults that experienced childhood bereavement revealed that two thirds of participants were clinically depressed at some time from late adolescence up to the present time. The study was conducted on 43 middle aged adults, consisting of 32 woman and 11 men aged between 23-56. This study also revealed that most of the participants still suffer emotionally from their experience of bereavement as a child.

The data revealed a pattern of poorer adjustment of adolescents who had lost a parent, as well as lower self- esteem. The data also revealed more emotional problems and higher rates of mental health concerns in teens that had lost a parent (Cubis et al., 1990). Bowlby further confirms this stating that there is strong evidence of the relationship between acute loss and increased vulnerability to psychiatric disorders and an important factor in adult depression (as cited in Holmes, 1993). Finally it is interesting to note that according to Rubin (1999) the loss of a [parent] will generally cause permanent effects in personality and /or life course of the bereaved individual.

Adolescent interventions

Interventions may be required to address the four specific needs of the adolescent griever: peer approval, guilt and shame, identity crisis, early adulthood transition.

- Adolescent grief peer group work or to create a space with other adolescents where one can feel accepted and safe to express their grief, thus removing the need to deny their grief and in turn perhaps avoiding complicated grief and other complications.
- To facilitate a safe space for the grieving teen to express their guilt and shame. Giving them the opportunity to say sorry and goodbye to the deceased parent, by way of Gestault empty chair, or use of visualisation or letter writing to parent. It is important to encourage them to express their feelings and say good-bye (Hooyman, 2006).
- To reinforce to the teen a sense of who they are and explore with them their values, beliefs and goals for the future.
- In addition, a therapist needs to 'check in' with the adolescent again upon transitioning into young adulthood. This often coincides with the adolescent starting a family of their own. This can often 'trigger' a fear that the same thing will happen again. Also once the adolescent becomes a parent themselves this can often bring up a feeling of loss at not having the missing parent around to ask for help and advice.

Other forms of grief therapy may be different forms of art therapy, such as drawing, painting, song writing, symbol work and story writing just to name a few (Geldard & Geldard, 1999). Other work may include grief work, resilience and self esteem.

When possible, such as when the parent is known to be 'dying' the parent may like to facilitate with a therapist or close family member a 'living message' to the adolescent. Armed with the knowledge of the four issues that can complicate an adolescents grief, the parent may address those issue to the adolescent. Thus

reducing any feelings of guilt or shame that may arise after the parents death. The living message may also allow the adolescent a smoother transition through their grief process.

In conclusion, this article has bought awareness to the unique grieving style of the adolescent. The adolescent world was then explored through the lens of Erikson's psychosocial development stage. The adolescent's distinctive grieving style was presented which included their need to 'fit in' with their peers, which may result in denying their grief. Secondly the guilt and shame they may feel about the way they treated their parent prior to their death. Thirdly the adolescent may feel forced into the parental role following the death of the parent, thus complicating their search for identity. Lastly, follow up with the adolescent as they transition into young adulthood, a stage that may trigger feelings relating to the loss of their parent. Research revealed the need for specific adolescent grief work and the impact unresolved and complicated grief may have on the adolescent.

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The efficacy of the twelve-step facilitation therapy for alcohol problems

By Derek Botha

PEER REVIEWED ARTICLE

Abstract: In a review of the literature, it was found that only four studies have used randomised controlled trials in attempts to determine the efficacy of the twelve-step facilitation therapy for alcohol problems. All four studies failed to support the purported comparative efficacy of the twelve-step facilitation therapy. This article briefly analyses the nature and results of these studies, and investigates the nature of the factors relating to the twelve-step facilitation therapy (Alcoholics Anonymous twelve steps and twelve traditions) that may have contributed to the limited research on alcohol problems using randomised controlled trials, and to the results. It is found that, unlike many of the other treatment modalities evaluated by researchers, such as cognitive-behavioural therapy and motivational enhancement therapy, the philosophy, ideas, rituals and beliefs of the twelve-step facilitation therapy seem unscientific and incompatible with the scientific paradigm of randomised controlled evaluation. Consequently, it appears that the methods through which change is accomplished using the twelve step facilitation therapy are different from the techniques that are ordinarily used in other psychotherapies.

1 Introduction

Although twelve step facilitation therapy (TSF) is considered to be an effective group intervention for alcohol problems (Flores, 1988), the paradox is that the efficacy[1,2] of TSF has not been systematically and empirically established. Not only has there been limited research to determine the efficacy of TSF, but none of the randomised controlled studies have supported the purported efficacy of TSF. The most recent randomised controlled study, entitled Project MATCH (Matching Alcoholism Treatment to Client Heterogeneity) (1997), also failed to confirm the efficacy of TSF in relation to two other standard therapy modalities. In addition, its results have led to uncertainty in the field of treatment for alcohol dependence and problems (Heather, 2001b). Within this context, the purposes of this article were twofold:

- firstly, to investigate the nature and results of randomised controlled studies aimed at determining the efficacy of the TSF for alcohol problems, and,
- secondly, to identify and discuss the nature of any factors relating to the use of TSF for alcohol problems that may have contributed to the limited research using randomised controlled studies, and to the findings of those studies.

2 Background to the review

In the mid-1990's research on alcohol treatment shifted away from the focus of whether or not a treatment worked, or which treatment was most effective, to the possibility that treatment outcomes would be improved when matching individuals to treatment based on individual characteristics (Mattson, Allen, Longabaugh, Nickless, Connors & Kadden, 1994). In the USA, the National Institute on Alcohol Abuse and Alcoholism initiated a multi-site clinical trial (Project MATCH, 1997) with the aim of determining whether or not alcoholics[3] with different characteristics responded selectively to three different treatment approaches, namely Cognitive-Behavioural coping skills Therapy (CBT), Motivational Enhancement Therapy (MET), or Twelve-step Facilitation Therapy (TSF)[4]. Results of Project MATCH indicated that there was a lack of statistical and clinical differences among the results of the three treatment modalities. These results challenged the view that patient-treatment matching would yield more positive outcomes. They also failed to indicate any efficacy of TSF relative to the other two modalities.

A search of the literature revealed that there were only three other reported studies, prior to Project MATCH, on the efficacy of TSF that used randomised controlled methods. These were the studies by Dittman, Crawford, Forgy, Moskowitz & MacAndrew (1967);

1. The most accepted method to establish whether or not a model of psychotherapy works, is by clinical trials that use monitored, manualised treatments, randomised assignment of participants, and a control/comparison group, which is an efficacy study. A study that focuses more on whether or not psychotherapy works as it is practised in the field in its unaltered state, is an effectiveness study. In this latter type of study, the individuals choose the type of treatment they prefer, and the nature of the treatment is not controlled – that is, there is no control and no randomness (Howard, Monash, Brill, Martinovich & Lutz, 1996). Some of the literature reviewed failed to distinguish between these two types of studies, and either clearly used the two concepts incorrectly, or randomly interchanged them (see for instance, Brown 2001; Heather, 2001b; McCrady & Delaney, 1995). Where appropriate, when referencing in the text of this review, the wording from the original source was amended to reflect the correct type of study, or studies, that were being referred to. However, original sources were quoted verbatim.
2. The contextual nature of research into the efficacy and effectiveness of TSF must be noted. There are four major sources of information on the efficacy or effectiveness of TSF (McCrady & Delaney, 1995). The first source is from controlled studies using randomised assignment to experimental groups – these would be efficacy studies. The remaining three sources are from studies of effectiveness: (1) quasi-experimental designs comparing TSF to other forms of treatment; (2) single group studies that follow subjects after involvement with TSF, and (3) treatment outcomes that look at the relationships between TSF attendance and professional treatment.
3. Alcohol abuse and alcohol dependence are the most common substance-related disorders, and are commonly referred to as alcoholism (Kaplan, Sadock & Grebb, 1994). However, because 'alcoholism' lacks a precise definition, it is not used in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). The DSM-IV distinguishes between alcohol abuse and alcohol dependence (DSM-IV, table 12.2-2; Davison & Neale, 2001). However, for ease of reference in this review, both the substance related disorders, alcohol abuse and dependence were deemed to be incorporated in the use of the terms 'alcoholics' and 'alcoholism'.
4. The Twelve Steps and the Twelve Traditions of Alcoholics Anonymous are attached. The use of TSF in Project MATCH was based on the principles of Alcoholics Anonymous that incorporate both the twelve steps and the twelve traditions of AA. Thus, the use of the term TSF in this review will refer to both the twelve steps and the twelve traditions of Alcoholics Anonymous.

Brandsma, Maultsby & Welsh (1980); and Walsh, Hingson, Merrigan, Levenson, Cupples, Heeren, Coffman, Becker, Barker, Hamilton, Mcguire & Kelly (1991). These studies also failed to sytematically and empirically establish the efficacy of TSF. These studies, and Project MATCH, were evaluated in this article as they were the only reported studies that used a randomised controlled methodology to determine the efficacy of TSF. This evaluation process commenced with an analysis of Project MATCH and its findings, as it was the most recent study, and its results have led to the aforementioned uncertainty in the field.

3 Project MATCH

Project MATCH was a multi-site collaborative study investigating the 'treatment matching' hypothesis (Project MATCH, 1997). It was designed to assess the benefits of matching clients showing alcohol dependence or abuse, to three different treatments with respect to a variety of client attributes. These three treatment modalities were: TSF, founded on the idea that alcoholism is a spiritual and medical disease; CBT, an approach based on social learning theory; and MET, a less intensive form of therapy based on the principles of motivational psychology (Heather, 2001b). Furthermore, CBT was hypothesised to be more useful for patients with higher alcohol involvement, cognitive impairment and sociopathy; TSF was hypothesised to be more useful for individuals with greater alcohol involvement and meaning seeking; and, MET was hypothesised to be more useful for clients with high conceptual levels and low readiness to change (Project Match Research Group, 1997; Brown, 2001).

These three individual modalities were delivered at ten treatment sites in the USA and involved a total of 1726 clients, divided into two parallel but independent clinical trials – an outpatient arm (n = 952), and an aftercare arm (n = 774). Clients within each arm were randomly assigned to three 12-week, manual-guided interventions. Each of the modalities was delivered by trained therapists on a one-to-one basis.

The results of this randomised, controlled clinical trial indicated that all three therapies were associated with significant and substantial reductions in both drinking behaviour and alcohol-related negative consequences over a 12-week therapy delivery period, and a 1-year follow-up period, with few differences in the relative effectiveness of the three therapies (Project MATCH, 1997, 1998a, 1998b).

Ironically, these results of Project MATCH have partly led to uncertainty in the field of treatment for alcohol dependence and problems (Heather, 2001b). In the context of this review, it would seem that a brief discussion of the results would be appropriate in order to contextualise them.

Although the results did not confirm the research hypothesis – that careful matching would improve overall success rates – they should not completely invalidate the potential usefulness of client–treatment matching. The trial identified and assessed the efficacy of only three clinically useful matching effects – several other possible forms of matching were not investigated.

Another aspect of the trial was that the overall effectiveness of the three treatments was the same, and this pattern did not change throughout a 3-year follow-up period (Project MATCH, 1998b). This result did not mean that the three treatments were ineffective; the absolute success and improvement rates of all three were impressive, although the research design did not include a 'no treatment' control group (Heather, 2001b). In other words, Project MATCH showed that TSF can be effective if routine treatment were to be carried out to the high standards of therapist training and quality control of treatment delivery in Project MATCH. In regard to the nature of this aspect of the trial, Brown has issued a word of caution by noting that Project MATCH was the largest clinical trial ever conducted, and each of the treatment modalities was manualised (Brown, 2001). Brown notes that ' … the careful monitoring of treatment delivery, limiting attrition and delivering an adequate amount of treatment may have served to make the modalities more similar than different with respect to therapist involvement' (503).

From these results, it would be an oversimplification to merely conclude that, no matter which of the three treatment modalities were to be used for problem drinkers, the same degree of outcome can be expected. Such an approach discounts the impact on the effectiveness of treatment of such variables as client motivation to change, level of therapist skill or empathy, or a combination of both (Heather, 2001b).

Finally, the practical implications of the results of Project MATCH have drawn criticism in that the study failed to address the influence of client satisfaction in relation to modality effectiveness (Donovan, Kadden, DiClemente, Carrol, 2002). These authors submitted that, in spite of the fact that the three treatments were similar in effectiveness, or even if one had been slightly less effective than the others, ' … the treatment of choice is likely to be determined by clients' preference, with any potential loss in therapeutic effectiveness likely being outweighed by the gain in other perceived benefits' (291).

In regard to using the results of MATCH as a referral basis, the following aspects are relevant:

Network support system: In the outpatient arm only, those individuals with a social support network supportive of drinking, did better with TSF than with MET or CBT (Project MATCH, 1998; Longabaugh, Wirz, Zweben & Stout, 1998; Heather, 2001a; Emrick, 2001).

Client anger: Also specific to the outpatient arm, the finding was that clients initially high in anger benefited more from a non-confrontational approach to acquire motivation to change their drinking behaviour (MET), than from TSF – actively encouraging angry clients to engage in TSF, may provoke an angry response, and thus adversely impact on the chances of good outcome on treatment (Project MATCH, 1998; Longabaugh et al, 1998; Heather, 2001a; Emrick, 2001).

Dependence level: Inpatients with a relatively high dependence on alcohol, may benefit more from TSF group oriented aftercare treatment than from treatment based on CBT ((Project MATCH, 1998; Longabaugh et al, 1998; Emrick, 2001).

For the purposes of this article, this analysis of Project MATCH and its results indicated that it did not confirm the hypothesis that careful matching would improve success rates, nor did the findings show any significant efficacy of TSF in relation to the two other modalities in the study, MET and CBT.

Research prior to Project MATCH

Only three studies prior to Project MATCH (Dittman et al, 1967; Brandsma et al, 1980; and Walsh et al, 1991) employed random assignment and adequate controls to compare the efficacy of TSF with no intervention, or alternative interventions, and in no case did they show TSF to advantage. These three studies will be analysed briefly.

In the Ditman et al (1967) study, 301 chronic drunk offenders were randomly assigned to one or other of three treatment conditions: to AA, to a psychiatrically oriented community alcohol treatment clinic; or to no treatment. It was also required that each offender report back to the court at the end of six months. Evidence of co-operation in clinic

treatment was given to the court by the clinic. In AA, such evidence was brought to the court by the offender in the form of signed statements from AA secretaries proving attendance at five meetings within 30 days. Based on records of re-arrest, the results of the study indicated there was no statistically significance among the three treatment groups. Ditman et al concluded that ' … forced referrals to AA and to an alcoholism clinic treatment program failed to reduce the likelihood of recidivism among a population of convicted chronic drunk offenders' (1967, 163).

In the second randomised controlled study, Brandsma et al (1980) examined the efficacy of four treatment modalities in terms of several variables at outcome and during a 1-year follow-up. The treatment modalities were insight therapy, rational behaviour therapy (administered by a professional), rational behaviour therapy (administered by a layman), and AA (TSF). There was also a control group who did not receive any active intervention from the researchers, but were at liberty to avail themselves of any treatment opportunities in the community. The court-referred patients were randomly assigned to one of the five groups. Brandsma et al found no differences at 12-month follow-up between TSF and no treatment, and at 3-month follow-up those assigned to TSF were found to be significantly more likely to be binge drinking, relative to controls or those assigned to other interventions (based on unverified self-reports). Limitations of this study were that the meeting locations for the delivery of TSF were prescribed, that the subjects were court offenders, and that they were required to attend only one AA meeting per week.

In the Walsh et al (1991) study, which was anchored in the work-site, the researchers ' … compared the effectiveness of mandatory in-hospital treatment with that of required attendance at the meetings of a self-help group, and a choice of treatment options' (775). They randomly assigned 227 workers newly identified as abusing alcohol to one of the three rehabilitation regimens: compulsory in-patient treatment; compulsory attendance at AA meetings (TSF); and a choice of options. The groups were compared in terms of 12 job-performance variables and 12 measures of drinking and drug use during a two-year follow-up period (Walsh et al, 1991). This study found that all three groups improved, and no significant differences were found among the groups in job-related outcome variables (Walsh et al, 1991). On seven measures of drinking and drug use, they found significant differences at several follow-up assessments. The hospital group fared best and that assigned to AA the least well; those allowed to choose a program had intermediate outcomes. Additional in-patient treatment was required significantly more often by the AA group than by the subjects assigned to initial treatment in the hospital. The differences among the groups were especially pronounced for workers who had used cocaine within six months before study entry. The estimated costs of inpatient treatment for the AA and choice groups averaged only 10 percent less than the costs for the hospital group because of their higher rates of additional treatment (Walsh et al, 1991).

Walsh et al concluded that ' … even for employed problem drinkers who are not abusing drugs and who have no serious medical problems, an initial referral to AA alone or a choice of programs, although less costly than inpatient care, involves more risk than compulsory inpatient treatment and should be accompanied by close monitoring for signs of incipient relapse' (1991, 775)

It must be noted that in none of these studies were cases that were referred to AA, screened for potential suitability, and in all cases, it is doubtful that subjects' circumstances made them appropriate candidates for TSF (Ogborne, 1993). Furthermore, all three studies were conducted using coerced populations (chronic drunkenness offenders, persons convicted of driving while drunk, employees referred to an employee assistance program) (McCrady & Delaney, 1995). One of the basic underlying philosophies of TSF is that it is intended to be a voluntary program open to persons who desire to stop drinking. It could be argued that it is not a fair test to evaluate the efficacy of TSF with persons who are compelled to attend TSF and who do not want to stop drinking (McCrady & Delaney, 1995).

It is therefore evident that there has been only a limited amount of research on the efficacy of TSF, using randomised controlled trials despite the large membership of AA, and the enthusiasm held by so many in the alcoholism field (Emrick, 2001). The evidence indicates that in all three randomised controlled trials, TSF was studied as a distinct alternative. However, all three had methodological weaknesses, and none of these controlled trials found TSF to be more efficacious than alternative treatment, or no treatment. It can therefore be concluded that although these findings may argue against mandating clients to TSF, they shed no light on the efficacy of this approach when used as intended: as a voluntary process (Miller, Brown, Simpson, Handmaker, Bien, Luckie, Montgomery, Hester, & Tonigan, 1995). In addition, Project MATCH failed to confirm the research hypothesis that careful matching of clients with the three treatment modalities (TSF, MET and CBT), would improve overall success rates. Thus, there have been no randomised controlled studies that have supported the purported superior efficacy of TSF. The question that then arises, is whether or not efficacy studies on TSF can be done? The next section investigates this question in order to identify and understand the reasons for this paucity of research on TSF, using randomised controlled methods, and the reasons for the lack of support for the efficacy of TSF. It outlines some of the main constraints imposed on research, using randomised controlled studies, because of the unique philosophies and characteristics underlying AA, and thus TSF when used on studies of alcohol problems.

4 Twelve-step facilitation therapy (TSF)

Research on TSF, using randomised controlled studies, has been hampered both by constraints imposed by the doctrine and philosophy of AA, and by features of its 'treatment' processes (Cook & Campbell, 1979; Dennis & Boruch, 1989). It would seem that some of the barriers to using randomised controlled trials could be as much attitudinal as scientific (McCrady & Delaney, 1995). These will be discussed.

4.1 Key concepts of TSF

There is no uniform consensus concerning exactly what the objectives of AA are, although it is agreed that it is a fellowship that exists to help its members stay sober (Nowinski, 1993). Furthermore, AA is not a formal treatment program but exists as a ' … collection of men and women who are connected by common desires: to not drink again and to be in fellowship with one another' (Nowinski, 1993). The twelve steps and traditions provide guidelines on how to organise groups whose aim is to help members achieve the objective of not drinking. Although rich in concepts, TSF lacks a formal theory of change, or of causation. Thus, in order to undertake research on TSF, it is important to understand that TSF is founded not on theory or operational constructs, but on ideas, ethics, rituals, beliefs and traditions (Nowinski, 1993). The task for a researcher is to translate these key TSF concepts – that is, ideas,

ethics, rituals, beliefs and traditions – into operational constructs, without losing their meaning (my italics) (Nowinski, 1993). Within the context of this review, it would seem that the most important factors that underlie these key concepts that help define TSF, and impose constraints on the use of randomised controlled studies, include faith, tolerance, and pragmatism (Nowinski, 1993). Each will be reviewed in turn.

4.1.1 Faith

TSF is grounded in faith and belief in a higher power (steps two and three), and is steeped in individual spirituality (Nowinski, 1993; Beutler, Jovanovic & Williams, 1993). The way that AA defines this higher power makes it an ultimately personal matter. It is the belief in and a willingness to rely on some power greater than the individual will, more than in science, that sustains the individual AA member. The locus of control is seen to be God, while prayer sustains and comforts the individual (Nowinski, 1993). Because so many clinicians involved in treating alcoholics have themselves successfully recovered by means of TSF, the same faith and acceptance that guided their personal recovery has led to their personal acceptance of the universal effectiveness of TSF (McCrady & Delaney, 1995).

Although it may be tempting for researchers to reframe steps two and three in terms of expectancies for change, hope or personal trust, this is not the same as the belief, faith and in reliance on some greater power. In other words, there are difficulties in translating this key TSF concept of faith and spirituality into operational constructs that make it accessible to research, without losing the meaning (Nowinski, 1993).

4.1.2 Tolerance

Just as spirituality is an integral part of TSF, so is the aspect of tolerance: 'No AA can compel another to do anything; nobody can be punished or expelled; Our Twelve Steps to recovery are suggestions' (Alcoholics Anonymous, 1952a, 129). Also, ' … the only requirement for AA membership is a desire to stop drinking' (Alcoholics Anonymous, 1952b, 139). These aspects indicate some of the tolerance issues in TSF that have led to its pluralism and adaptability (Nowinski, 1993). For the researcher, this would mean that there is an absence of standards in the TSF culture. In other words, there is no standard AA program, no standard AA meeting or group; and no standard measure of success, except for not drinking today (Nowinski, 1993; Cook & Campbell, 1979; Denis & Boruch, 1989). There is also no standard member, as membership is a dynamic population that oscillates between involvement and non-attendance (McCrady & Miller, 1995). Consequently, those involved with AA may be exposed to experiences that vary with the groups they attend and the characteristics and motivations of sponsors (McCrady & Irvine, 1998). Unlike the standardised, quality-controlled interventions that many treatment researchers consider as prerequisites, AA is a purposefully 'unorganised', non-standardised, non-exclusive, open-ended movement that engages individuals in a loosely defined mutual self-help process (Ogborne, 1993). Thus, controlled research studies aimed at determining the efficacy of TSF have been confronted by the inevitable and demonstrable variations in the experiences of the individuals exposed to the movement.

Furthermore, AA's open-door policy invites a heterogenous grouping of potential beneficiaries. Unlike many formal treatment programs, AA does not screen out those considered as unsuitable due to various factors, such as, for instance, inability to pay or mental health problems (Ogborne, 1993). In fact, those who relapse are welcome to return, as are abstainers seeking to prevent relapse. The challenges posed to researchers evaluating the efficacy of AA, posed by its unstandardised and open-ended nature are also compounded by the influence of the process of 'self-selection' in exposure to AA experiences. For instance, members are at liberty to attend as many or as few meetings as they wish, or determine their level of commitment to events and meetings. The significance of such individual interactions complicates the evaluation process, and will be missed if the research methodology fails to take them into account (Ogborne, 1993; Cook & Campbell, 1979; Denis & Boruch, 1989).

4.1.3 Pragmatism

Literature on AA makes a point that the ' … twelve steps to recovery are suggestions,' (Alcoholics Anonymous, 1952a, 129; my italics). This indicates the pragmatic approach and a reluctance of AA to become dogmatic. Another instance of this pragmatism is revealed in an AA publication that opens by advising the reader: 'Here we tell only some methods we have used for living without drinking. You are welcome to all of them, whether you are interested in AA or not' (Alcoholics Anonymous, 1952b, 1). In essence, this approach may represent a significant limitation for research that is typically based on ' … more control than this over independent variables such as treatment protocols' Nowinski, 1993, 36).

4.2 Some methodological issues

Efficacy studies on TSF require randomised controlled conditions. However, these preconditions bring with

The twelve steps (of AA)

STEP ONE We admitted that we were powerless over alcohol – that our lives had become unmanageable.

STEP TWO Came to believe that a Power greater than ourselves could restore us to sanity.

STEP THREE Made a decision to turn our will and our lives over to the care of God as we understood Him.

STEP FOUR Made a searching and fearless moral inventory of ourselves.

STEP FIVE Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

STEP SIX Were entirely ready to have God remove all these defects of character.

STEP SEVEN Humbly asked Him to remove our shortcomings.

STEP EIGHT Made a list of all persons we had harmed and became willing to make amends to them all.

STEP NINE Made direct amends to such people wherever possible, except when to do so would injure them or others.

STEP TEN Continued to take personal inventory and when we were wrong, promptly admitted it.

STEP ELEVEN Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us, and the power to carry that out.

STEP TWELVE Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

them collateral consequences - the ability to generalise TSF studies involving only individuals who have agreed to randomisation and other conditions, may then become limited.

Another consequence of using the research process of randomisation, is that it may be compromised by negative or compensatory reactions of those assigned to a less attractive treatment (Nowinski, 1993). For instance, those subjects assigned to the TSF modality may be disappointed if they were in fact seeking exposure to the MET or CBT modality. This could result in adverse attitudes to change or attempts to subvert the research protocol.

The availability of multi-variate data analysis methods could be considered to possibly reduce the need to use random assignment as the only means to control for factors that compound effects of social interventions (Nowinski, 1993).

4.3 Concluding comments on TSF

Unlike many of the other 'treatments' evaluated by researchers, such as CBT and MET, the philosophy, ideas, rituals and beliefs of TSF seem unscientific and incompatible with the scientific paradigm of randomised controlled experimentation (Vaillant, 1983). Thus, constraints have been imposed on research, both because of the distinct characteristics of TSF, as well as some of the methodological requirements imposed by the paradigm of randomised controlled studies.

5 Conclusion

Comparative research, using randomised controlled trials, has been hampered both by constraints imposed by the ideas, ethics, rituals, beliefs and traditions of TSF for alcohol treatment, and by some of the features of its treatment format. The underlying factors of faith, tolerance and pragmatism for TSF mean that it proposes a different set of constructs as compared with conventional psychotherapy programs, such as CBT and MET, by which they explain how change occurs. This lack of evidence of the efficacy of TSF, despite the efforts of sophisticated researchers, tends to support the notion that TSF and the individual and collective spiritual faith that underpin it, cannot be separated and investigated with specific quantitative methodologies, and is a challenge to researchers to consider research strategies that respect that reality.

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The twelve traditions (of AA)

1. Our common welfare should come first; personal recovery depends on AA unity.
2. For our group purpose, there is but one ultimate authority – a loving God as He may express himself in our group conscience. Our leaders are but trusted servants; they do not govern.
3. The only requirement for AA membership is a desire to stop drinking.
4. Each group should be autonomous except in matters affecting other groups or AA as a whole.
5. Each group has but one primary purpose – to carry its message to the alcoholic who still suffers.
6. An AA group ought never endorse, finance or lend the AA name to any related facility or outside enterprise, lest problems of money, property and prestige divert us from our primary purpose.
7. Every AA group ought to be fully self-supporting, declining outside contributions.
8. AA should remain forever non-professional, but our service centres may employ special workers.
9. AA, as such, ought never be organised; but we may create service boards or committees directly responsible to those they serve.
10. AA has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.
11. Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films.
12. Anonymity is the spiritual foundation of all our traditions, ever reminding us to place principles before personalities.

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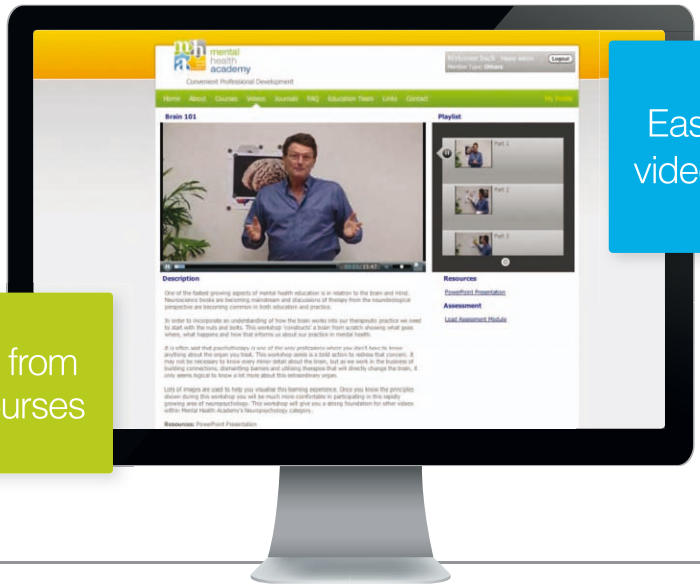

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PAPER PRESENTED AT THE FOURTH ASIA PACIFIC RIM INTERNATIONAL COUNSELLING CONFERENCE, KUCHING, AUGUST 2013

Mindfulness and positive psychology: Towards a flourishing environment for university students

By Dr Ann Moir-Bussy

PEER REVIEWED ARTICLE

Introduction

In the context of a counsellor in training, the cultivation of an individual's internal resources (e.g., positive emotions, happiness, strengths, love, hope, spirituality, purpose, self-esteem and coping skills) using positive psychology interventions together with other strategies (e.g., mindfulness, meditation, professional development, supervision, peer support groups, journaling, exercise and nutrition), provides a foundation upon which students can competently monitor and manage their self-care as they prepare to enter the workforce. However, as asserted by Christopher, Christopher, Dunnagan and Schure (2006):

> Faculty in counseling training programs, often give voice to the importance of self-care for students during the training period, and into practice after training is completed. However, few programs address this in their curricula. (Christopher et al., 2006, p. 494)

In many cases, students are expected to develop and achieve the practice of self-care themselves. In addition, university counselling centres often have long waiting lists which results in students not being able to access help when it is most needed. In a study exploring the use of self-care strategies including 'meditation-yoga-relaxation techniques, spirituality-religion-self-awareness, career guidance and networking' by students undertaking a doctorate in psychology, researchers recommended the inclusion of education and training on self-care strategies in university curriculum for graduate psychology students (Goncher, Sherman, Barnett, & Haskins, 2013, p. 58).

In this article, we explore how education and training in mindfulness practices and positive psychology interventions cultivate not only self-care strategies for counselling students, but also assist them in dealing with the challenges of the therapist-client relationship. Firstly, we will provide a brief overview of mindfulness and positive psychology and how they are being utilised in the helping professions, particularly in the context of self-care and the subsequent benefits for the therapist-client relationship. Next we will provide reflections from Australian university students who participated in mindfulness activities, followed by narrative excerpts from Hong Kong counselling students who initiated a positive psychology intervention in their own lives. All excerpts were given to the author by the students after they had completed the course.

Mindfulness

The concept of mindfulness is rooted in Buddhist psychology but at the same time it is imbued with ideas from other philosophical traditions including Greek philosophy, existentialism and phenomenology from the Western tradition and transcendentalism and humanism in America (Brown, Ryan, & Creswell, 2007). The application of mindfulness in a variety of settings is both well-researched and well-documented (Shapiro & Carlson, 2009; Brown et al., 2007; Snyder & Lopez, 2005; Shapiro, 2009). Brown et al. (2007) assert that mindfulness is part of a long-standing tradition 'that recognizes the adaptive

This paper is a reflection on two studies which explored how counselling students from Hong Kong and Australia developed self-compassion, self-care and positive coping strategies, reduced their stress levels and engaged in flourishing relationships after adopting a regular practice of mindfulness through meditation, qigong, yoga or positive psychology interventions. The Hong Kong students provided written reports after implementing a positive change in their lives, while the Australian students provided reflective responses following their participation in a mindfulness practice over one semester. The reflections support the benefits of mindfulness practices and positive psychology for counsellors in training and their clients. The implications for future counselling education and training curricula are discussed.

value in bringing consciousness to bear on subjective experience, behaviour and the immediate environment' (p. 215). Similarly, Brown and Ryan (2003) defined mindfulness as a 'receptive attention to and awareness of present events and experience' (p. 822). Shapiro and Carlson (2009) speak of it as fundamentally 'a way of being – a way of inhabiting one's body, one's mind, one's moment-by-moment experience' (p. 5). However, while it is an innate human capacity, the pressures and stress and stimulus of modern day life often intervene as one attempts to keep one's head above water. For example, there were situations where Chinese students in Hong Kong in their early 20's are caring for a parent dying of cancer and looking after smaller brothers and sisters, while other students juggle part-time jobs on top of their heavy study load and then attempt to study in the early hours of the morning. The absence of effective self-care and coping strategies can leave individuals with these life challenges feeling anxious, stressed and depressed (Christopher & Maris, 2010).

Mindfulness practices of meditation, yoga and qigong are commonly used by many people and have been reported to enhance an individual's emotional, physical, mental and spiritual well-being (Chrisman, Christopher, & Lichtenstein, 2009; Hick, 2008; Schure, Christopher, & Christopher, 2008). In a qualitative study conducted by Chrisman et al. (2009), the master's counselling students reported 'feelings of relaxation and calmness' following an in-class qigong exercise (p. 250). In another study exploring mindfulness practices, the graduate counselling students reported enhanced centeredness, energy and a sense of mind-body-emotion connection after practicing qigong (Schure et al., 2008). Similarly, other students found meditation promoted relaxation, mental clarity, 'awareness and acceptance of emotions and personal issues'. The remaining students found yoga practices enhanced their awareness of their body and energy, 'mental clarity and concentration' (Schure et al., 2008, p. 49).

From a self-care perspective, education in mindfulness practices offers counsellors in training strategies they can utilise to proactively manage their health and well-being and consequently reduce the potential of stress, professional burnout (Hick, 2008; Schure et al., 2008), 'compassion fatigue, and vicarious traumatisation' (Christopher & Maris, 2010, p. 114).

For students of counselling and psychotherapy, mindfulness and mindfulness practice are not only an important dimension but a necessity if they are to be able to form empathic relationships with clients and sit with them and consciously attend to them in a caring manner (Christopher & Maris, 2010; Hick, 2008; Shapiro & Izett, 2008). Fundamental for a therapist is the capacity to be present, to intentionally listen in a way that is non-judgmental, be accepting and receptive, in other words, be empathic (Corey, 2013; Hick, 2008). Research shows that empathy is a strong predictor of positive therapeutic outcomes (Bohart, Elliott, Greenberg, & Watson, 2002; Miller, Taylor, & West, 1980, as cited in Bien, 2008; Watson, 2002, as cited in Corey, 2013). Additionally, Carl Rogers emphasised congruence, which means the therapist needs to be aware of what he or she is feeling in order to feel with the client and consequently offer unconditional positive regard (Corey, 2013). Moreover, researchers have found that the attributes of the therapist are more highly related to the therapeutic outcome than the treatment

model or type (Lambert & Simon, 2008). Therapist attributes including acceptance, understanding, warmth, empathy and being supportive of the client (Lambert & Simon, 2008), are attributes which can be effectively cultivated and enhanced through education, training and effective use of self-care strategies by the therapist (Bien, 2008; Lambert & Simon, 2008).

Positive psychology

The term 'positive psychology' was coined by Abraham Maslow in 1954 and he asserted:

> 'The science of psychology has been far more successful on the negative than on the positive side. It has revealed to us much about man's shortcomings, his illness, his sins, but little about his potentialities, his virtues, his achievable aspirations, or his full psychological height.' (Maslow, 1954, p. 354).

In other words, positive psychology focuses on the strengths and potential of a person, the positive attributes and what is going right for a person rather than on what is wrong, with the aim of improving quality of life and well-being. Building on the ideas of Maslow and pioneers like Donald Clifton who studied human strengths and George Vaillant who studied effective coping (Diener, 2009), Martin Seligman brought positive psychology to the forefront of psychology in 1999. Positive psychology is based on four key areas which relate to 'well-being, happiness, positive emotions and character strengths' (Donaldson 2011, p. 5-6). More specifically, Fredrickson and Kurtz (2011) assert that positive emotions contribute to the broadening and building of a person's 'attention and thinking' resulting in improved individual growth and awareness, mindfulness of the present moment, ability to deal with challenges, ability to adapt and be flexible in social relationships and situations, and generally maintain a healthier state of well-being (p. 35-36).

While there have been some studies which have found mixed results for the use of positive interventions, in a meta-analysis reviewing research conducted on 51 different positive psychology interventions, Sin and Lyubormirsky (2009) found evidence which supports the efficacy of these types of interventions in enhancing well-being and reducing negative emotions, thoughts and feelings.

Positive Psychology interventions offer counselling students a range of self-care strategies from which they can draw on for both themselves and their clients. Some of the positive psychology interventions reported in research to date include positive psychology based individual therapy, positive writing exercises, gratitude and personal strength activities, Fordyce's happiness program, meditation, mindfulness, forgiveness, hope therapy, counting kindnesses and goal training (Sin & Lyubormirsky, 2009).

In addition, researchers have found that participant well-being was further improved when the positive intervention duration increased (Emmons & McCullough, 2003; Sin & Lyubormirsky, 2009). Similarly, Seear and Vella-Brodrick (2013) conducted a study assessing two positive psychology interventions and concluded that interventions with shorter durations did not result in significant benefits for participants in comparison to those who continued the intervention over a longer period. Moreover, Seear and Vella-Brodrick (2013) found that practice, frequency and motivation were key contributing factors for achieving enhanced participant well-being.

Mindfulness class reflections

The participants for this reflection were Master of Counselling students from an Australian University who participated in a course which included teachings on mindfulness practices. These students were in their final year of study and were also completing an Internship. A total of seven students participated in the mindfulness classes over one semester of study.

As an activity within a counselling unit of study, students were asked to choose and engage in one mindfulness practice during the semester and keep a journal to monitor the effects on their own life, their study and their work with clients. At the end of the semester, students submitted a short report summarising their experiences. The practices chosen by students included qigong, yoga and meditation. At the completion of the course the author asked the students if it would be useful to write up reflections on their use of mindfulness and five students wrote a de-identified summary and gave it to the author . Two chose not to complete a summary. The students' reflections were quite insightful and they showed that a range of physical, psychological, mental, emotional and relationship benefits were achieved through their chosen mindfulness practice.

Yoga

Some students reported not only physical benefits from yoga but also improvement in their concentration and ability to be more present with their clients. This was particularly true for those who maintained a regular practice. For those who practiced intermittently, the benefits were still noticeable but not as long-lasting.

Meditation

A student in her fifties found that meditation in the form of mindfulness helped her the most. She had explored qigong and spent many of her early years practicing yoga and applying Eastern philosophy to her daily mindful practice. She said,

> I had a little book called *Metaphysical Meditations*. I would sit in a peaceful garden, cross legged in a yoga pose with my eyes closed and say over and over again, "God show me the way, show me the light', which was one of the prayers from the book. I would try to clear my head of all random thoughts and simply focus and meditate on a steady stream of light in my mind's eye. This certainly produced a measure of temporary peace which enhanced my sense of well-being tremendously. However, when the hustle and bustle of life crowded in on me that temporary peace would seem to vanish and stressful feelings were left in place.

Her searching led her and her husband to seek for truth and peace along many different paths to fulfil the deep longing in their hearts. Eventually they embraced Christianity and her meditation became grounded in a Christian philosophy and lifestyle.

Qigong

One of the students found that her ability to be present in relationships including her therapeutic relationships with clients had been enhanced through practicing mindfulness and qigong:

> Another significant improvement I've noticed is in my emotions and relationship with others. When I have been absorbed in regular mindful practice I became aware that I was seeing others in a different, more positive light. That is, others' positive qualities became more evident as I was feeling better in myself. I believe this was perhaps a result of not projecting my issues or tension onto others, which has had far reaching

benefits. Similarly, in the workplace I have observed that I have become less defensive and not as impacted by workplace tensions. And, importantly, I have improved my boundaries with clients as I am becoming more aware of my own needs and feeling better within myself. Also with counselling clients I am more satisfied with 'just being' with the problem and not pushing for solutions. As a result, I have noticed I have received better feedback from clients' satisfaction rates. Overall, I am experiencing more empathy for myself and others by tuning into my own feelings, which increase my self-awareness and allows difficult thoughts and feelings to dissipate more quickly.

A female student in her forties reported:

> I have been involved in yoga practice for four years and have found numerous benefits, emotionally, physically and psychologically. Recently, whilst I have been studying, it has been essential to deescalate anxiety levels, so that I am able to focus on key assignments in the Masters' Program. Qi Qong has been a new practice for me to adopt and I have found it beneficial in our lectures to help me ground and focus… I had a recent experience when I could not relax or wind down, whilst walking along the beach. I decided to sit quietly with my eyes closed and remembered some of the exercises we had learnt in class. I walked to the deck and stood there and closed my eyes again. I commenced doing one of the Qi Qong exercises for ten minutes. I found I became completely immersed in the practice and was not aware of any peripheral distractions or issues. When I opened my eyes, I felt a sense of inner calm, my breathing was slower and much more relaxed. As I walked back to the car I realised how wonderful I felt, with not a care in the world.

She also reported that the practice of qigong had strengthened her ability to listen more attentively to her clients. Similarly, another student in her thirties found that qigong gave her physical, psychological and relationship benefits. She commented:

> As a student studying my Master of Counselling I have been engaging in a variety of mindfulness based activities such as Qi Qong, meditation and yoga. Throughout the semester, I have become aware of a multitude of holistic benefits from practicing regular mindfulness techniques. Physically, I noticed the most significant 'shift' or energy balancing with the Qi Qong exercises we engaged in during the workshops. On several occasions I could literally feel the energy between my hands, and then shifting and clearing my energetic field. I also felt significantly more relaxed and focused after completing the Qi Qong.

A deeper relationship to oneself and more awareness of one's own feelings leads to an embodied awareness and presence with the client.

Another student who was new to qigong commented:

> Over the last semester, I have participated in my university class with all the Qi Qong exercises that we have been taught to do. I found them good. However, at home I prefer to practice my own form of mindfulness techniques which I have been doing for years and with which I feel very comfortable. I still my mind by focusing on Jesus. I say his name over and over and express gratitude for all He has done for me and for all He means to me. If I am troubled of distressed I bring these concerns to God. Sometimes I concentrate on my breathing and consciously choose to relax different parts of my body, but always with my focus on Jesus. I feel the compassion and love He has for his people and this constantly influences my love and concern for others.

The above resonates with what qigong Master Chunyi Lin teaches. He says "Through your heart you are connected to what Gandhi called "the most powerful force the world possesses", the power of unconditional love' (Lin, 2011, p. 7). Chunyi Lin (2011) builds his teaching on the Chinese philosophy of universal energy that flows through the cosmos and through our bodies in the form of yin and yang energy. The different forms of qigong which are about cultivating or working with the energy in our body, are not tied to any particular religion and one's practice and meditation may focus on God, Jesus, Allah, Buddha or love, compassion, forgiveness and kindness. Such is the power of mindfulness practices.

General comments about mindfulness practices

One of the students noted personal psychological benefits from practicing mindfulness over a period of time, stating:

> I have noticed that I am able to focus more in the present moment and feel more grounded as a result. Although my mind may have been racing and at times worrying about the amount of work I needed to complete, I am able to recover my focus more readily and my concentration has improved as I able to bring my focus back to the present moment. I have particularly noticed that I have not been projecting into future worries, or likewise, dwelling on past issues. I find generally I am struggling less with 'what is' in my life and there is less struggle and stress as a result. Also thinking in the here and now has led to a reduction of feeling overwhelmed by future troubles and study stresses.

Commentary

A deeper relationship to oneself and more awareness of one's own feelings leads to an embodied awareness and presence with the client. In Buddhist practice one is taught to generate kindness to oneself first by acknowledging one's own difficult emotions and thoughts. The next step is to generate this kindness towards others. A simple intention before sitting with clients is to relax, breathe deeply and gently and fill oneself with love and compassion, or to imagine oneself filled with universal energy or filled with the compassion of the Buddha or of Christ. Bien (2008) suggest 'dwelling on kindly intentions', such as:

- May I be happy.
- May I be peaceful.
- May I have abundance.
- May I be safe.
- May I have ease of well-being.
- May I be free of negative emotions. (Bien, 2008, p. 50)

The therapist then repeats this for the client (Bien, 2008). Chunyi Lin (2011) uses the power of visualisation to assist in bringing about that gentle presence and awareness. Shafir (2008) shares the prayer she uses on the way to meeting her clients:

> First, let me consider the mystery of what is about to occur. Let me remember that my patient is a unique being and that my interaction, to the extent that it's genuine, will be unprecedented. Let me remember that each moment is brimming with possibilities, that by listening mindfully,

> I may be able to heal; by foregoing judgment, I may be able to see more deeply; by letting myself be touched by their experience, I will convey to the patient that I care (Shafir, 2008, p. 230).

Thoughts are energy, according to the great qigong Masters and positive thoughts bring better outcomes and more positive results. This was also proved scientifically by Matsuro Emoto, a Japanese scientist who researched and discovered the power of water, which, after being frozen and viewed under a microscope, portrayed beautiful crystals (Emoto, 2003, 2004). He also found that by putting positive thoughts onto water, even dirty water, it was transformed into beautiful crystals, whereas pure water revealed distortion and no crystal when exposed to negative thoughts (Emoto, 2003, 2004). De Quincey (2009) has also written extensively about the power and importance of awareness and consciousness if our world is to survive and not move headlong towards destruction. Teaching student counsellors the skills of developing mindful practices, whether it be qigong, meditation yoga or other mindful practices, is essential, if they are going to enable healing for themselves and their clients.

Teaching student counsellors the skills of developing mindful practices ... is essential, if they are going to enable healing for themselves and their clients.

Positive psychology reflections

Based on the presumption that the components of a cultural system can best be understood through their relationship with other components of the system, and therefore it should be explained in the terms of culture as whole (Vygotsky, 1978), it is argued that theories, objectives, and methods of mental health interventions are profoundly influenced by their sociocultural context and origins (Hwang & Chang, 2009). Therefore, before presenting the reflections from the Positive Psychology class it is necessary to briefly explain the cultural context for this student group.

Chinese students are strongly influence by Confucianism, Taoism and Buddhism, all of which address self-cultivation or *xiu-yang,* which means 'rectifying one's mind and nurturing one's character with a particular art of philosophy' (Hwang & Chang, 2009, p. 1011). The purpose of self-cultivation is to foster more harmonious relationships and a sense of moral duty to family and to the country. A class on positive psychology at a university in Hong Kong was the ideal forum for self-cultivation and it also enabled the lecturer to begin to explore with them, ways and means of initiating positive change in their lives and subsequently reducing the destructive impacts of stress and pressure.

Furthermore, for the Chinese student in particular, the self-in-relationship is paramount (Ho, 2001; Sun, 2008), and a high value is placed on relationships and relational harmony, and 'collectivist beliefs place group interests above self-interests' (Wong, 2012, p.10). In consideration of this, Moir-Bussy (2006) in her PhD research found that for the Chinese 'relationship with others implies communication and ways of behaving that are essential to maintain harmony'. Hence the positive psychology course was designed in such a way that students would be able to relate their learning and experiences to the context of their own families and relationships (p. 37). Moreover, it is acknowledged that the influences of modernisation and globalisation have placed stress on families' relationships, and in many cases, some of the young adult students have identified challenges related to a generation gap between themselves and their parents.

The students for this reflection came from three classes with approximately 30 students in each studying for their Bachelor of Social Science (Honors) in Counselling and Psychology.

Course details

The positive psychology course which was held over one semester had three main purposes of a) the student actually experiencing the power of discovering their own strengths and abilities; b) how they could use these strengths and abilities in difficult times or in dealing with the stresses and pressures of their daily lives; and c) how they could improve their quality of life including physical, mental, emotional and spiritual aspects. Students also learnt about positive emotions, motivation, strengths, leisure, flow and mindfulness, relationships and love, creativity, wisdom, and religion and spirituality and their effects in their lives. In addition to this content the course also incorporated mindfulness and qigong practices as a support for their learning.

Each class began with a mindfulness practice – either qigong or a mindfulness meditation – which assisted the students to become more aware of what was happening for them physically and emotionally.

Procedure

As a major assessment task, students were asked to engage in a project of change with the aim of bringing about a change in their own life. When the students were considering possible change projects, some students chose to work on relationships within the family; whereas, other students felt there was a strong imbalance in their life due to the predomination of work and study and subsequent lack of sufficient sleep they needed to feel refreshed. Moreover, many students reported that they did not go to bed until 2 or 3am each day and that they constantly felt tired. Others found they ate more junk food each day, did not know how to cook and rarely had a balanced diet, felt lethargic, stressed, overweight and generally lacking in exercise.

The students were asked to decide on a project of change in their life and identify a theory of change that would help them to accomplish the change, such as the Transtheoretical Model of Change encompassing stages of pre-contemplation, contemplation, preparation, action and maintenance (Prochaska & Di Clemente, 1984). As part of the task, they were asked to: a) keep a journal and log for the whole semester documenting what they achieved each day; b) gather evidence from those who knew them well, such as friends and family to support their efforts; and c) write an academic essay at the end of the semester about their journey, experiences and process.

In a discussion at the end of semester the author asked a few of the students if they would be willing to share their experiences for the benefit of future counselling students.

A summary describing the outcomes students experienced are provided below categorised by the type of change.

Qigong. Two students took up the practice of qigong, learning from their mother and gaining her support and evidence that they practiced every day. They noted that it helped them in their

studies because they could concentrate more and were more relaxed.

Exercise. Several students decided on an exercise regime, ranging from taking up a formal training under a gym instructor to walking or jogging on a regular basis. A powerful example of the influence of change came from a student who decided she would walk from the train station to the university and back every day. While this change sounds simple, the walk to the university was uphill all the way and included climbing many steep steps along a path that led through trees and along the road for two kilometres. She noted in her journal that she gradually became much more mindful as she walked, and began to take photographs of the things she saw on the way – a kitten in the tree, a squirrel, children playing and the sunlight through the trees. She kept these photos in her journal and wrote comments about the effects they had on her. She invited other students to join her and soon a small group took the walk every day, giving each other positive encouragement. The effect at the end of the semester was remarkable as the student had lost weight, was smiling a lot more and now enjoying her studies. Her parents commented in her journal how she was more positive at home and the positive effect this had on her younger brothers and sisters.

Relationships. Some students wanted to work on relationships within their families. One student commented that as both parents worked and the children were all at school, they seldom did anything together, and because everyone was tired there was often bickering and arguments. She talked to her parents about her project and told them she needed to change something in her life for the positive. She proposed that her family do something together every Sunday and planned where they could go and what they could do, such as a meal out together, visiting a park and taking a picnic, or cooking at home together. She took photographs and wrote each week on the effect this change was having on her family. At the end of the semester her parents also wrote in her journal thanking the lecturer for the assignment which had rekindled harmony and love in their home because of the change initiated by their daughter.

Forgiveness. An example of mending relationships through forgiveness was reported between a student and her father. Her parents had divorced when she was 12 years old. Her mother had suffered a lot financially after this and the daughter developed anger towards her father because of this, as both mother and daughter felt unsupported. At 22 years of age, the daughter realised for herself that her anger towards her father was not helping any of them and she wanted to find a way to change this and at least form a relationship with her father. She began by reading about forgiveness and discovered a book by Marci Shimoff – *Happy for no reason* (2008) that demonstrated steps towards forgiveness. Her first approach to her father was through email and she was surprised at his warm response. Over the coming weeks she emailed and then phoned but still did not feel forgiveness towards him. She continued with her project and finally found by Week 11 that she could let go and invited him to dinner at what had been one of his favourite restaurants. Her final academic paper on the project demonstrated her journey towards positive self-development and the renewal of positive relationships, all of which had a strong influence on her attitude and approach to her studies.

The above are just a few examples of how positive psychology, mindfulness and qigong influenced changes in the students, their families and their environment, and showed them that they had the ability to initiate and facilitate change both for themselves and others.

Conclusion

This brief review of what students from two different cultures were able to achieve through positive psychology, and mindfulness practices, illustrates and builds on a growing body of research that points to the benefits of cultivating such practices, particularly for students training to be counsellors. Mindfulness supports positive well-being, physical and psychological health and decreases pathology. As Shapiro and Carlson (2009) note, 'The aim of cultivating positive qualities, including wisdom, compassion and virtue, is at the heart of the original intentions of mindfulness' (p. 129). While only very small studies, further exploration on a larger scale will be undertaken with a wider body of students in the future as, 'A mindful psychology offers an opportunity to approach psychological health and well-being from a new paradigm, a new way of seeing (Shapiro & Carlson, 2009, p. 129).

Dr Ann Moir-Bussy is program leader and senior lecturer in counselling at the University of the Sunshine Coast (USC). She has extensive experience as a counsellor and counsellor educator and was lecturer and coordinator of the counselling programs at the University of New England from 2002–mid 2007 and an assistant professor in the Department of Counselling and Psychology at Hong Kong Shue Yan University from 2007–2012. Ann is a level 4 registered counsellor and supervisor with the Australian Counselling Association (ACA) and is also the vice president of ACA.

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ACA COLLEGE OF SUPERVISORS (COS) REGISTER

ACA SUPERVISOR COLLEGE LIST		Medium key: FTF: Face to face | PH: Phone | GRP: Group | WEB: Skype		
Contact	**Suburb**	**Phone Number**	**SUP PP Hourly**	**Medium**
AUSTRALIAN CAPITAL TERRITORY				
Hun Kim	Downer	02 6255 4597	Upon Enquiry	FTF
Mijin Seo - Kim	Downer	02 6255 4597	Upon Enquiry	FTF
Karen Rendall	Barton	0431 083 847	Upon Enquiry	FTF
Brenda Searle	Canberra Region	02 6241 2765 or 0406 376 302	$100 to $130	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
Moira Berriman	Hamilton	0416 038 026	Upon Enquiry	FTF
Sandra Bowden	Lysterfield	0438 291 874	Upon Enquiry	Face to Face
Patriciah Catley	Narellan	02 9606 4390	Upon Enquiry	FTF
Patricia Cheetham	Kensington	1300 552 659	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 Daniel	Turramurra	02 9449 7121 or 0403 773 757	Upon Enquiry	FTF
Karen Davey-Phillip	Lake Munmorah	0418 216 836	Upon Enquiry	FTF
Brian Edwards	Forresters Beach	0412 912 288	Upon Enquiry	FTF
Aaron Elliott	Cardiff	0408 615 155	Upon Enquiry	FTF
Linda Elsey	Wyee	02 4359 1976	Upon Enquiry	FTF
Wendy Gibson	Koolewong	02 4342 6746	Upon Enquiry	FTF
David Gotlieb	Bowral	0421 762 236	Upon Enquiry	FTF
Kim Michelle Hansen	Putney	02 9809 5989 or 0412 606 727	Upon Enquiry	FTF
John Harradine	Cremone	419953389	FTF & WEB $160; GRP $120	FTF/GRP/WEB
Margaret Hutchings	Yamba Grafton	0417 046 562	Upon Enquiry	FTF
Vicki Johnston	Eastlakes	02 9667 4664	Upon Enquiry	FTF
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 Jane Quayle	Hornsby	0414 322 428	$90	FTF/WEB/PH
Judith Reader	Stockton	02 4928 4880	Upon Enquiry	FTF
Deborah Rollings	Sutherland	0427 584 554	Upon Enquiry	FTF/PH

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NEW SOUTH WALES *(CONTINUED ...)*				
Veronica Sandall	Mullumbimby	420436460	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
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
Laura Banks	Broadbeach	0431 713 732	Upon Enquiry	FTF
Maartje (Boyo) Barter	Wakerley	0421 575 446	Upon Enquiry	FTF
Christine Boulter	Coolum Beach	0417 602 448	Upon Enquiry	FTF
Iain Bowman	Ashgrove	07 3102 4844	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
Erin Annie Delaney	Beenleigh	0477 431 173	Upon Enquiry	FTF
Catherine Dodemont	Grange	0413 623 162	$40 Grp; $100 indiv	FTF/GRP/PH/WEB
Heidi Edwards	Gympie	07 5483 7688	Upon Enquiry	FTF
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
Anne-Marie Houston	Bundaberg	0467 900 224	Upon Enquiry	FTF
Beverley Howarth	Mitchelton	0409 619 107	Upon Enquiry	FTF
Merrilyn Hughes	Canning Vale	08 9256 3663	Upon Enquiry	FTF
Kim King	Yeppoon	0434 889 946	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
Jodie Logovik	Urraween	N/A	Upon Enquiry	FTF
Sharron Mackison	Caboolture	07 5497 4610	Upon Enquiry	FTF
Maggie Maylin	West End	0434 575 610	Upon Enquiry	FTF

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Contact	**Suburb**	**Phone Number**	**SUP PP Hourly**	**Medium**
QUEENSLAND *(CONTINUED ...)*				
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
William James Sidney	Loganholme	0411 821 755 or 07 3388 0197	Upon Enquiry	FTF
Deborah Stevens	Kingaroy	0411 661 098	Upon Enquiry	FTF
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
Leeanne D'arville	Salisbury Downs	0404 476 530	Upon Enquiry	FTF
Adrienne Jeffries	Stonyfell	08 8332 5407	Upon Enquiry	FTF
Pamela Mitchell	Waterfall Gully	0418 835 7867	Upon Enquiry	FTF
Carol Moore	Old Reynella	08 8297 511 bus hrs or SMS 0419 859 844	Grp $35, Indiv $99	FTF/GRP/PH
TASMANIA				
David Hayden	Howrah North	0417 581 699	Upon Enquiry	FTF
Benjamin Donald Turale	Hobart	0409 777 026	Upon Enquiry	FTF
VICTORIA				
Joanne Ablett	Phillip Island	0417 078 792	$100	FTF/GRP/PH/WEB
Danielle Aitken	Kilcunda/South Gippsland	0409 332 052	Grp $35, Indiv $70	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
Judith Beaumont	Mornington	0412 925 700	Upon Enquiry	FTF/GRP/PH/WEB
Zohar Berchik	South Yarra	0425 851 188	Upon Enquiry	FTF
Kathleen Brennan	Narre Warren	417038983	$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
Lehi Cerna	Hallam	0423 557 478	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	0437 735 807	Upon Enquiry	FTF

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Contact	**Suburb**	**Phone Number**	**SUP PP Hourly**	**Medium**
VICTORIA *(CONTINUED ...)*				
Linda Davis	Gippsland Leongathal	0432 448 503	Upon Enquiry	FTF
Patricia Dawson	Mooroolbark	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
Lisa Derham	Camberwell	0402 759 286	Upon Enquiry	FTF
Sara Edwards	Dingley	0407 774 663	Upon Enquiry	FTF
Karen Efron	Northcote	0432 391 887	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
Kaye Allison Jones	Camberwell	0417 387 500	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
Marguerite Middling	Ballart	03 5333 4840	Upon Enquiry	FTF
Paul Montalto	Thornbury	0115 315 431	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
Lynne Rolfe	Berwick	03 9768 9902	Upon Enquiry	FTF
Claire Sargent	Canterbury	0409 438 514	Upon Enquiry	FTF
Kenneth Robert Scott	Bunyip	03 5629 5775	Upon Enquiry	FTF
Gabrielle Skelsey	Elsternwick	03 9018 9356	Upon Enquiry	FTF/PH/WEB
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
Natalie Wild	Knoxfield	0415 544 325	Upon Enquiry	FTF
Cas Willow	Turalgan	03 9327 2293 Or 0428 655 270	Upon Enquiry	FTF/PH/WEB
Rosslyn Wilson	Knoxfield	03 9763 0772 or 03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Michael Woolsey	Seaford/Frankston	0419 545 260 or 03 9786 8006	Upon Enquiry	FTF
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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Contact	**Suburb**	**Phone Number**	**SUP PP Hourly**	**Medium**
INTERNATIONAL				
HONG KONG				
Yuk King Lau		N/A	Upon Enquiry	FTF
Dina Chamberlain		+852 6028 9303	Upon Enquiry	FTF
Fiona Man Yan Chang		+852 9198 4363	Upon Enquiry	FTF
Pui Kuen Chang		N/A	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
Winnie Wing Ying Lee		N/A	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 2643 5347	Upon Enquiry	FTF
SINGAPORE				
Deborah Cameron		+65 9186 8952	$100	Face to Face/ Group/Phone/Long Distance/Skype
Eugene Chong		+65 6397 1547	Upon Enquiry	Face to Face
Roderick Boon Leng Chua		+65 911 84687 or +65 9118 4687	Upon Enquiry	FTF
David Kan Kum Fatt		+65 9770 3568	Upon Enquiry	Face to Face
Gan Su Keng		+65 6289 6679	Upon Enquiry	FTF
Ellis Lee		N/A	Upon Enquiry	FTF
Dan Ng		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
Kwang Mong Sim		N/A	Upon Enquiry	FTF
Saik Hoong Tham		N/A	Upon Enquiry	FTF

SUBMISSION GUIDELINES

WANT TO BE PUBLISHED?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

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

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

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

Counselling Australia is designed to inform and discuss relevant industry issues for practicing counsellors, students and members of the Australian Counselling Association. It has an editorial board of experienced practitioners, trainers and specialists. Articles are invited to be peer reviewed and refereed or assessed for appropriateness by the editor for publishing. Non-editorial staff may assess articles if the subject is of a nature as to require a specialist's opinion.

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

Editorial policy

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

Previously published articles

Articles that have been previously published can be submitted as long as permission for reprint accompanies the article.

Articles for peer review (refereed)

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

Conditions

- References are required to support both arguments and personal opinions 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.

AIPC

Gain Entry Into An ACA Professional College

With An ACA Accredited Specialty Vocational Graduate Diploma

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

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

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

Get Direct Entry Into A Professional College

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

Flexible And Cost Effective

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

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

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

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

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

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

Become A Self Employed Mental Health Social Support Trainer

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

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

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

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

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

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

What Training is Required?

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

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

You're Fully Supported

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

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

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

Take the first step now.

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

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

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