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Fear of weight gain in patients with anorexia nervosa

The Impact of Domestic Violence on Children: Linking Theory to Practice

The process of constructing Behaviour Support Plans for young people with special needs

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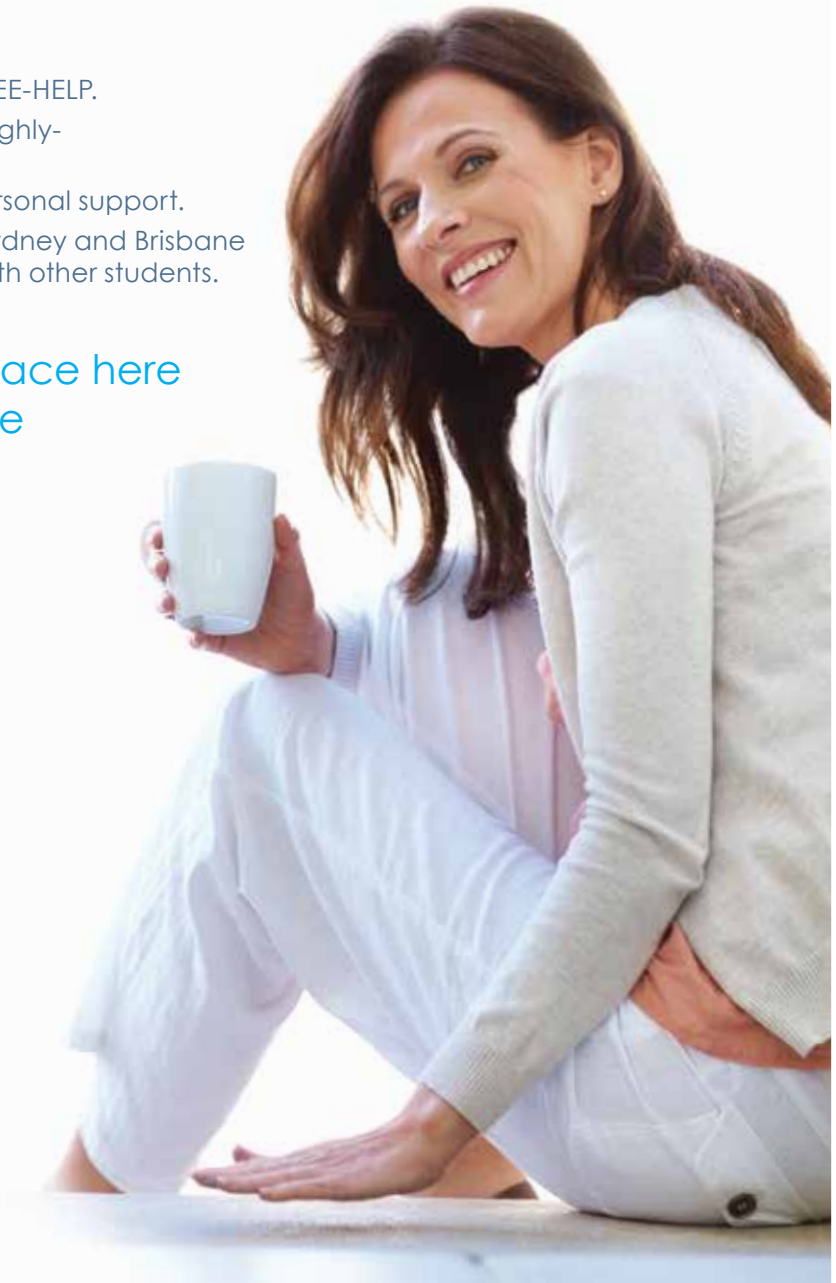

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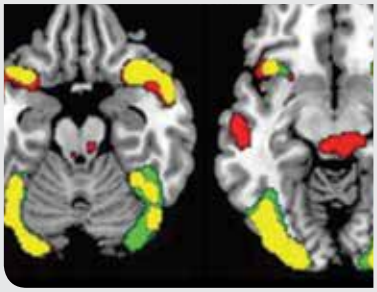

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See page 47 for peer-reviewed article submission guidelines.
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ACA – outreach in action

By Philip Armstrong FACA

Special Editorial – ACA Outreach Program Goes to Fiji

The ACA outreach program was established over a decade ago to help support the development of mental health services in developing and developed countries within the Australasian region. To date, ACA has worked with organisations in Indonesia, Malaysia, Singapore, Hong Kong, and the Philippines.

ACA was contacted by the University of the South Pacific (USP) in early July this year, requesting help to develop a program in counselling and also to establish a professional body. This request was soon followed by a formal letter of invitation to visit the University's main campus in Suva, Fiji and meet with a committee of stakeholders to spend four days developing a curriculum and establishing the foundations required to raise a peak body. The impetus for this was the recognition after cyclone Winston of a dire need to develop mental health services in the region. It had been identified that there was a need to respond to natural disasters, such as forced migration due to displacement caused by rising ocean levels and severe weather events. A need for counselling services within the school system also had been noted as a primary concern. To meet these needs, USP, in consultation with the Fijian government, decided to develop a counselling program. It was decided to deliver a Diploma of Counselling through the USP TAFE, and it was at this point that USP contacted ACA for support.

USP also decided to make the bold move of applying to be a Registered Training Organisation (RTO) in Australia, making it the first offshore RTO to be registered in Australia. The reason for this was so that graduates of the counselling program would be able to register with ACA and more importantly have a qualification that was transportable within the region. As an RTO, USP will be able to deliver a counselling qualification that meets the Australian Qualifications Framework level 5 and is fully accredited in Australia. As this was a ground-breaking decision, USP called on ACA to help with the process of developing an accredited counselling diploma that was appropriate for Fijian counsellors and at the same time met Australian standards. This was quite a challenge, magnified by the fact that the Industry Skills Council had recently released a new Diploma (CHC51015) to replace the old package and. Therefore, we did not have any comparisons with which to work. This did, however, have the advantage of working off a clean slate.

We (myself and the ACA Industry Liaison Officer, Tom Parker) arrived at our hotel late in the evening on Thursday the 4th of August, after a four-hour drive from Nadi International Airport to Suva. We then worked for three solid days, starting at 8 am on Friday and working over the weekend, to go into Monday with a solid program ready to be evaluated by an Industry Reference Group (IRG) made up of key stakeholders from Fiji. Monday was an early start, with a breakfast meeting at 7.30 am with the Vice-Chancellor of USP and the Director of TAFE. We then travelled back to USP, where we met with the IRG, who were very happy with what they saw, and the program was approved without change.

The qualification we developed was made up of 17 units: thirteen core units and four electives. Each unit required us to document how we would meet the following criteria:

- "elements", which define the essential outcomes,
- "performance criteria", which describe the performance needed to demonstrate achievement of the element,
- "foundation skills", which describe the required literacy, numeracy, and employment skills that are essential to performance,
- "knowledge evidence", essential knowledge required to complete effectively tasks outlined in the evidence and performance criteria required in the unit,
- "assessment conditions", skills that must be demonstrated in the workplace or a simulated environment and that reflect workplace conditions.

The IRG left after morning tea, and then we then convened the first meeting of the steering committee to establish a peak

Left to right Philip Armstrong, Shalen Kumar, Nicholas Fuata, Pranil Deo, Anu Mani, Aminiasi Driu, Tom Parker

body. After much discussion, it was agreed that the peak body should be a regional association and not a Fijian Association. This made a lot of sense considering USP was made up from 12 Pacific countries. I then was asked to lead a discussion about the essentials of developing a counselling association. A discussion followed, regarding the makeup of the committee and Fijian law in relation to the rules of establishing an association. A Chair was voted in, jobs were allocated and the meeting ended with congratulations all round.

It was indeed a great pleasure to be invited to be involved in the development of the first Diploma of Counselling designed specifically for the South Pacific region. A discussion was held about the future development of a Bachelor and Masters degree in Counselling. I am confident that, when the time is right and these qualifications are developed, there will be no requirement for external consultation. I can say that the USP committee with whom we worked were not only extremely enthusiastic but they were frighteningly efficient. I have not previously seen a committee develop a Diploma program within three days; these were some of the most committed people with whom I have worked. They worked straight through the weekend without any complaint, working eight-hour days, not including work completed in the evening.

Tom and I left exhausted early on Tuesday morning (6 am) to commence our four-hour drive back to the airport, but we were buoyed by the energy that was present from our new Fijian colleagues. Ironically, I did not go straight home. I flew to Brisbane to catch a domestic flight to Sydney, where, on the Wednesday, I Chaired a meeting of the Industry Reference Committee of the Industry Skills Council, to discuss the new training Community Services package, which includes the new Diploma of Counselling. I was very proud to announce that we now had a new offshore partner. I then had the weekend to prepare for a trip to Papua New Guinea (PNG) with our ILO on the Monday, to join in discussions about developing mental health services in PNG as part of the ACA Outreach program.

The University of the South Pacific (USP) is an intergovernmental organisation and a public research university, with a number of locations spread throughout a dozen countries in Oceania. It is an international centre for teaching and research about Pacific culture and environment. USP's academic programs are recognised worldwide, attracting students and staff from throughout the Pacific Region and internationally. The colonial link and the establishment of the University of the South Pacific in 1968 allowed the education system to adopt the qualification system of the Commonwealth. The University of the South Pacific is the only university in the Oceania region to be internationally recognised outside of Australia, New Zealand, Hawaii, and Guam with its Bachelors and other awards programs. USP is owned by the governments of 12 Pacific Island countries: the Cook Islands, Fiji, Kiribati, Marshall Islands, Nauru, Niue, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu.

Technology Update

With Dr Angela Lewis MACA

All about Cloud Computing 101

Very simply, if someone is using cloud computing it means they are storing their files and data remotely instead of on the hard drive of the computer on their desk, a physical device such as a data-stick or on their company's computer system. Using a cloud computing environment means the computer service and/or file storage is provided by another company and accessed over the internet. What causes confusion is that there is no actual 'cloud' as such. Instead, a cloud is simply the universal symbol and term to describe the concept of hardware, software, communication protocols and files being located out there 'somewhere'. It is believed the phrase originated from the cloud symbol used by flow charts and diagrams to symbolize the cloud back in the 1960s.

While the idea of using cloud computing sounds rather fancy and more like something a large company would use, most of us are actually using some aspects of cloud computing most days without even realising it - like when you access Webmail. If you log into a Webmail service such as that provided by Optus or Telstra or use a Hotmail or Gmail account, (perhaps you don't have access to your own computer or you are on holidays or travelling for work or using your smart phone to access mail); then you are on the cloud as your are accessing your email using the Internet. The days when your email could only sent and received by the program running on your computer such as MS/Outlook are long gone, because most email providers now allow you to access your email on the Internet which means you can access it anytime and anywhere. With webmail your emails are stored and processed on servers (computer equipment) located in a remote location somewhere in the world, (even though we are still calling it the cloud), because it is remote to us and accessed online.

Another way we are using cloud computing without calling it that is when we jump on Google to look up information, buy something or read the news. Google uses the Internet to send your query to one of its many networked computers which could be located anywhere in the world and this information is then sent back to you via Google and thanks to cloud computing. If you are using a Kindle to read a book, then its stored in the cloud, if you have popped your holiday photos on Flickr you are also using the cloud – you get the idea.

As well, preparing, using and sharing documents over the internet is a new example of cloud computing, with Google Documents for example allowing you to log onto a web-based service and create documents, spreadsheets and presentations.

DROPBOX – TAKE YOUR FILES AND DOCUMENTS WITH YOU

I have recently started to use a cloud file sharing service called Dropbox, found at www.dropbox.com. This very popular and easy to use service lets you store and

Let's say for example you are going to Europe for a holiday but you need access to particular files. Putting them into your Dropbox account means that you can easily log into it and access these files, including sharing them by either giving someone access to the folder or emailing them a link.

share files and photos and access them anywhere that has an Internet connection. Let's say for example you are going to Europe for a holiday but you need access to particular files. Putting them into your Dropbox account means that you can easily log into it and access these files, including sharing them by either giving someone access to the folder or emailing them a link. Dropbox will also sync the copies of the files you have in the folder to other devices. This means if you set up a Dropbox folder on your own computer and/or your smartphone, place a file in it and then make changes to that file (regardless of which Dropbox folder), then it will automatically update and synchronize the copies.

Using the travelling to Europe example, I make changes to a presentation that is stored in Dropbox while I am sitting in an Internet café in London. When I come home and use my own computer, the copy that is sitting on my Dropbox folder at home will already have been updated. The first two gigabytes (GB) of storage are free, as is the app itself; 100 GB of storage will cost $10 a month.

If you have no need to make your files and data accessible online, then another way to think about using sites such as Dropbox is as a way of backing up your files in case something happens to the computer where you have your data saved. While I still backup my computer to a hard-drive regularly, I also now put a copy of my files into Dropbox so they are also on the cloud, which gives me another form of backup if my physical devices fail.

As is always the case, you should do your own due diligence before using these services and think about the security aspect of saving data online as there is always a chance of security breaches and hackers into any online system. Some other file sharing/storage/backup providers include:

GOOGLE DRIVE

Google Drive (drive.google.com) holds on to old versions of files for up to 30 days, so you won't be out of luck if you accidentally delete something The first 5 GB are free; the next 100 GB cost $5 a month.

ICLOUD

Apple's iCloud service (apple.com/icloud) lets you backup and access music, photos, apps, documents, and other info from multiple devices but doesn't offer file sharing (to do that, download FileApp Pro, for $5.)

Microsoft Word Hints

It's been awhile since we looked at using Word, so here's a few tips and hints to try out.

Type anywhere on a page: Word allows you to easily start typing anywhere on a page and I must admit it's a simple tip I forget to use myself. Firstly be sure you are in Print Layout mode (click the View Menu and then click the Print Layout icon). The beauty of this function is that you don't have to start at the top of the page or put in any blank lines if for example you want to start typing at the bottom of the page – instead Word will automatically fill in the space above the cursor with blank lines. The key to getting it to work easily is to move your mouse to where you want to type, then holding the mouse still and ensuring you see the I-beam before you click the left mouse button. You can then easily start typing at the position where you have clicked.

Generating Filler Text: sometimes you may need to put some filler/nonsense text into a document to illustrate where text should go or in order to help show page breaks, columns, image placement etc.

It is easily done by typing this command anywhere on the page: =lorem(p,l)

Replacing the letter 'p' with how many paragraphs you want and the letter 'l' with how many lines in each paragraph. (e.g. =lorem(5,10) would give me five paragraphs with 10 lines in each.

Remove Manual Formatting: this will strip off a mixture of formatting from a selected amount of text. After selecting the text expand the Styles section on the Home Ribbon and locate the icon that looks like a little letter A with an eraser. Clicking that button will strip the text back to the underlying style, usually Normal with no formatting.

For more tips, hints and reference material on technology and social media, visit me anytime at www.angelalewis.com.au and remember to always do your own research on any information provided here to ensure you make an informed decision before visiting any sites or trying out any of the hints provided.

Study challenges notion of fear of weight gain in patients with anorexia nervosa

A study from Inserm, Paris Descartes University and Sainte Anne Hospital suggests that anorexia nervosa might not be explained by fear of gaining weight, but by the pleasure of losing it... and that the phenomenon might begenetically influenced. Published in Translational Psychiatry, this study, directed by Prof. Gorwood, head of the Clinic for Mental and Brain Diseases, challenges the notion of fear of weight gain in anorexia patients.

Often associated with major psychological distress, anorexia nervosa is an eating disorder that mainly affects girls and young women. Diagnosis is based on three international criteria:

- restriction of food intake leading to weight
- loss, a distorted perception of weight and body,
- and an intense fear of becoming fat.

Although there is no pharmacological treatment, Prof. Philip Gorwood's team has focused on these clinical criteria.

As the researcher explains: "When research is going nowhere, it is important to call into question the criteria at the very root of the disorder. We have therefore re-evaluated the last criterion, although it is quite prominent in patient discourse, by assuming that it is a mirror image of what is really involved, i.e. a reward for losing weight. We established the postulate that patients felt pleasure at becoming thin rather than fear of becoming fat."

So as not to be influenced by patients' discourse and analysis of their eating disorders, the researchers used a "skin conductance test," which measures the subject's sweating rate when exposed to various images. The emotion caused by certain images actually leads to a rapid and automatic increase in sweating.

The researchers showed images of people of normal weight or overweight people to 70 female patients consulting the Clinic for Mental and Brain Diseases

(CMME) of Sainte Anne Hospital. For these patients, of varying weight and with different degrees of disease severity, viewing these images caused much the same reaction as in healthy subjects. Conversely, when looking at images of thin bodies, the patients showed positively evaluated emotions, whereas healthy subjects had no particular reaction.

Anorexia nervosa is a highly heritable disorder (70%). One of the genes most often associated with anorexia nervosa codes for BDNF, a factor involved in neuron survival and neuroplasticity. In patients with anorexia nervosa, the study indicates that the increase in sweating experienced when viewing images of thin bodies is explained by the presence of a specific form (allele) of the gene in question. This result was confirmed after examining potential confounding variables such as weight, type of anorexia or duration of the disorder.

The conclusions of this work: support the genetic approach as a different way of addressing the key symptoms of anorexia nervosa; orient research toward reward systems rather than phobic avoidance; finally, they suggest that certain therapeutic approaches, such as cognitive remediation and mindfulness therapy, might have a clear beneficial effect on this illness.

SOURCE:

INSERM (Institut national de la santé et de la recherche médicale) Study challenges notion of fear of weight gain in patients with anorexia nervosa

Accessed at: www.news-medical.net/news/20160608/Study-challenges-notion-of-fear-of-weight-gain-in-patients-with-an

New study sheds light on link between gut microbiome and the brain

Intestinal bacteria that can boost bravery or trigger multiple sclerosis: An increasing body of research results confirms the importance of the "gut-brain axis" for neurology and indicates that the triggers for a number of neurological diseases may be located in the digestive tract. "The gut microbiome can influence the central nervous system, the development of nerve cells and the immune system. A better understanding of its effect could revolutionize our therapy options," noted Dr Patricia Lepage from the Institut National de la Recherche Agronomique in Jouy-en-Josas, France, at the Second Congress of the European Academy of Neurology (EAN) in Copenhagen.

Gut microbiota influences behaviour

The gut microbiome is the aggregate of human gut microorganisms with all its bacteria, archaea, viruses and fungi.

For a long time, it seemed far-fetched to think that the microbiome could also be responsible for processes outside the digestive tract. Yet the scientific community keeps uncovering further amazing details. Recent studies on laboratory animals which grow up without any microorganisms (germ-free) show for example that microorganisms in the gut are even capable of influencing behaviour. Dr Lepage: "Intestinal microbes can verifiably produce neuromediators that have an effect on the brain. Germ free mice showed less anxiety than their conspecifics whose gut was populated with commensal microbiota. However, there is only scant evidence thus far on how this process works in the human brain."

It has been proven in the meantime that the gut and the brain communicate with each other via several routes including the vagus nerve, the immune system, the enteric nervous system or by way of microbial metabolic processes. For instance, intestinal bacteria convert carbohydrates into short chain fatty acids, e.g. in butyric acid.

This strengthens the connections between the cells and reinforces the blood-brain barrier, which serves as a cellular

wall to protect the brain from infections and inflammations.

Gut microbiome regulates brain processes

For the neuroscientist Prof John F. Cryan (APC Microbiome Institute, University College Cork, Ireland), there is no question that the gut microbiome regulates fundamental brain processes important for the development of neurological diseases: "We studied the brains of germ free mice. In one region, the prefrontal cortex, we found increased myelination compared with animals kept under normal conditions. This may have direct implications for myelin-related disorders. Microbiome-dependent processes have also been shown to include adult hippocampal neurogenesis and microglia activation, i.e. the activation of brain and marrow cells similar to immune cells."

Experimental models on the origin of autoimmunity suggest that the gut microbiome plays an important role in this context, too. This insight opens up a new approach for finding the cause of multiple sclerosis (MS). MS is an autoimmune disease that results from a combination of genetic and environmental factors. Dr Gurumoorthy

Krishnamoorthy from the Max Plank Institute for Neurobiology in Martinsried, Germany: "Apparently, the bacteria that can trigger multiple sclerosis are not disease-causing bacteria but rather useful bacteria needed for digestion."

A study with genetically modified mice showed that animals featuring normal intestinal microbiota and subject to no external influences developed inflammation in the brain. By contrast, mice kept in a germ-free environment remained healthy. As Dr Krishnamoorthy explained, the immune system of the mice with normal intestinal microbiota is activated in two phases: First, T-cells become active and multiply in the lymphatic vessels of the intestinal tract. Together with surface proteins in the myelin sheath, they then stimulate B-cells to form diseasecausing antibodies. Dr Krishnamoorthy: "Both trigger inflammatory reactions in the brain, which destroy the myelin sheath in phases - very similar to the way MS unfolds in human beings." This process suggests that it is not disorders in the nervous system but rather a change in the immune system that leads to MS. Researchers assume that gut microbiota in human beings can likewise cause the immune system to overreact to the myelin sheath if a corresponding genetic predisposition exists. It is still unclear, however, which bacteria are involved in the development of MS.

Gut microbiome

The microbiome consists of up to 1,000 different types of bacteria and of about 100 trillion cells. As such it has ten times as many cells and 150 times as many genes as the human genome. The microbiome co-evolves with its human host in a symbiotic relationship. The development of the gut microbiome as a finely tuned ecosystem depends on a number of factors: whether and which microorganisms a person absorbs from his/her mother's birth canal at the time of birth; whether a person is subject to antibodies; what food a person eats; infections; stress and genetic predisposition. Elderly individuals who are in poor health often have a lower diversity of microorganisms in their microbiome or inflammation-promoting manifestations.

SOURCE:
European Academy of Neurology

The Neuroscience of Listening, Empathy, and Microskills

By Allen Ivey, Mary Bradford Ivey and Carlos Zalaquett

The counseling relationship changes the brain, facilitating neurogenesis and strengthening the development of new neural networks. The conversation, which is counseling, can also help "rewire" the brain for more effective living. Neuroscience and neurobiology have shown that the vast majority of what our field has done for years is correct and makes a positive difference for our clients. Empathy is a necessary (and sometimes sufficient) condition for the relationship, which can enable client change by itself. Recent neuroscience findings on empathy show that the original ideas of Carl Rogers are even more complex than we have thought, but our basic understanding remains solid.

Listening is the building block of the relationship. New Japanese brain research using functional magnetic resonance imaging (fMRI) reveals that "Listening lights up the brain." Kawamichi and colleagues found that the Rogerian microskills of attending behavior, paraphrasing, reflecting feelings and summarizing create the foundation for a strong relationship and the benefits that we see stemming from this alliance (see Figure. 1). The centrality of listening and relationship is not new to the counseling field, but at the same time, it is highly reassuring that the foundation of ACA's humanistic orientation now has fMRI evidence supporting what we have known for years. Listening enables us to bring out client stories and facilitates growth and development.

Kawamichi H1, Yoshihara K, Sasaki AT, Sugawara SK, Tanabe HC, Shinohara R, Sugisawa Y, Tokutake K, Mochizuki Y, Anme T, Sadato N. (2015). Perceiving active listening activates the reward system and improves the impression of relevant experiences. Soc Neurosci. 2015;10(1):16-26. doi: 10.1080/17470919.2014.954732. Epub 2014 Sep 4. By permission of Taylor and Francis Publishers

Counselors activate key brain structures when they listen. The ventral striatum becomes active when encountering abstract

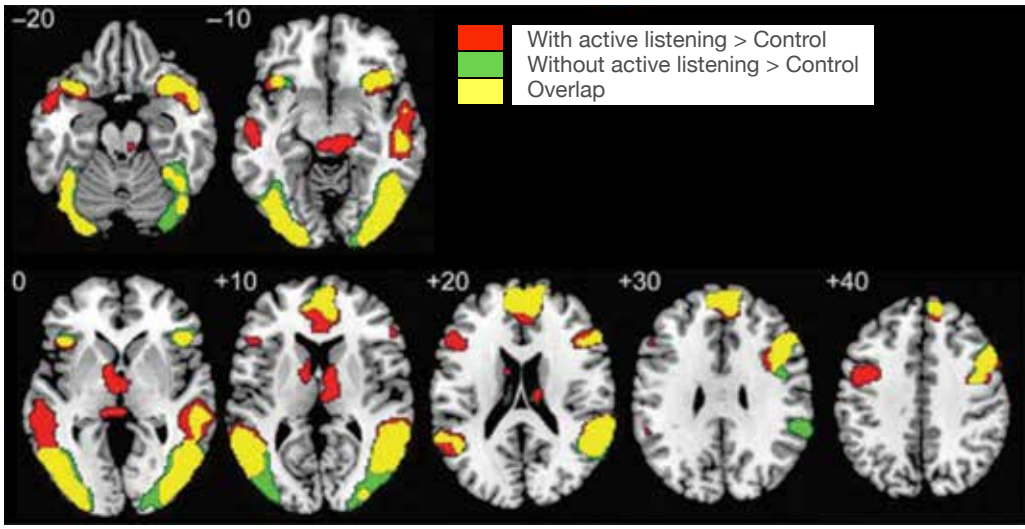

Figure 1 Perceiving active listening activates the reward system.

Image: Taylor and Francis Publishers*

positive communication. This has been described metaphorically as a "warm glow." We think of Rogerian positive regard, authenticity, and being with the client as key aspects of listening. The microcounseling approach identified the concrete behaviors of listening in1966 and originated the term "attending behavior." The importance of culturally appropriate eye contact, body language, vocal tone, and verbal following has since become a basic standard counseling practice and the skills course. "If you are puzzled in the session and don't know what to do, listen!"

The right anterior insula has been identified as key in emotional appraisal. Ayda and colleagues writing in the 2015 *Journal of Neuroscience* point out that it identifies what is salient and has a close connection with the anterior cingulate cortex, concerned with empathy, emotion, and reward anticipation. Together they are important in inhibitory control, a critical factor in dealing constructively with emotion.

Mentalizing is also termed Theory of Mind (ToM). ToM/mentalizing is the "ability to attribute mental states — beliefs, intents, desires, pretending, knowledge, etc. — to oneself and others and to understand that others have beliefs, desires, intentions, and perspectives that are different from one's own."

Medial PFC and superior temporal sulcus are associated with emotion, memory, and complex cognitive processes such as TOM/mentalizing, which provide the basis of holistic empathy. The superior temporal sulcus is involved in the perception of where others are gazing (joint attention) and is thus important in determining where others' emotions are being directed (Michael Beauchamp, 2015).

Polyvagal Theory and Safety

Stephen Porges in 1995 originated a theory, focused on the parasympathetic nervous system's vagus nerve, which provides evidence supporting our empathic approach. Porges prefers the word "compassion," which certainly Rogers emphasized, but did not name it that way. The vagus nerve extends from the brainstem to the abdomen and helps to regulates heart rate, breathing, and digestion. Called metaphorically "rest and digest," the vagus does much more than that and is a vital biological part of helping our clients slow down during difficult

times in the session. Vagal regulation takes the form of calming, enabling us to deal with stress appropriately. Porges points out that vagus calming functions are key to feelings of safety. This, in turn, leads to attachment theory. We cannot move fully into the world unless we feel safe.

Physiological needs and safety rest as the foundation of Maslow's Hierarchy of Needs (see Figure 2). What Porges has done returns us to Maslow, but with a difference. We too often focus on self-actualization in counseling and therapy with insufficient attention to Maslow's foundation of physiological and safety needs. Porges has brilliantly and perhaps unintentionally clarified the importance of Maslow's original ideas. He has identified the vagus nerve and its connections as the physiological basis for safety. If we are to conduct effective counseling and therapy, we need to provide a safe environment in an effective relationship. As part of that, the calming function of the vagus provides body safety for counseling.

Porges focuses on four factors of compassionate relationship that will sound familiar to those who have worked with the concrete microskills identified behaviors of listening. Using somewhat different terminology, Porges gives considerable attention to prosodic vocal tone (quality of intonation), gestures/body language, and style of eye contact as key to building feelings of safety. He also speaks of socialization where verbalizations provide content to these key nonverbal dimensions. Furthermore, he provides additional specifics that can help guide the client to a calming state (e.g., taking a deep breath) .These feelings of safety, in turn, are rooted in physiology, as Maslow suggested years ago, although Porges provides a precision which only now is possible.

Counseling Skills, Calming, and Activating

The microskills framework focused first on listening skills and attending behavior in 1966-68 with a research group at Colorado State University (Ivey, Normington, Miller, Morrill, and Haase). At that time, the 3 V's + B were identified through study of videotaped sessions—visuals, vocal tone, verbal following, body/facial language. Porges adds important information to the foundational interview skill of attending, for it is here that we provide safety. Through an authentic and safe relationship and listening we can encourage feelings in the body, supporting cognitive change. We are not just counseling with words, we are working with the whole of the client's body, brain and mind. An axiom of today Microcounseling is the mind-brain-body axis operating in an atmosphere of persons and the environment.

Bringing out client concerns via careful listening is usually, but not always, calming. Thus, additional microskills based on attending are important to include. Paraphrasing, encouraging, reflecting feelings, and summarization are needed to bring out the client story. As stories of client issues develop and evolve, there is a natural tendency to relax in a safe environment. The calming relationship itself increases the flow of the pleasurable neurotransmitter dopamine to the body.

But at the same time, client issues may activate the sympathetic nervous system and resulting in stress and observable tension in the body, as well as increasing heart rate and changing breathing. It is here, of course, that a calm and effective counseling relationship becomes all the more essential. Stories of strength and resilience, as well as family and friends supports the ability of clients to face and surmount difficulties and challenges. And we need to maintain awareness that it takes many positives to work against the negatives that clients face. The basic skills of attending are critical. A warm supportive vocal tone, culturally appropriate body language and eye contact, plus careful attention to verbalizations almost inevitably will lead to calming.

Activation of the sympathetic nervous system (SNS) is necessary for change and creative movement while relationship and safety provide the foundation for action. We tend to only associate the SNS with the amygdala's "fight or flight," but is it much more than that. Simply put, the sympathetic nervous system makes it possible and its stimulation is necessary for locomotion, learning, change, work, and play. The influencing microskills are more activating and thus are associated primarily with the SNS, although an allostatic balance with skills/strategies of confrontation, interpretation/reframe, reflecting meaning, of directives, logical consequences, and psychoeducation are best provided in an environment that combines both safety and challenge. Cognitive behavioral therapy and several other systems tend to focus on influencing clients to change and they do it well. But, unsaid and present in effective CBT, is relationship, appropriate calming, and listening to client stories before the action influencing skills come into play (e.g. automatic thought charts, reframing, desensitization, etc.).

Counseling and therapy seek to provide an allostatic balance of calming and activation with an underlying background of physiological safety. We can take risks, learn, and develop in a compassionate counseling relationship. The influencing skills provide often necessary routes toward action and behavioral and cognitive change. All of these skills, used effectively, lead to learning and strengthening new

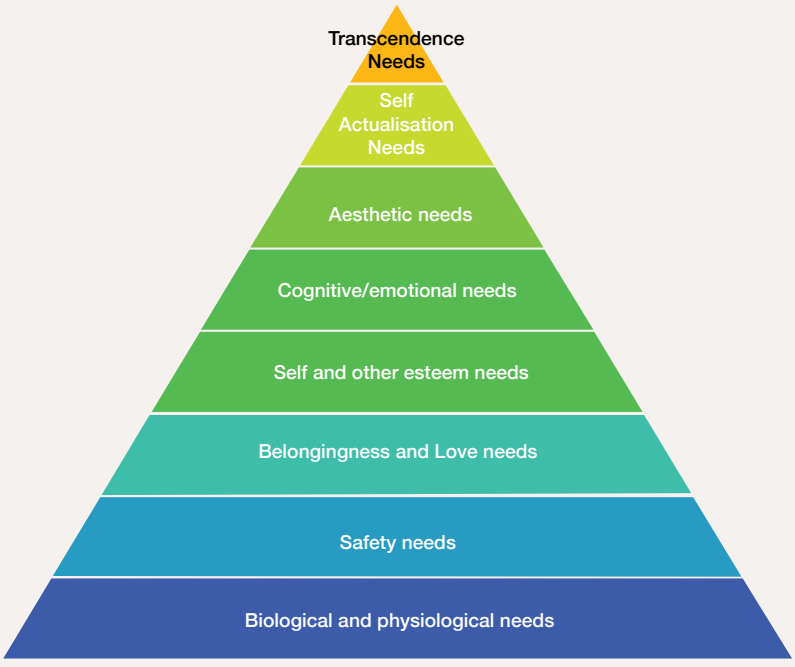

Figure 2 Maslow's Hierarchy of Needs

neural networks—and, at times, new neurons (neurogenesis).

These networks of neurons provide the basis for various components of empathy, such as cognitive empathy, affective empathy, and mentalizing. Listening, the capacity to "see" the world as other sees it, and the ability to sense the emotional states of others are greatly facilitated by empathy. A meta-analysis conducted by Fan et al. (2011) across 40 fMRI studies showed that affective empathy is associated with increased activity in the insula, while cognitive empathy is associated with higher activity in the midcingulate cortex and the dorsomedial prefrontal cortex. (MCC/dmPFC). Eres et al. (2015) found greater gray matter density in both places. These findings are similar to those of the Japanese researchers.

The advances in neuroscience confirm that empathy is a multicomponent construct, essential in navigating our social environment and developing deeper intellectual and emotional understanding. Mirror neurons, of course, are central in that process enabling us to enter the world and mind of our clients. Affective empathy help us understand the emotions experienced by others, while cognitive empathy help us understand client verbalizations, thought patterns, and behaviors. Decety's research show that these two processes are supported by different parts of the brain and Eres research demonstrates that there are volumetric differences among them. This means that we know where in the brain these processes are originated and how much gray matter is involved. Armed with this knowledge we can train these specific locations to increase or decrease activity or to increase neuronal connections, with the specific purpose of enhancing cognitive or affective empathy.

Neuroimaging studies by Lamm, Decety, and Singer show that emotional components are shared vicariously. When we experience direct pain ourselves (first-hand sensation), the somatosensory motor cortex, insula, and anterior cingulate cortex (ACC) are activated. When we watch others experience pain (second-hand pain), the insula and ACC are activated, but not the somatosensory cortex. The insula integrates visceral and autonomic information with salient stimuli, acting as an infrastructure for the representation of subjective bodily feelings of positive and negative emotions.

Affective empathy, the emotional dimension of empathy, helps us experience, in a conscious way, the emotional state of the other person. At the same time, affective empathy will often enable us to feel at least some of the client's emotions in our own body. Affective empathy implies a self-other distinction, as well as an understanding of the origin of the other person's emotional experience. Why is this important? Because it increases our general sensitivity to the emotions of others, enhances our capacity to fully understand their emotional experience, and facilitate helping behavior.

Cognitive empathy, the thought/thinking dimension of empathy, is our ability to understand the minds of others and predict their behavior without necessarily sharing their emotions. It builds social expertise in a world populated with emotional humans. Cognitive empathy with minimal affective empathy could also facilitate competitive, antagonistic, and deceptive behavior. Cognitive empathy relies on dorsal regions of the medial prefrontal cortex for behaviors such as perspective taking, direct and reflected self-knowledge.

Mentalizing, a holistic brain process, is the spontaneous sense we have of ourselves and other persons. It is a central process in holistic cognitive/affective empathy. Human behavior is based on fluid mental states, which makes understanding others difficult. All of our actions are driven by needs, feelings, desires, beliefs, or reasons. When we interact with others, we automatically (unconsciously) read their underlying mental states and base our responses on what underlies the other person's behavior. Humans are natural mind readers and mentalizing is the process by which accurate mind reading is achieved, but obviously some understand others quite inaccurately, often because they do not listen fully. At times, counselors make serious errors in mentalizing when they unconsciously "mix up" their own experiences with the thoughts and feelings of the client. Sometimes mentalizing is consciously done, like when we try to understand if somebody is upset with us and why. Whether consciously or not, we are always mentalizing, we are always trying to make sense of our social world and our place in it.

Mentalizing affects our wellbeing in many different ways when we apply it to ourselves. It provides a sense of self-awareness, self-concept, and self-control. It serves as the basis of relationships. It helps us empathize with another person and see things from their perspective. This is the cornerstone of common human interactions, healthy relationships, and effective counseling and therapy. It makes possible the automatic or conscious moment-to-moment adjustments we make to the verbal and emotional responses from other people.

Mentalizing is also central to resilience, or the capacity to adapt to adversity and challenges. Persons that can mentalize in the face of challenging or traumatic events are less vulnerable to stress and mental disorders. Conversely, promoting mentalizing in persons afflicted by mental disorders improves their quality of life and accelerates recovery. Furthermore, it increases their capacity to make meaning of adversity, develop a sense of purpose, facilitate problem solving, enhance flexibility, improve communication, and promote mutual empathy.

Attending behavior and skilled observation are basic to mentalizing and empathy. The skill of paraphrasing is most closely related to cognitive empathy, while reflection of feeling refers to affective empathy. Summarizations, particularly of extensive client comments, is key to mentalizing. The goal is to understand the client's cognitive and affective worlds, but also integrate them in a way that requires understanding the client's mental state more fully. Most summaries are primarily cognitive, but includes client emotional and feeling tone. As emotions are often first reactions and typically occur before cognition regulates emotion, counselors need to consistently think about (mentalize) the possibly underlying unsaid emotions.

Furthermore, the most fulfilling counseling interactions involve a meeting of minds. Clients feel reassured when they sense that they are in tune with the counselor. They feel heard and understood. They sense that they are not alone and experience a sense of safety.

There are other aspects of cognitive and affective empathy and mentalizing. These allow identification with the other and provide the bases for transference, and countertransference. Emotional contagion is the automatic adoption of another person's emotions. Mimicry is the automatic synchronization of emotional expressions and behaviors. In both, the self-other distinction is lost. You become the other, preventing the facto your capacity to help. Sympathy represents an emotional response and motivation caused by your concern for the wellbeing of the other person. This is your compassionate response to the other, but not recognition of the emotional state of the other.

Why should we be interested in all of

the above? For starters, we use empathy to communicate with others and build relationships, especially counseling relationships, and to consolidate our understanding of others, including our clients. Empathetic listening is critical for building a therapeutic relationship and a successful counseling intervention. Deficits in empathic listening may lead to ineffective counselors, deficient counseling relationships, and potentially damaging interventions.

Last but not least, based on over 500 studies on the microskills and the newly learned neuroscience information we can educate counselors and therapists about the importance of becoming more cognitively and affectively empathetic. In turn, these counselors may teach their clients how to listen—this can be supplemented by video feedback with recorded practice sessions.. Further more, some of us are better at cognitive understanding, while others are more skilled in affective empathy. Mentalizing and accurately understanding others is a base for competent counseling and therapy and takes considerable practice and experience.

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PEER REVIEWED ARTICLE

The Impact of Domestic Violence on Children:Linking Theory to Practice

By Tara Hamilton MACA

Research has found that children exposed to domestic violence are negatively affected in terms of health outcomes, trauma symptoms, behavioural difficulties, social and psychological impacts (e.g., Bedi & Goddard, 2007; Blackburn, 2008; Evans, Davies, & DiLillo, 2008; Felitti et al., 1998; Holt, Buckley, & Whelan, 2008; Humphreys et al., 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003; Meltzer, Doos, Vostanis, Ford, & Goodman, 2009; Rizo, Macy, Ermentrout, & Johns, 2011; Sety, 2011; Sterne & Poole, 2010). In working with this population it is important to provide services for not only the children and their mothers, but the fathers who abuse their partner, as they require support in their role as fathers as well as perpetrators of violence (Peled & Perel, 2003; Queensland Government, 2016). This paper will put forward two theoretical approaches: Men's behaviour change programs with an emphasis on the father role and trauma-informed practice when working with children impacted by domestic violence.The implications these theories have on policy and practice will also be reviewed.

Literature Review

More than 100,000 Australian children per year are affected by domestic violence (DV) with serious emotional, psychological, social, behavioural and developmental consequences (ABS, 2006). In the Australian Bureau of Statistics Personal Safety Survey, of those individuals who reported the use of violence by their current partner, 111, 700 were looking after children (ABS, 2006). Moreover, in a National Crime Prevention Survey, almost one quarter of Australian children reported witnessing physical domestic violence against their mother (Indermaur, in Sety 2011).

There are numerous definitions of domestic violence (Sety, 2011), however for the purposes of this paper, DV will be defined as the following: "…also called intimate partner violence, occurs in a variety of forms including physical, emotional, and economic violence within any type of relationship against any person" (Bryce et al., 2015, p. 68). In addition, it is important to recognise that the majority of victims and survivors of domestic abuse are female and offenders of abuse are male, thus this paper will be focusing on the male as the perpetrator of violence (Bryce et al., 2015).

Various terms are used to define the experience of children affected by domestic violence including: witnessing violence, exposure to violence, experiencing direct abuse, hearing or seeing violence, and living with domestic violence (Sety, 2011). Other experiences may include: accidentally hurt, attempted to intervene, occurred in utero, victim of threats or child abduction (Edleson, 1999; Humphreys, Houghton, & Ellis, 2008). The common theme throughout these terms is the physical presence of the child during the violence or as a target of direct abuse (Sety, 2011). However, distinguishing between their presence and direct abuse becomes challenging, as patterns of abuse are often complex and entwined (Sety, 2011).

Research by Kitzmann and colleages (2003) suggest that children who witness violence experience a similar level of negative psychosocial outcome as children who directly experience physical abuse. The meta-analysis examined 118 studies of psychosocial outcomes of children exposed to DV and found a significant correlation between exposure and child problems. Further, witnesses' psychosocial outcomes were not significantly different from children who were physically abused or witnessed physical abuse (Kitzmann et al., 2003). Therefore, this paper will use the definition that encompasses all forms in which children may be affected by violence (Sety, 2011).

The Impact on Children

Several studies have demonstrated that children who have been affected by domestic violence are significantly impacted in many areas including physical, psychological, emotional, social, behavioural, developmental, cognitive wellbeing and functioning (Bedi & Goddard, 2007; Blackburn, 2008; Evans et al., 2008; Felitti et al., 1998; Holt et al., 2008; Humphreys et al., 2008; Kitzmann et al., 2003; Meltzer et al., 2009; Rizo et al., 2011; Sety, 2011; Sterne & Poole, 2010). This paper will focus predominantly on school-aged children and how domestic violence affects this age group. Within the school-yard, children can display externalising behaviours including hostility, aggression, and oppositional behaviour, as well as internalised behaviours including shyness, withdrawal, passiveness, depression, anxiety and low self-esteem (Sterne & Poole, 2010). In addition, exposure to DV can negatively impact attention and concentration skills, cognitive abilities, language development, school achievements, attendance, and social development (Sterne & Poole, 2010).

HEALTH IMPACTS

In one of the largest scientific studies of its type, Felitti and colleagues (1998) found that adverse childhood experiences, or ACEs, including exposure to psychological, physical or sexual abuse, were strongly correlated with increased health risks as adults (Felitti et al., 1998). The study included 9, 508 adults who filled in a questionnaire, which asked about their history of exposure to ACEs including psychological (2 questions), physical (2 questions), or contact sexual abuse (4 questions), substance abuse (2 questions), parental mental illness (2 questions), violent treatment of mother/ stepmother (4 questions), and family member imprisonment (1 question). Participants were defined as being exposed to a category if they responded

"yes" to one or more of the questions from each category. The researchers then correlated the participants' scores on health outcomes. The authors found a strong correlation between exposure to abuse or household dysfunction during childhood and many risk factors for several leading causes of death (Felitti et al., 1998).

TRAUMA SYMPTOMS

Exposure to domestic violence can potentially produce catastrophic and long-term trauma symptoms in children (Holt, Buckley, & Whelan, 2008). Thus, reducing trauma symptoms is a commonly targeted goal in interventions for children impacted by DV (Rizo et al., 2011). Trauma is the emotional, psychological and physiological residue that remains from experiences of threat, violence and challenging life events (Australia Childhood Foundation, 2010). Trauma can impact on all elements of children's development including memory, emotions, learning, relationships and behaviour (Australia Childhood Foundation, 2010). In the most extreme form, some children living with DV display symptoms of posttraumatic stress, although the more common pattern is traumatic hyper-arousal (Bedi & Goddard, 2007). This means, children who have experienced DV will have a heightened autonomic arousal indicated by a higher resting heart rate, and increased stress response (Bedi & Goddard, 2007). Other trauma symptoms include anxiety (Kitzmann et al., 2003), intrusive re-experiencing of the violence in dreams or flashbacks and emotional withdrawal (Evans et al., 2008). Further, violence that involves injury, threatened or actual death is more likely to be traumatic for the child (Kitzmann et al., 2003).

LEARNING AND BEHAVIOURAL DIFFICULTIES

Research suggests that approximately 40 per cent of children exposed to DV display clinically significant behavioural problems (Holden et al, in Sterne & Poole 2010). Children can be negatively affected in terms of their speech, language development, and cognitive abilities due to heightened stress. Moreover, children who live in fear have difficulties with concentration and attention. In addition, absence from school means missed learning opportunities and growth (Sterne & Poole, 2010). A study by Blackburn (2008) found that children, aged six to nine years, exposed to violence perform worse on reading and phonological awareness tests than children from non-violent homes. Social impacts. Children also experience serious social consequences as a result of exposure to domestic violence (Sterne & Poole, 2010; Sety, 2011). In the first US study observing the relationship between domestic violence exposure and bullying, researchers found that children exposed to DV exhibit higher levels of generalised aggression (Bauer, in Holt et al 2008). Moreover, children may respond to stressful situations by becoming aggressive or hostile, while others may avoid the situation and physically run away (Sterne & Poole, 2010). Further, children may experience social isolation, difficulties forming friendships, and bullying (either as a victim or perpetrator) (Sterne & Poole, 2010).

Psychological impacts. Children affected by domestic violence can live with unbearable levels of fear and insecurity (Sterne & Poole, 2010). However, anxious children do not always present at school, thus their anxiety may go unrecognised. Some of the children's fears include: injury or death to their mother, violence occurring while they are in school, injury to themselves, safety of pets, family separation, and punishment for telling someone. Symptoms that children may exhibit include low self-esteem, fear of

authority figures, separation anxiety, and being preoccupied (Sterne & Poole, 2010). Moreover, children exposed to DV also score high on post-traumatic stress disorder (PTSD) scales, and often meet criteria for PTSD diagnosis (Evans et al., 2008). Further, these children can show more signs of depression and conduct disorder than children from non-violent homes (Meltzer et al., 2009).

OTHER IMPACTS

Some research suggests that boys exposed to violence tend to externalise their feelings such as through aggression and hostility, whilst girls internalise their feelings, which can result in depression and anxiety (Holt et al., 2008; Meltzer et al., 2009). Moreover, research has found concomitant rates for IPV and physical abuse at 55 percent, as well as coexisting IPV and sexual abuse at rates of 40 per cent (Goddard & Hiller, in Bedi & Goddard 2007). Further, violence may influence gender stereotypes as they begin to identify with their same-sex parent (Cunningham & Barker, 2007). Children may then learn males are the perpetrators and females are the victims as they live with violence against their mother (Cunningham & Barker, 2007).

Coping and Resiliency

While it is evident that children exposed to DV are at risk of many negative outcomes, research demonstrates that up to 54 per cent of children show resilience (Martinez-Torteya, Bogart, Von Eye, & Levendosky, 2009; Richards, 2011). Resiliency is dependent on many factors including age, gender, pre-existing vulnerabilities, social support, biological and psychological risk factors (Bedi & Goddard, 2007). Moreover, primary school-aged children have many protective factors such as teacher support, access to guidance counsellors, and school friendships (Sterne & Poole, 2010).

Theoretical Approaches

Specialised programs play an important role in diminishing the impact domestic violence has on children as previously described (Sety, 2011). In a large meta-analytic review over a span of 20 years, Rizo and colleagues identified 31 articles most relevant to intimate partner violence (IPV) interventions for children (Rizo et al., 2011). The interventions included counselling/therapy, crisis/outreach, parenting, and multi-component interventions, which were delivered to children, their parents, or both. The review demonstrated promising findings across all categories. The intervention goals were often similar, suggesting that there may be specific goals to target when working with children impacted from IPV. Moreover, the review identified that researchers have predominantly offered services to either the children, their mothers or both, while the offending fathers are ignored (Rizo et al., 2011).

Some research suggests that boys exposed to violence tend to externalise their feelings such as through aggression and hostility, whilst girls internalise their feelings, which can result in depression and anxiety

Feminist Theory: Men's Behaviour Change Programs

Including men who use violence in interventions is crucial as Domestic Violence Prevention Minister Fentiman explains; "perpetrator programs have to be a part of the mix as there cannot just be shelters and counselling to support women without trying to stop the man behind the violence" (Courier Mail, 2016, p. 21). Recently, attention has focused on engaging men in programs to foster significant and positive change in men's gender-related attitudes and practices, including men's use of violence (Peacock & Barker, 2014). Consequently, community-based interventions have been steadily implemented to combat violence (Peacock & Barker, 2014).

According to the 'Domestic and Family Violence Prevention Strategy', Men's behaviour change programs (MBCPs) are incredibly important for offending males to receive the appropriate support to end their violence (Queensland Government, 2016). The key outcome of this particular service is so that children can grow and develop in safe and secure environments (Queensland Government, 2016). Most of the MBCPs draw on elements of two main theories: the feminist and psychological explanations of violence (Day, 2015). These theories reflect a common view about the nature of the problem as generated within a context of gender relations, socialisation and learning, and an orientation to intervention focusing on changing behaviours and ways of thinking about interpersonal relationships (Day, Chung, O'Leary, & Carson, 2009).

Unfortunately, there are very few programs that focus on men in their role as fathers and how their violence impacts upon their children (Rizo et al., 2011). One preliminary intervention program in Canada called 'Caring Dads: Helping Fathers Value Their Children' was specifically designed for men who maltreated their children and/or who exposed their children to abuse of their mothers (Scott & Crooks, 2007). The program runs for 17 weeks and focuses on change in the use of abusive parenting strategies, in attitudes and beliefs that support unhealthy parenting, and in men's understanding of the affect it has on their children. In an evaluation of this program, the researchers firstly found that the program is fulfilling a need due to the amount of referrals and requests. Second, there was a match between the program's underlying theory and the characteristics of referred clients such as entitlement and over-controlling behaviours. Of these clients, half of them used violence against their children's mothers. For a second group of men, an intervention around exposing their children to DV, using them to "get back at" their mothers, and undermining the mother-child relationship were needed. This group of fathers, however, had managed to develop a reasonable relationship with their child(ren) despite ongoing abuse of their mothers (Scott & Crooks, 2007).

Evidence was provided for the program's success in terms of retention rates and client satisfaction (Scott & Crooks, 2007). Further, community stakeholders identified the value in the program for ensuring children's safety and wellbeing and are using the feedback to assist in ongoing monitoring and risk management. Lastly, pre- and post-assessments revealed that the father's level of hostility, denigration, rejection of their child, parenting stress, and their angry arousal to child and family situations significantly decreased. In addition, outcomes improved when the focus of evaluation was matched with the client (Scott & Crooks, 2007).

In a similar voluntary program called 'Strength to Change' in north-east England, the authors explored ways in which men's roles and constructions of themselves as fathers contribute to enhanced motivation to change abusive behaviours (Stanley, Graham-Kevan, & Borthwick, 2012). The authors found

that men who were currently involved in children's social services were more likely than other participants to engage in the program for longer than five sessions. Moreover, the men's desire to regain access to their children or avoid care proceedings was an extrinsic motivation that appeared to be effective in securing men's engagement in the program. In addition, their children functioned as a form of intrinsic motivation as the men developed their understanding of the impact their abusive behaviour had on their children and viewed their participation as becoming a 'better father' (Stanley et al., 2012).

In another intervention for maltreating fathers, Scott and Lishak (2012) examined the clinical significance of pre- to post-intervention changes in parenting, co-parenting and generalised aggression. In regards to parenting, the findings demonstrated change in over-reactivity, hostility and laxness at levels comparable to other parenting interventions. Moreover, the results provided evidence for an increase in men's respect for the commitment and judgment of their children's mothers (Scott and Lishak, 2012).

In contrast, some researchers have suggested interventions for men can be problematic and even dangerous (Peled & Perel, 2003). Researchers argue that interventions for men who abuse raise concerns concerning its potential harmful effects on abused women and children. It has been proposed that the fathers who abuse may misuse the intervention to continue their controlling and abusive behaviour toward their partners and children. For instance, men may use the intervention as a proof of their competence as a father, which can be brought up in times of conflict with his partner or during interactions with criminal justice systems (Peled & Perel, 2003).

Notwithstanding, fathering interventions such as the ones described are important, as all fathers should be responsible for the wellbeing of their children and thus deserve adequate social support in their role as fathers whether abusive or not (Peled & Perel, 2003). However it is important to realise that this is only one component of the many varied services required to address a significant social issue (Day et al., 2009). Another service that is crucial for assisting children impacted by domestic violence are programs for children themselves (Queensland Government, 2016).

Trauma-focused Practice

As previously described, the literature clearly demonstrates the association between exposure to DV and trauma symptoms in children (e.g., Bedi & Goddard, 2007; Campo, 2015; Evans et al., 2008; Holt et al., 2008; Kitzmann et al., 2003; Meltzer et al., 2009; Osofsky, 2003; Overlein, 2010; Rizo et al., 2011; Sety, 2011). Trauma-informed care is often recommended in responding to children impacted by domestic violence (Campo, 2015). Trauma-informed practice does not necessarily focus on treating childhood trauma; instead it refers to models of interventions that are aware of the possibility that individuals may be victims of trauma and that the issues they present with may be symptomatic of that trauma (Campo, 2015). In fact, many of the interventions included in Rizo and colleagues' meta-analysis focused on decreasing trauma symptoms as one of the goals in their approach and they were all effective in treating the children's symptoms (2011).

There are a large number of randomised controlled trials (RCTs) assessing psychological interventions for traumatised children (Dowd & McGuire, 2011). Randomised trials of anxiety management training and eye movement desensitisation (EMDR) have been documented; however the intervention that has attracted considerable interest and is perhaps the most widely disseminated is trauma-focused cognitive behavioural therapy, or TF-CBT (Cary & McMillen, 2012; Cohen, Mannarino & Deblinger, 2006; Stallard, 2006). For example, in a study by Cohen and colleagues (2011), a community-provided TF-CBT was compared with usual community treatment (child-centered therapy) for children with IPV-related PTSD symptoms (Cohen, Mannarino, & Iyengar, 2011). The children and their mothers were randomly assigned to a group and received eight sessions of that treatment. The researchers found the TF-CBT participants experienced significantly greater PTSD diagnostic remission and fewer adverse events (Cohen, Mannarino, & Iyengar, 2011).

In fact, TF-CBT is the recommended intervention for treating traumatised children by the National Institute for Clinical Excellence (2005) and by the American Centre for Child Protection (Chadwick Centre for Children and Families, 2004). Further, it is the treatment rated the most efficacious by the Child Physical and Sexual Abuse: Guidelines for Treatment (Saunder, Berliner, & Hanson, 2004). In a systematic review by Cary and McMillen (2012), TF-CBT studies were evaluated in its ability to reduce symptoms of posttraumatic stress symptoms, depression and behaviour problems in children. The review found a significant difference between the TF-CBT condition and comparison conditions in reducing symptoms of PTSD, depression and behaviour problems. Further, this difference held for PTSD at twelve months post-treatment, thus demonstrating its effectiveness in treating trauma symptoms (Cary & McMillen, 2012).

Another intervention that is specifically trauma-focused is a relatively new school-based program that focuses on the neurobiology of trauma and toxic stress (Australian Childhood Foundation, 2010). Traumatised children respond to their environment with limited access to the resources in their cortex responsible for thinking, logic, analysis and problem solving. Trauma-informed practice supports children by resetting their baseline internal stress and arousal levels to bring back their functioning cortex. Trauma-informed practice supports an emphasis on using the school space – its routines, relationships and activities in and around its students – facilitative and flexible to the needs of all children, and in particular to those affected by toxic stress and trauma (Australian Childhood Foundation, 2010).

Implications for Policy and Practice

It is clear that exposure to domestic violence has a significant impact on children and is greater than previously understood (Overlein, 2010). Therefore, counselling professionals and policy-makers need to be made aware of this serious social issue (Overlein, 2010). From the theory, it is clear there is a need for more specialised programs designed to meet the needs of both children and parents, particularly fathers who are the majority of the time, the perpetrators of domestic violence (Bryce et al., 2015).

The relationship between the different policy responses of family law, child protection and domestic and family violence are often complex and fraught, which Hester (2011) has referred to as the 'three planet model' (Campo, 2015). Each sector has their own history, philosophy, laws and sets of professionals, which makes responding to children exposed to DV difficult and sometimes leads to unsafe situations. Child abuse or neglect in the context of a relationship breakdown

in Australia can intersect two separate legal systems. This is due to the state-based child protection system having a responsibility for investigating child safety concerns, while the federal family law systems are responsible for post-separation parenting arrangements (Higgins & Kaspiew, in Campo 2015).

The lack of a comprehensive approach is concerning given the prevalence of child abuse and neglect in family law cases (Campo, 2015). The Australian Institute of Family Studies' (AIFS) Evaluation of the 2012 Family Violence Amendments demonstrated that there is an increasing emphasis on recognising family violence and safety concerns across the family law system. However, the AIFS also noted that refinements in practice are necessary, in addition to developing effective screening methods across the family law system (Campo, 2015). Moreover, another debate in policy and practice is whether domestic violence is recognised as a form of harm to children. This has led to policy and legislative responses to women and children that are potentially challenging. Despite this contention, it is now mandatory in New South Wales, Tasmania and the Northern Territory to report cases of domestic and family violence (DFV) where children are present. However, as the majority of children in DFV cases are reported as being at risk of emotional abuse, the system has been overburdened, while child safety has not necessarily been improved (Campo, 2015). It has been suggested that an unintentional consequence of mandatory reporting is that women are less likely to call the police with the fear of their children being taken away (Cross et al. & Humphreys, in Campo 2015).

In a study by Zannettino and McLaren (cited in Campo 2015), perceptions of domestic and family violence (DFV) and families' needs confounded effective collaboration. The study found that child protection workers tended to hold mothers responsible for protecting their children from abuse, while DFV workers are focused on the offending partner and how domestic violence affects a mother's relationship with their child and capacity to parent. Thus, the authors argued that a collaboration between sectors is necessary to focus on empowering the mother, strengthening the mother-child relationship, and enhancing children's emotional wellbeing (Campo, 2015)

Policy has responded to children's needs by developing child-aware approaches under the initiative of the National Framework for Protecting Australia's Children 2009-2020 (Campo, 2015). These approaches work within a framework of early intervention and prevention that recognise parents can in many ways adversely affect children. A major component in this framework includes the capacity for adult services such as domestic and family violence services to be understanding to the needs of children and the ways in which parental problems can impact on children (Campo, 2015). Moreover, school-based prevention programs such as SPACE are widely supported in advocacy and policy frameworks such as the National Plan to Reduce Violence against Women and Their Children (COAG, in Campo 2015). However, in the AIFS review of DFV response services and interventions for children, a lack of funding and qualified staff were reported in meeting the demands of therapeutic interventions. Moreover, existing programs had long waiting lists (Campo, 2015).

Research suggests there is a need to explore the role that the father plays in the child's life as an offender of violence and to consider the need for specialised programs for men with fathering roles.

Research suggests there is a need to explore the role that the father plays in the child's life as an offender of violence and to consider the need for specialised programs for men with fathering roles (Stanley et al., 2012). Although, it has been suggested it may be difficult to engage abusive fathers in programs like these due to men's lack of accessibility, practitioner's reluctance to engage with threatening or violent men, and a lack of preparedness to cope with the complexities of family relationships (Stanley et al., 2012). In addition, there are very few MBCPs around and the ones in progress are significantly underfunded (Day et al., 2009).

Moreover, a gap has been identified in both policy and practice between conceptions of fathers and their identity as offenders of domestic abuse (Stanley et al., 2012). A study by Harne (cited in Stanley et al. 2012) found that very limited attention has been provided to the fathering of men who are also perpetrators of domestic violence. Although many MBCPs have been rolled out for male perpetrators, little acknowledgment has been given to men's roles as fathers (Stanley et al., 2012).

One of the strongest practise-based recommendations from the Family Law reforms was introducing tools and systems for screening families for domestic violence (Bagshaw et al., 2010; Kaspiew et al., 2009a). For example, Kaspiew and colleagues (2009a) suggested services such as Family Relationship Centres could facilitate early identification and referral for families experiencing violence in the separation process. Thus, future practice could consider the use of screening and risk assessment tools in the general assessment of family needs such as during healthcare visits for pregnant women or home visits for parents of young children (Sety, 2011). Moreover, there needs to be a clearer understanding of the impact of violence on children, including understanding the impact of trauma on children and the diverse forms of violence as previously described (Sety, 2011).

In conclusion, this paper has identified the adverse effects that exposure to domestic violence can have on children. These include physical, psychological, emotional, social, behavioural, developmental, and cognitive functioning (Bedi & Goddard, 2007; Blackburn, 2008; Evans et al., 2008; Felitti et al., 1998; Holt et al., 2008; Humphreys et al., 2008; Kitzmann et al., 2003; Meltzer et al., 2009; Rizo et al., 2011; Sety, 2011; Sterne & Poole, 2010). Two theoretical perspectives have been suggested in addressing these issues. The first perspective was drawn from feminist and psychological theories involving Men's Behaviour Change Programs with an emphasis on the fathering role. These services are crucial for the prevention of domestic violence, however it is not to be relied on to manage the threat it poses on children's development and safety (Stanley et al., 2012). Thus, trauma-focused interventions for children have also been offered as the research shows the correlation between exposure to DV and trauma symptoms in children (e.g., Bedi & Goddard, 2007; Campo, 2015; Evans et al., 2008; Holt et al., 2008; Kitzmann et al., 2003; Meltzer et al., 2009; Osofsky, 2003; Overlein, 2010; Rizo et al., 2011; Sety, 2011). Finally, the implications for policy and practice were discussed, which addressed the need for future research in intervention programs for both the fathers who perpetrate violence and their children who are exposed.

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ARTICLE

The process of constructing Behaviour Support Plans for young people with special needs

By Milê Glamcevski MACA and John Bromley

Introduction

The process, with which Behavioural Specialists develop support plans in children with special needs, parallels how the Industrial and Organisational (I/O) psychologist approaches change. Based on the general model of organisational change (Cummings & Worley, 2001), encompassing French (1969) action research and the contemporary action research models (Bunker & Alban, 1992), the process of developing support plans (change models) can be summarised into a number of integrated stages. These stages are generally referred to as the entry, diagnosing, planning and implementing, evaluating and maintenance phases. In order to provide a platform for a more systematic understanding to support plans (change models), the I/O approach is applied to better construct and evaluate Behavioural Support Plans (BSPs).

The I/O approach can be used in evidence based discussions to review support plans, as it provides a depth of literature that is yet, predominantly untapped by behavioural specialists. The literature indicates the importance of the following phases; 1. Entry 2. Contract 3. Diagnosing 4. Planning and Implementing of change, 5. Evaluating and 6. Maintenance. This is a review of the I/O approach, the behavioural specialist and the parallel processes of developing Behaviour Support Plans (BSP) and the change model.

Industrial/Organisational (I/O) Approach to the 'change model'

The phases of the change and the activities conducted within each are discussed.

ENTRY AND CONTRACTING

Viewed technically as the initial steps in an organisational intervention (Margulies & Raia, 1978), the entry and contracting phase may actually be the major determinant of whether the activity moves forward or stagnates and terminates. When a member of an organisation contacts a psychologist or consultant, a relationship is about to be formed.

What determines the entry will be resolving three issues; agreeing on the current level of organisational functioning and the issues to be addressed, the relevant client system for those pertinent issues, and the appropriateness of the particular practitioner that has been contacted. Once resolved the parties can move to the next phase.

DIAGNOSING

Closely linked with a felt need, or problem, that has earlier been identified, is the need for an adequate diagnosis. It is not enough for somebody to perceive a gap between the current organisational state or functioning and a desired future state, but the gap that is so perceived needs to be real, objective and quantifiable—therein lies the importance of diagnosis. This is not suggesting that diagnosis is a detached process. On the contrary, it is one of the most compelling situations that require cooperation and joint efforts in the whole process of intervention. The coalition (conceived between the organisational operatives and the change agent), that will eventually guide the change process should be formed at this stage. Although diagnosing an organisation is a complex process, even more complex is ensuring that the diagnosis is correct. This is imperative because the intervention itself derives from the diagnosis.

Diagnosis will presuppose that there is a framework for understanding the organisation (Harrison, 1994; Harrison & Shiron, 1998). Diagnosis as expected can be at the individual, group, or organisational level, this will invariably affect the design component and the throughput associated with each level of analysis (Cummins & Worley, 2001; Havelock & Hugerman, 1983; Kotter, 1996). Data collection, analysis and feedback and follow-up will continue to

be iterative until the coalition has satisfied itself through the same process of testing and data collection, that they have reached an adequate or acceptable diagnosis.

PLANNING AND IMPLEMENTING CHANGE

Intervention usually involves planning a series of activities intended to help organisations and systems improve their performance and activities. Diagnosis allows practitioners to form a series of intended outcomes, through which they can transfer know-how to other members in the organisation. There are several situational factors on which this supposition hinges. It is pertinent to determine differences among organisational members, either in their cognitive, affective, or behavioural dispositions. As the management style and the support structures for allowing change to happen is important for implementing change. The agent of change (the practitioner) and the target of change (the organisation) in other words need to be attuned to the process for effective planning and intervention to occur.

Implementing the change can fall into three general stages (Jones, 2004). Firstly, the coalition needs to find ways of minimising, controlling and overcoming resistance to change. Secondly it is wise to determine who will control the implementation process. Although internal consultants work fine in many instances, in other occasions, active collaboration with the external consultant is desirable. Thirdly, there is the need to determine which strategy will deliver on the promises that change offers (French & Bell, 1990).

EVALUATING AND MAINTAINING

Generally evaluation can involve two kinds of feedback, one is implementation feedback that utilises the iteration in the process and the second is evaluation feedback. The former, checks on the process to ascertain that it is being implemented properly while the later, checks on whether the intervention is producing the expected results.

Change efforts are said to have been in the maintenance phase only when the effort persists, or the intervention last, or seems to hold in the desired direction. According to Cummins and Worley (2001), there are five performance indicators associated with maintenance; these are Knowledge, Performance, Preference, Normative consensus and Value consensus. It is not to be expected though that all five performance indicators need to be present simultaneously, however, the sequence followed and the more indicators that are present the more confidence in the intervention's effort. Institutionalising change occurs when both at the top of the organisation with top-level management and at lower levels with organisational members, strive to maintain the same change.

Practicians and behavioural specialists should be able to draw parallels between an I/O approach to change and constructing BSPs. Before these parallels are explored in more details with the behavioural lens, the I/O can also provide an insight in how a team works in these environments.

BSPs Phases

The BSP phases are analogous to the I/O phases for change, hence they can be examined, discussed and conducted in a similar manner.

ENTRY AND CONTRACT FORMULATION PHASE

After identification of young person with special needs who is exhibiting behaviours of concern (BoC), an entry (getting to know) process is required. Within the entry process, generally, the young person, parents, teachers, school, psychologists and allied health professionals are appraised, to agree on current levels and

Continued page 24

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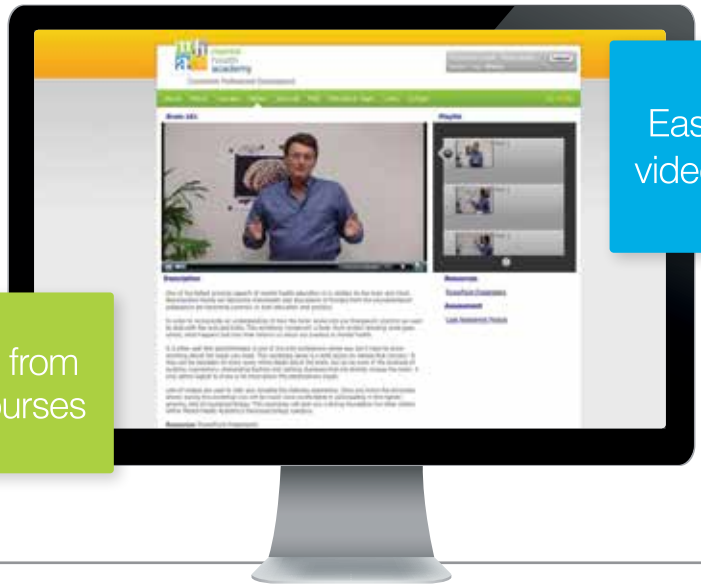

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Understanding Will

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

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issues to be addressed. The entry process aims to determine an optimum structure, and build rapport amongst those involved.

The appraisal and rapport building is complex and necessitates a wide-ranging, comprehensive and functional understanding of the current levels of performance and motives. The appraisals are carried out via interviews, formal assessments, psychometrics, behavioural assessment, observations, team building games, group discussions, etc. In paralleling with I/O it moves to determine the entry by resolving its three primary issues; agreeing on the current level of functioning, identifying the issues, and the appropriateness of the particular practitioner.

Once entry and appraisals have been conducted a contract can be entered into. Bateman and Linden (1998) early work still is poignant in its explanation of the importance of BSPs by affirming they are binding commitments to resources by a system (school, community, family) and thus must be written with great care. Teams responsible for the formal development of written BSPs, are required to investigate characteristics of the needs and services to be provided, along with the goals and objectives.

A BSP describes the behavioural and other supports requirements, specifically designed to meet the unique needs of a young person with special needs (Anderson, Chitwood, & Hayden 2010). The plan is developed at program meetings, and its provisions are detailed in the formalised BSP document. Formalised BSPs should be more than an outline and management tool of the young person's behaviour. It should be an opportunity for parents, educators and others to work together as equal participants to identify the young person's needs, devise the provisions to meet those needs, and anticipate outcomes (Chesterfield County Public Schools, 1991). It is a document that is revised as the needs of the young person change.

DIAGNOSIS PHASE

The Diagnosis phase is about determining the change required, desired and available in the network the young person, families and the community systems which they live in. Here is the potential to accurately define and understand the issues and conditions which can allow the correct support and assistance for improved quality of life and happiness of both the young person and their families.

When developing and detailing BSPs there needs to be consideration given to domestic, community and behavioural skills for the young person. The principal focus should be on acquiring basic skills for community living including domestic, social, recreation/leisure and educational domains. During the assessment, an underlying principle is that all behaviours have a purpose, and that the behaviour expressed can be seen as communicative of the purpose. Two common domains of behaviour assessment are Functional behaviour and Adaptive behaviour; both need to be considered.

It is recommended by key findings that the assessment of the young person and his/her environment include a large range of domains. The clinical interview, listening and researching are the cornerstones of good assessment and will expected to be used to high level competencies. The assessor will be qualified and experienced in using appropriate assessment tools (Sattler 2011; Snell, & Brown, 2000). It is recommend that comprehensive knowledge of medical conditions is gained by consultation and support from the young persons' medical supports. The assessment of a young person's communication skills should be done by incorporating watching and listening as the young person plays and talks.

A review of available information in school reports, Individual Educational Plans, academic assessments s and possibly intellectual assessments such as WISC-IV, will be used to measure academic functioning. Consider

investigating satisfaction, happiness and motivation for attending academic institution(s).

It is recommended by key researchers that the family is viewed as consisting of those who have relationship and reside (or spend significant time in the residence) with the young people and the network of individuals and relationships that are associated with the family (kin). This belief includes awareness of the significance that relationship, interdependence, and connectedness among family members has in understanding and assessing the young person's safety, caregiver protective capacities and family cohesiveness. To a large extent, the result of the Family Functioning Assessment is a full picture and description of a family system.

When developing BSPs there needs to be consideration given to domestic, community and functional skills for the young person(s) with special needs, the principal focus should be on acquiring basic skills for community living including domestic, recreation/leisure and vocational domains (Beck, et al., 1994; Wehman, 2005; Felce, 2010). Young people will typically need instruction and support in managing health and safety skills, personal social skills, self-awareness and socially responsible behaviour including recreation (Beck, et al., 1994; Dymond, 2007).

The identified outcomes and principles need to be socially valid, reflect functional priorities, require active participation by young persons as well as parents, teachers and others, foster self-determination and are individualised for the young person according to their unique set of requirements and environment (Snell, & Brown, 2000; Dymond, 2007).

PLANNING & IMPLEMENTATION PHASE

Goals are statements of what a young person with special needs can reasonably be expected to accomplish in a specific time frame for a specific area. A goal is written to address a BoC in the present level of performance, including social and community interaction.

Goals reflect answers to the question, 'What do we want the young person to be able to do?' The goals must reflect knowledge of the young person's current functioning in each BoC. Priorities are established in choosing goals based upon the young person's risk with BoC, limitations, age and expectations for the future. Thus the goals in the BSPs are stated in terms of measurable, observable behaviours, inclusive of the major deficit areas identified in the present level of performance i.e. communication, behaviour, academics, socialisation, self-help, perceptual motor, gross motor, vocational, etc. Goals also provide answers to the questions; What skill or behaviour? How, in what manner or at what level? and Where, in what setting or under what conditions?

The principal focus on developing BSPs should be on acquiring basic skills and behavioural support for community living including domestic, recreation/leisure and vocational domains. This needs to be reflected in a written document (the BSP) the is a follow-on from the earlier phases. This document needs to have consensus from the BSP team and carried out in the manner and spirit it was written in.

The periodic review of BSPs provides an evaluation of the young person's progress toward meeting the goals and objectives. Additionally, BSPs serve as the focal point for clarifying issues and cooperative decision making by parents, the young person, school personnel and others in the best interest of the young persons.

A well-developed BSP should exhibit the following characteristics:

1. Comprehensive, covering all BoC, including communication, behaviour, socialisation, academics, perceptual-motor skills, vocational and transitional.
2. Specific goals and objectives are stated in measurable, observable behaviours.
3. Sequential based on a developmental or functional sequence of skills.
4. Understandable, in that the language is comprehensible to the audience; especially the parents.
5. Mutually developed and represents a consensus among parents, the young person, and support personnel.
6. Realistic and appropriate goals and objectives, for the young person's current level of functioning and probable growth/development rate.

EVALUATION PHASE

The team approach to BSPs start with a set of objectives and tries to give feedback on results to the young person's progress in order to show the effectiveness of the work done. Evaluation aims to understand what is happening and why, evaluation also includes review and feedback, which is used to manage effective maintenance for change. Evaluation is often most useful when there is implementation of the knowledge gained, that utilises the process to determine the support (action) has been applied correctly. Evaluation is always part of continuing process and cannot be a separate entity. Evaluation becomes an important tool for talking about and negotiating goals. The form of the evaluation is dependent on the inner forces of the support team and organisations. It is therefore necessary to find a way to shape the evaluation instruments and procedures accordingly.

In evaluation of effective change, Fisher and associates (Fisher, Parker, Purcal, et. Al., 2008) describes how it is critical to look at the success (and failure) of any systems (family and community system) on a regular basis to improvement the change process. The I/O approach offers excellent insight and offers recommendations utilising a quality improvement approach, regular data collection to ensure that feedback is collected from families, staff and service providers to provide an understanding of the benefits or limitations of the BSPs.

Reports (in line with the legislative requirements and Quality Frameworks) should outline evidence-based benefits and limitations that presented whilst facilitating BSPs.

The team approach to BSPs starts with a set of objectives and tries to give feedback on results to the young person's progress in order to show the effectiveness of the work done.

MAINTENANCE PHASE

According to Cummins and Worley (2001), meaningful change occurs when the change effects are maintained and the effects persist. Learning is the participants' understanding of new ways of acting and acquisition of new skills as a result of an intervention. Behavioural changes include participants' actions while performance changes are reflected in objective measures, as well as more subjective performance appraisal ratings.

Persistent behaviour change is successful when there is a change in a behaviour, or set of behaviours, for individuals at all/most levels of measuring the behaviour. This can include a wide range of positive behavioural changes. Some of these positive behavioural changes include communicating openly, sharing intentions, motives, needs, feelings, and cognitions relevant to the situation. Collaborating, solving problems, taking responsibility, taking initiative for getting whatever information, cooperation, services, or materials are needed from

For Behavioural specialists, generally good BSPs follow a systematic process to provide young persons with acquired skills that enable them to live in their community.

other relevant parties inside or outside of the family/school environment. Other significant positive behavioural changes include respecting and supporting others by providing recognition for a job well done.

Team Approach to change

An I/O psychology approach can be used to improve the team approach to develop Behaviour Support Plans for young persons with special needs. Before beginning the phases of developing BSPs, it is important to clarify the role of the team and Behavioural Specialists who will provide the architecture to develop the plan.

THE TEAM

The BSP team that builds programs which lead to positive change, ttypically consists of school employees, primary care givers, health professional, parents, support staff, occupational therapists, physiotherapists, psychologists, teachers, etc. The opinions of the young person themselves should also be central to the team (Dymond, 2007; McDonnell, et al. 1993). Administrators and behavioural experts are invaluable contributors for a truly comprehensive team support approach (Wehman, 1996; Dymond, 2007).

A team approach is critical because many young people with special needs have requirements that extend beyond a single domain (Inge, et al., 1993). It is important that all those involved with the young person are happy to work together. The aim should be to work from the individual's strengths. Often the highly successful team determines specific role responsibilities for its members (O'Driscoll, Taylor, & Kalliath, 2003).

The team approach offers a self-determined method that allows a multi-disciplinary group to have input into the direction and quality of support. It also provides foresight and long term planning that enables and promotes the young person to enter the community as a functioning member (Inge, & Dymond, 1994; McDonald, et. al. 1993).

BEHAVIOURAL SPECIALIST

Behavioural specialists generally require a number of specific skills, knowledge, attitudes and other characteristics that are pivotal to the success of the endeavour (Havelock & Hugerman, 1983). Notably, diagnostic ability, basic research methods skills, knowledge of the methods and theories within the specific consultants orientation, skill of empathy, problem solving ability, objectivity, flexibility, honesty, conciseness, trust, and imagination have been indicated as required (Neilsen, 2014).

When the Behavioural specialist applies an I/O psychological approach to BSPs, it requires an evaluation of participants, teams and optimum outcomes. It requires a commitment to resources, which includes reviewing and defining characteristics of the needs and services to provide to the team and the young persons.

Any integrative system requires a well defined process to identify the young persons with special needs who have BoC and require BSPs (Haynes, 1997; McVilly, 2002). Once identified school, home and community require BSPs for the successful progression, improved quality of life and social skills of these young persons (Anderson, Chitwood, & Hayden, 2010). The need for change, centres around a need for a more systematic approach of teams developing BSPs, and team members having their role clearly defined but flexible enough to deal with the variety of special needs of the young persons. Also there is a need to focus on delivering the young person to community living. These are the skills and direction the Behavioural specialist is able to bring to bear.

For Behavioural specialists, generally good BSPs follow a systematic process to provide young persons with acquired skills that enable them to live in their community. Much of the I/O literature talks about the consultation process and the phases of change, to improved teams measurable outcomes (Cohen, & Bailey, 2007; Lovelace, Shapiro, & Weingart, 2001). For the Behavioural specialist using a change model it is important to articulate and work systematically. Therefore, the phases used in the I/O can also be applied in context. Of note is that these phases and the interaction of the client-consultant are not altered if the consultant is internal or external to the organisation (Hackman, 1987; Highhouse, 2001;McVilly, 2002).

Conclusion

Teams responsible for the formal development of BSPs, investigate characteristics of the needs and services to provide, along with the goals and objectives. A team support approach, commonly involves school employees, parents, school support staff, teachers and psychologists/behavioural specialist, but can (and often does) include occupational therapists, physiotherapists, primary care givers and other health and community professionals that need to function effectively. Good BSPs are comprehensive, specific, sequential, understandable and have realistic goals, which represent a consensus among the young person, parents and other. Application of industrial/organisational psychological principles can be an effective way of improving the development of BSPs.

Irrespective of the many social, economic, technological, cultural, and political problems that face communities, there is a struggle to create positive conditions in which learning takes place and provide the best opportunities in a given situation. As evaluators of programs, people cannot ignore the never-ending struggle to make judgement calls about activity/interventions which creates the conditions or obstacles for social integration of those with special needs. A systematic team approach with a well defined support team can have major impact on the quality and success of the young persons with special needs, as well as deliver them successful to community living.

As seen in the parallel of I/O change model and BSP development, there is the opportunity to review decades of untapped research to provide additional information and better understand how to support children requiring BSPs.

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PEER REVIEWED ARTICLE

Triggers to gambling Situations of prisoners before their incarceration in Australia

By Bernard Fan MACA

Introduction

Problem gambling has been studied in many countries over the past two decades. The most severe form of gambling is defined as a mental health disorder and is classified as an impulse control disorder in the DSM-IV-TR. Problem gambling, or ludomania, is defined as an urge to continuously gamble despite harmful negative consequences (American Psychiatric Association 2000). Problem gambling is diagnosed as clinical pathological gambling. In Australia, problem gambling is not defined by diagnostic criteria. According to Ministerial Council on Gambling, problem gambling is characterized by difficulties in limiting money or time spent on gambling which leads to adverse consequences for the gambler, others or the community (Gambling Research Australia).

It is estimated that up to 2.1% of Australian adults had a gambling problem (Productivity Commission 1999). In Western Australia, it is estimated that the prevalence of problem gambling of adult population is 0.7% (Productivity Commission 1999).

Link between problem gambling and crime

It is speculated that there is a strong link between problem gambling and crime. A survey found that gambling was the most common motivation for fraud in Australia (Productivity Commission 2010). A study reported that 20% of women and 34% of men stated that gambling had contributed to their current imprisonment (Baron & Dickerson, 1999). Gambling-related crimes committed against an employer were largely crimes of opportunity, with many offenders exploiting their access to cash, and control over accounts and auditing processes to defraud employers or clients. Severe problem gamblers are significantly more likely to commit income-producing crimes, such as theft, burglary, break-in, fraud, forgery and drug dealing (Sakurai & Smith 2003). As people's gambling addiction is so intense which cause them financial difficulties, they will seek all legitimate alternatives, including selling their properties, borrowing from families and financial institutes, in order to continue financing their gambling. As all legitimate financial resources are exhausted, gamblers may resort to final option of illegal sources of income and commit crime. Gamblers particularly resorted to crime when they have desperately embarked on the 'chasing' of previous losses. As debts mount, problem gamblers are more likely to commit income producing crime to finance their gambling to chase the losses and to pay their debts (Lahn, 2000, Lahn 2005, Sakurai & Smith 2003). In addition, much of the criminal behaviour, including drug offences, has been directed at financially funding their gambling (Victorian Responsible Gambling Foundation 2013). The most serious current offences recorded for problem gamblers were property crime (37.1%) and violent crimes (28.6%) (Lahn & Grabosky 2003). These surveys have suggested that gambling played a contributory role in crime.

However, there was lack of assessment over gambling addiction on offenders. Despite the lack of official statistics, there were a number of surveys indicating the relationship between gambling and crime in Australia (Jones 1989, Lahn, 2000, Lahn & Grabosky 2003, Lahn 2005, Sakurai & Smith 2003). Australian studies have estimated rates of problem gambling among offenders to lie between 17% and 30% (Lahn & Grabosky 2003). One study in Queensland prisons reported that 31% of incarcerated offenders had gambling problem (Australian Institute for Gambling Research and the Labour and Industry Research Unit 1996). Another study in South Australia prison found that 33% of male prisoners were classified as probable pathological gamblers (Marshall, Balfour and Kenner 1997). Study in Adelaide reported 52% of prisoners had a lifetime prevalence of problem gambling (Riley & Oakes 2015). In Australian Capital Territory, it was reported that 34.3% of prisoners had SOGS scored 5 or more which indicated they had gambling problem (ANUCGR 2003). That prevalence is 18 times higher than in general population (Lahn 2005). The prevalence rate of problem gambling among prisoners is 22% in Western Australian (Jones 1989, O'Connor & Jones 1998). These Australian studies have suggested that the rate of problem gambling among offenders is greater than among the general population.

In a survey, 25% of female gamblers and 32% of male gamblers in prison felt they would like help with their gambling problem (Baron & Dickerson, 1999). Without treatment, incarcerated offenders might not be able to break the cycle of gambling addiction, debt and crime. They are more likely of re-offending. As gambling had directly contributed to the offences of these prisoners, there is a strong need of running a gambling treatment program at prisons.

In treating prisoners to deal with their gambling problems, it is necessary to understand the situational factors that trigger to their gambling addiction (Turner, Littman-Sharp, Toneatto, Liu & Ferentzy 2013). This study is to examine the trigger situations to gambling of the prisoners before their incarceration.

Method

This program is the first gambling therapeutic program running in Western Australia prisons. The program had been run in total 8 prisons in Western Australia,

including 2 minimum security prisons, 4 medium security prisons and 2 maximum security prisons.

Participants

There was no screening for the prisoner's gambling problem in the selection of their participation. Promotion of the program was done through putting flyers in notice board, newsletter, and information session for the prisoners. All participants were asked to sign a consent form to express their voluntary participation in the program. They were allowed to withdraw from the program anytime if they wished. Beside given their consent of joining the program, the form also collected their demographic information including their ethnicity, place of birth, age, and gender.

During the program, our project has received total 96 referrals for this gambling education program. Their age ranged from 19 years old to 57 years old, with an average age of 33.36 and median age of 34. Among the referrals, 88 prisoners were male and 8 prisoners were female. There were total 66 participants, 59 males (89.3%) and 7 females (10.7%) who have finished the programs. The mean age was 33 and median age was 34 for male prisoners while the mean age was 36.57 and median age was 40 of female prisoners. Their ethnicities include Caucasian Australians, Indigenous Australians, Englishes, Scottish, Irish, Italians, Zimbabwe, Vietnamese, Hong Kong Chinese, Iraqi, Iranian, Indians, Jewish and Romanian. Among the participants, 20 reported they also took drugs, 12 reported consumed alcohol and 2 reported having both drug and alcohol while gambling.

Measure

Early Intervention Gambling Health Test (Eight) Gambling Screen (Sullivan 1999 & Gamblers Rehabilitation Fund 2009) and Inventory of Gambling Situations (Turner, Zangeneh & Littman-Sharp 2006, Littman-Sharp et al 2009) were used in this study. Participants were asked to do a self-completed EIGHT Gambling Screen test and the Inventory of Gambling Situations (IGS) to help them to look at their gambling problem.

The EIGHT Gambling Screen comprises eight questions to assess problem gambling, with four or more 'yes' answers indicating that gambling may be an issue in their life. It is designed to be brief and can be self-completed in approximately one minute in order to provide prompt assessment and feedback. It is also useful to identify problem gambling into different levels. A score less than 3 represents Level 1 or non-problem gamblers. A score of 4 or 5 represents Level 2 or problem gamblers. A score of 6 or more represents Level 3 or pathological gambling (Sullivan 2006).

The IGS was designed by the Centre for Addiction and Mental Health (CAMH) and widely used in Canada and United States. IGS is a 63-item self-report questionnaire. IGS has good psychometric properties with a high internal consistency of Cronbach's alpha 0.97 for the overall scale, and 0.96, 0.92, 0.87 and 0.82 for the four factors of Negative Affect, Positive Affect, Gambling Cues and Social Situations respectively (Petry, Rash & Blanco 2010). The IGS subscales are reliable with Cronbach alpha ranged between 0.86 and 0.98 (Turner, Littman-Sharp, Toneatto, Liu & Ferentzy 2013). The IGS total score was significant correlated with all indices of gambling severity. In this study, participants were asked to do the paper-and-pencil formats in prisons and then the researcher administered it online to get the individualised Client Profile results that detail the situations in which that particular client has gambled excessively (Littman-Sharp, Turner & Toneatto 2009). The Client Profile can help clients to identify their area of vulnerability and recognise those situations that are most likely to trigger their problem gambling behaviour. The subscales of the IGS include Negative Emotions, Conflict with others, Urges and Temptations, Testing Personal Control, Pleasant Emotions, Social Pressure, Need for Excitement, Worried about Debts, Winning and Chasing, and Confidence in Skill. Identifying situations to gamble is useful to design an individualised treatment plan for people with gambling problems (Petry et al. 2010). Moreover, participants were asked to do a Life Line activity to depict the initial and peak of their gambling career history, and any

significant life events happened prior to and triggered to their severed gambling activity.

Results

Some demographic characteristics of the participants in this study have compared to the data of prison population data of Australian Bureau of Statistics (2015). In this study, 88 referrals were male (91.6%) and 8 were female (8.3%). According to Australian Bureau Statistics (ABS 2015), male accounted for 92% whilst women accounted for 8% of all adult prisoners across all the sates and territories, which is very similar to the gender proportion of the referrals in this study. The percentage of the participants who completed the study including 59 males (89.3%) and 7 females (10.7%) is also close to the national figure. Comparing their ethnicity, Aboriginal and Torres Strait Islander (ATSI) prisoners accounted for 27% of national prisoner population (ABS 2015). In this study, there were 8 (12.1%) Indigenous Australians completed the program. The proportion of prisoners born in Australia was 81.39% which included the ATSI 27% prisoners (ABS 2015). So the national proportion of non Indigenous prisoners was around 54.39% of Caucasian Australians (ABS 2015). Our participants of 33 (50%) of Caucasian Australians was close to the national figure. The proportion of prisoners with Middle East country origin is Iran 0.24%, Lebanon 0.61%, Iraq 0.44% (ABS 2015) while our figure is 1 Iraqi (1.5%), 1 Iranian (1.5%) and 1 Jews (1.5%). The national figure of African origin is 0.62% (ABS 2015) whilst our study is 1.5% (1 Zimbabwe). The ABS (2015) national figure of United Kingdom is 1.71%, Italian is 0.22%, Romanian is 0.14%, Vietnamese is 2.16%, Hong Kong is 0.35% and Indian is 0.31% while our participants of UK (4 Englishes, 1 Scottish, 1 Irish) is 9.1%, 2 Italian (3%), 1 Romanian (1.5%), 6 Vietnamese (9%), 2 Hong Kong (3%) and 4 Indians 6%.

Regarding their gambling activities, proportion of female prisoners played slot machines in casino was 42.8%, poker game in casino, scratch card, online poker game and horse racing in TABS were 14.3% respectively while proportion of male prisoners played poker game in casino was 57.6%, horse racing in TABS was 20.3%, online poker game was 11.8%, stock market was 3.3% and poker machine was 1.6% in this study.

The results of the EIGHT Gambling Screen in this study showed that there were 53 participants scored 6 or more as level 3 or pathological gamblers, 11 participants scored 4 and 5 as level 2 problem gamblers, and 2 participants scored as level 1 non-gamblers. There were total 96.9% of participants classified as problem gamblers and pathological gamblers in this study.

Table 1. Correlation between IGS Subscales and EIGHT screen (N=66)

IGS Subscales	EIGHT Screen
Conflict with others	0.4178
Negative Emotions	0.3992
Testing Personal Control	0.2669
Urges and Temptations	0.4538
Need for Excitement	0.2869
Social Pressure	0.3021
Pleasant Emotions	0.2652
Confidence in Skills	0.2251
Winning and Chasing	0.4068
Worried about Debts	0.4196
Total IGS Score	0.4244

All correlations are significant at the 0.001 level (2-tailed)

According to Littman-Sharp, Turner & Toneatto (2009), people who score 0 to 25 means they are rarely triggered to gamble by this situation, score 25 to 50 are sometimes triggered by this situation, 50 to 75 are frequently triggered by this situation and score over 75 means they are very frequently triggered by this situation. One study found that IGS subscales were significantly correlated with DSM-IV and South Oaks Gambling Screen (SOGS-R) ranged between $r = 0.51$ and $r = 0.75$ as it is hypothesised that problem gamblers should score higher on IGS (Turner et al. 2013),. However, the correlation between EIGHT Gambling Screen and IGS subscales was not high in this study, ranging between r = 0.2251 and r = 0.4538. The strongest correlations between EIGHT Gambling Screen and IGS subscales were Urges and Temptations $r = 0.4538$, Worried About Debts $r = 0.4196$, Conflict with others $r = 0.4178$ and Winning and Chasing $r = 0.4068$ (Table 1). The weak correlation result may be due to the relative small number of participants in this study.

In this study of IGS, there were 9 prisoners who were frequently or very frequently triggered by 10 situations, 7 prisoners by 9 situations, 3 prisoners by 8 situations, 7 prisoners by 7 situations, 11 prisoners by both 6 and 5 situations, 2 prisoners by 4 situations, 3 prisoners by 3 to 1 situation, and 7 prisoners were not triggered by situations to gamble frequently.

Discussion

As we looked into age of prisoners, the mean and median age of female was higher than the male prisoners. Moreover, the proportion of female prisoners scored high in 9 and 10 IGS subscales was much higher than male prisoners. This phenomenon corresponded to the hypothesis that women start gambling later in life but they develop gambling problems more rapidly (Rosenthal & Leiseur 1996).

In this study, some participants were susceptible to one or two trigger situations of IGS but most participants were subjected to more gambling trigger situations. A high score on IGS scale indicates the type of situation in which they have often gambled heavily in the past. This information is valuable for the therapist and the client in treatment planning. The results showed that IGS Client Profile result is much individualised and various among all participants.

Despite the IGS Client Profile is much individualised, when the life line stories were presented together, some common theme was recognised. Some patterns of IGS Client Profile were also found among some prisoners with similar backgrounds in this study. Firstly, the proportion of female prisoners (42%) being frequently and very frequently triggered by 10 or 9 subscales of IGS was higher than the proportion of male prisoners (23%) being triggered by so much subscales of IGS. Female prisoners reported higher proportion in response to Conflict with Others (66%) and Negative Emotions (83%) compared to male prisoners 21% and 42% respectively. Moreover, male prisoners reported high proportion (73%) in response to Confidence in skill than female prisoners (66%). These results confirmed to the Rosenthal and Lesieur (1996) hypothesis that women problem are “escape seekers” and they resorted to gambling as a way to escape to numbing or oblivion while male gamblers are “action seekers” and they believe in their skills and strategy in betting.

Moreover, their trigger situations to gambling also were corresponding to their description in their life line stories. One female prisoner described she was overwhelmed in looking after her autistic

son. While the other two female prisoners had conflict with their teenager children and other two had conflict with their partners. On the other hand, there were 8 male prisoners had conflict with their partners. One male prisoner reported death of his parent. There were other two Vietnamese prisoners reported stress of debt and also stress of doing drug traffic which drove them resort to gamble to release the stress. Their description of stressful life events were corresponding to their high score in IGS subscales in Negative Emotions and Conflict with Others.

The other pattern of IGS is related to the prisoner's ethnic backgrounds. Prisoners of Vietnamese background were more likely to gamble in response to Urges and Temptations, Need for Excitement, Social Pressure, Pleasant Emotion, Confidence in Skills and Winning and Chasing. Prisoner of Indian background were more response to situations of Negative Emotion, Conflict with Others, Urges and Temptations, Need for Excitement, Confidence in Skills, and Winning and Chasing. Prisoners of Middle East background were mainly in response to Confidence in Skills, Winning and Chasing, and Worried about Debts. The lower proportion of ethnic minorities in this study corresponded to a study of impact of gambling on four ethnic minorities, including Arabic, Chinese, Greek and Vietnamese which found that rates of gambling among these four cultural groups were lower than that of general community in Victoria, Australia (VCGA 1999). Raylu & Oei (2004) also reported high rates of gambling among some cultural groups of Chinese and Jews than Caucasian Australians. High risk of developing gambling problem among immigrants was due to a number of factors including social isolation, boredom, loneliness, emotional stress and depression. These high risk factors were reflected in their high score of IGS subscales in Need for Excitement, Pleasant Emotion. Gambling provide a way for immigrants to escape their negative emotion and stress. Moreover, immigrants like Chinese, were motivated to gamble which can improve their status and social standing during the process of winning ((Feldman, Radermacher, Anderson & Dickins 2014). A number of prisoners of immigrant backgrounds reported they wished to win big money so as to improve their self esteem and living initially. These explained the ethnic minorities scored high in Urges and Temptations, and Winning and Chasing in our study.

On the other hand, prisoners of UK background were likely to gamble in response to Urges and Temptation, Winning and Chasing, Need for Excitement and Pleasant Emotion. ATSI prisoners were more likely triggered to gamble by all situations except testing Personal control and Worried about Debts. Caucasian Australians were more likely triggered to gamble in response to domains of Temptation Situations, Positive Affect Situations and Gambling Cycle Situations but not the Negative Emotion domain.

In general, there were 33 prisoners responded to all 3 Positive Affect Situations, while there were 22 prisoners responded to all 3 Gambling Cycle Situations and 20 prisoners to all 2 Temptation Situations. Positive Affect Situations are the most common triggers for prisoners to gamble before their incarceration. In this study, most prisoners reported that they learned gambling either from their parents, friends or workmates. Some of them reported that their parents first took them to casino or horse racing track to celebrate their 18 years old birthday. So they usually started to go to gamble with friends or families. It also corresponded to the hypothesis that culture beliefs and values were passed to members by family, especially their parents, who show their positive attitude and approval towards gambling (Raylu & Oei 2004). Initially, they viewed gambling as a social function to meet friends or to have fun. Only after they got addicted to gambling, they gradually went to gamble alone. It explained they were more likely triggered by the Pleasant Emotion and Need for Excitement than by Social Pressure. In this study, all prisoners could memorise the big win they had before their intensive gambling activity. As prisoners involved in gambling for a period of time, it enhanced their confidence in skills but also increased their expense and losses in gambling. Then, they were pre-occupied in a spiral of winning and chasing. Therefore, most prisoners were in response to subscales of Confidence in Skills, Winning and Chasing, and Worried about debts in their later gambling stage.

These triggers also correspond to the pathways of pathological gamblers to criminal behaviour. As pathological gamblers attempt to chase their losses, they initially try legitimate sources, such as loan from financial institution and borrow from friends and families. Once the legitimate sources are exhausted, the urges to gamble and financial pressures will push gamblers to utilise any available means to obtain fund to pay their gambling debts and to continue their gambling. Once the urges to gamble override their moral restraint, those pathological gamblers will resort to criminal activity and justify their action. And their offenses were primarily nonviolent offenses against property, such as forgery, fraud, embezzlement, income tax evasion, employee theft, fencing stolen goods, selling drugs and hustling (Leisure 1984, Meyer & Fabrian 1992, Blaszczynski, McConaghy & Frankova 1989, Blaszczynski 1994, Blaszczynski & McConaghy 1994). Factors contributing gamblers to involve in illegal activity depend on their personal value, legitimate and illegitimate opportunity, perceptions of risk, threats and chance (Lesieur 1987). Therefore, cultural value is important in developing of gambling and determining of criminal behaviour. The culture values include family attitude, ethnic value and also sub-cultural influence of neighbours and friends.

For example, Aboriginal prisoners were not triggered to gamble frequently by Worried about Debts in our study. It is related to their cultural value of financial concept. Indigenous Australians do not attempt to tackle their financial problem but merely leave it behind. Moreover, they involve extended family networks and tackle their financial difficulties in collective family perspective (Fan 2013). Therefore, financial stress and gambling debts may not be the main reasons contribute Aboriginal prisoners to their illegal activity.

Another example is a Jews prisoner who explained that he beared the responsibility of investing in stock market on behalf of his families, relatives and friends. His gambling like investment motivation was due to a collectivistic cultural value. He involved in the spiral of winning and chasing thereafter and finally bailout which caused him to be persecuted of fraud.

It is interesting to note that non immigrant participants in this study were not much triggered to gamble by Worried about Debts. Some of them reported they earned more money through drug dealing than from gambling. They also did not feel the financial stress. The main reason to gamble was to enjoy the thrilling during gambling. This explained they scored higher in Need for Excitement subscales. It is assumed that the action of gambling is more importance than the monetary gain or loss (Abt, McGurrin & Smith 1985).

Most prisoners of UK background,

especially the male participants in this study, reported that they followed their fathers to horse racing tracks when they were young. They also learned consuming alcohol while gambling there. Their reported gambling history was corresponding to the finding of relationship between gambling attitudes, involvement and gambling problems in adolescence (Casey et al 2011, Dixon et al 2016).

Moreover, prisoner of Italian background reported that they felt guilty because gambling problem has brought shame to their families. Therefore, collective family value is prominent in Italian culture. This phenomenon depicts that collectivistic cultural value presents not only in Asian cultures but also in some European country with high context culture.

In addition, the participants in this study had a high co-morbid problem of gambling and substance abuse. There were total 34 (51%) participants reported either consumed drugs, alcohol or, both drug and alcohol while gambling in this study. Most of them reported they took methamphetamine in order to keep awake to continue gambling over 2 or 3 days. Therefore, it is common for them being arrested for possession of illegal drugs. Moreover, as prisoners were under drug influence, their impulse control reduced and at high risk to commit illegal activity. Lloyd, Chadwick and Serin (2014) reported a moderate correlation among gambling, substance use and crime. Besides, participants in our study also reported that as they deeply involved in gambling and gambling losses caused immense financial stress to them, they were induced by drug dealer inside casino to join drug traffic and selling drug. The level of stress has caused them to focus for sources of money in order to get out of trouble. Finally, they broke their moral restraint and justified their illegal activities (Lesieur 1979). It is important to note that some prisoners who had no financial stress after committing crime. In this study, they stated that they enjoy the thrill of illegal activities and perceived committing crime as gambling for not being caught. Therefore, in addition of problem gamblers and pathological gamblers, those recidivists are "offence gamblers" who gamble on the risk of being caught and enjoy the thrill of committing crime. Each success of crime also increases their confidence in skill also.

Conclusion

Hence, there is a strong need to run a gambling education program at prisons. However, there is a gap in the system as those with gambling addictions go unnoticed — making it likely they will become repeat offenders. Therefore, recognizing inmates with gambling addiction is the first step in breaking the cycle of gaming, debt, crime and recidivism. In treating pathological gamblers, it is important to acknowledge their trigger situations and cultural values in contributing to their gambling problem and illegal activity. Once they recognise the triggers to their gambling, they become aware of their problems and enhance their motivation to change. Besides identifying their triggers situations, it is also worthwhile to explore their motivation to quit and recognise the period when they restrain their gambling in the future research.

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PEER REVIEWED ARTICLE

Stressors and coping in transgender individuals

By Grace Lee

Abstract

Transgender individuals have been subject to a range of minority and other stressors as a direct result of their non-conforming identity. This study researched the experiences of eight transgender people in Victoria and used Interpretive Phenomenological Analysis (IPA)to analyse the cognitive, emotional and behavioural impacts of being transgender. The journey of each participant from early childhood through to adulthood was examined. Common themes and sub-themes were identified, as was the impact of a variety of coping skills. The main themes included a sense of difference and negative appraisals of self which resulted in hiding and secrecy. Secrecy and hiding commenced early in life and led to entrenched negative mechanisms of coping. Coping mechanisms during the hiding phase included concealment, sublimation, denial and even humour to normalise the behaviour.

KEYWORDS

transgender, gender identity coping, minority stress, hiding, interpretative phenomenological analysis

Transgender is a term used to describe an individual whose gender identity does not match their biological sex. A transgender woman is a person assigned male at birth but who to some degree identifies as a woman rather than a man. This article reports on a research project that looked at the question of the way a group of adult transgender women coped during their lives prior to coming out. Specifically, what it was like living secretly as a transgender woman; what anxieties and stresses were present and how did the women cope with these difficulties?

Mental health within the transgender community

Transgender individuals have been subject to a range of minority and other stressors as a direct result of their non-conforming identity. These stressors can be realities such as physical and verbal abuse and discrimination, or could be due to the fear of such events occurring.

A number of studies in Australia, New Zealand (NZ) and the United Kingdom (UK) have demonstrated a significant risk to the mental health of transgender people. Recent studies have consistently demonstrated much poorer mental health outcomes for transgender people (Couch et al., 2007; Hyde et al., 2014; Leonard et al., 2012; McNeil, et al., 2012; Smith et al., 2014). By way of example, the prevalence of depression amongst transgender individuals has been reported as to be as high as 53 per cent of those surveyed in a 2007 Australian report (Couch et al., 2007). Similarly, the levels of suicidal ideation, and attempted suicide have been found to be well above the national average for non-LGBTI individuals with 63 per cent of transgender respondents in a UK study reporting that they have thought about attempting suicide in the preceding 12 months (McNeil et al., 2012). A study in the United States reports similar figures, with 32 per cent of transgender survey respondents reporting having attempted suicide (Clements-Nolle, Marx, & Katz, 2006). It is important to note that although mental ill-health amongst the Australian transgender population is significantly poorer in terms of conditions such as anxiety, depression and substance abuse disorders, the prevalence of conditions such as schizophrenia and bi-polar disorders are much the same as the general population (Leonard & Metcalf, 2014).

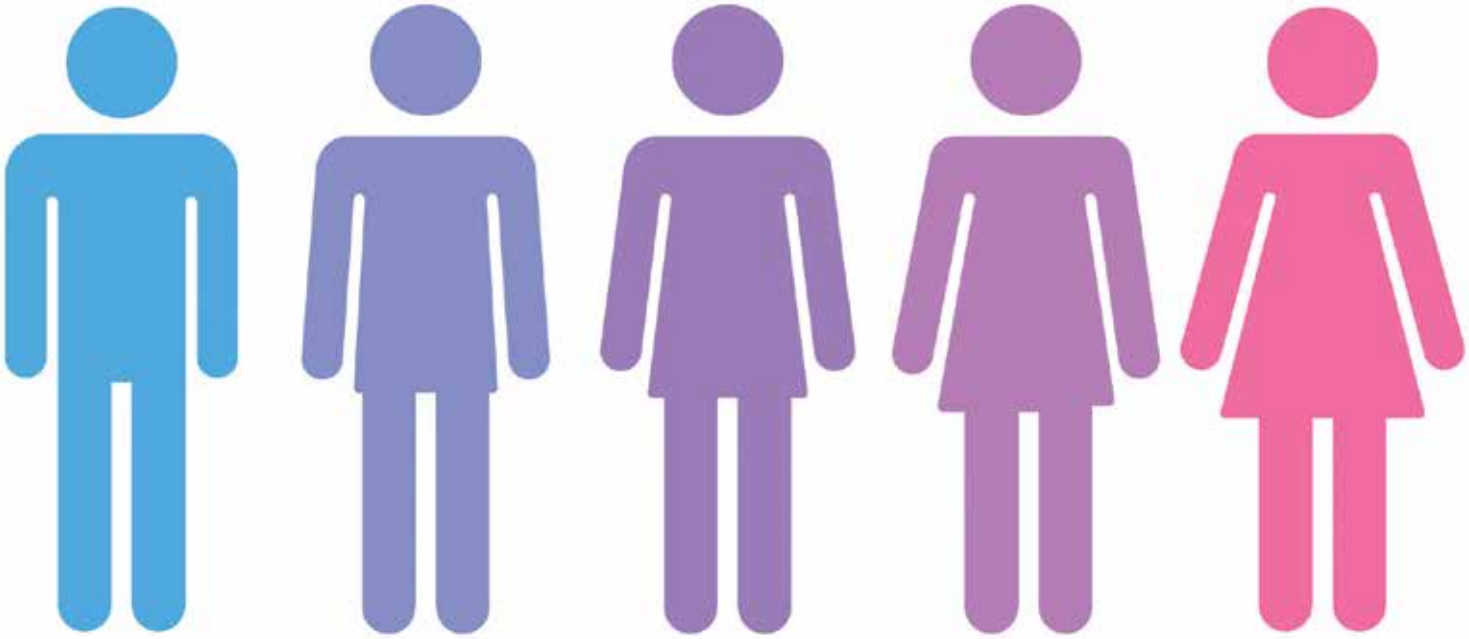
Minority Stress

Recent studies (Bockting et al., 2013; Levitt & Ippolito, 2014a) have suggested that transgender populations may suffer the consequences of minority stress in a similar way to the LGB populations studied by Meyer (2003), and that Meyer's model has applicability to transgender groups. The nature of the stressors for transgender populations have been explored (Levitt & Ippolito, 2014a) and the key areas of stress have been identified as: violence and threats to personal safety; risks to employment and opportunities; equitable access to health care and education; limited social supports and challenges to intimate relationships. These issues were also prevalent in Australian studies such as Private Lives 2 (Leonard et al., 2012) and From Blues to Rainbows (Smith et al., 2014).

Coping

A transactional model of stress and coping was proposed by Folkman, Lazarus, Gruen, & DeLongis (1986) and was based on the relationship between a person and their environment, and awareness that cognitions occurring within a given situation will result in emotional responses., which in turn may drive behaviours. Folkman and Lazarus (1988) proposed that coping involves a diverse range of cognitive and behavioural strategies for problem solving and emotion regulation. Some coping mechanisms or responses used by transgender individuals have been classified in two ways: facilitative and avoidant (Budge,

Transgender individuals have been subject to a range of minority and other stressors as a direct result of their non-conforming identity. These stressors can be realities such as physical and verbal abuse and discrimination, or could be due to the fear of such events occurring.



Adelson, & Howard, 2013), and emotion-focussed and problem solving/behavioural (Nadal et al., 2014). Problem focussed approaches include aggressive efforts such as standing one's ground, rational problem solving and seeking alternatives whereas emotion focused coping involves distancing, applying self-control, seeking social support, avoidance, and positive reappraisal by finding something good in a bad situation.

It was proposed that the concealment of one's stigmatised identity could be a major source of stress for transgender individuals, especially before coming out (Pachankis, 2007). Stigma has been defined in this case as "some characteristic individuals possess (or are believed to possess) that conveys a social identity that is devalued in a particular social context" (Smart & Wegner, 1999).

Methodology

This study was approved by the Human Research Ethics Committee at the Cairnmillar Institute. Each participant was provided with a plain language statement summarising the aims, objectives and methodology of the study and each participant provided their written consent to participate.

This investigation used Interpretative Phenomenological Analysis (IPA) as the method of enquiry. The phenomenological approach seeks to capture a person's account of some of their life experiences, and the recollections are subjective rather than objective (Spinelli, 2005). The researcher's subjectivity is important as the personal experience of the researcher serves to inform the enquiry and the interpretation (Smith & Osborn, 2003). The process of IPA involves hermeneutics; and analysing the textual narratives of study participants, where the researcher attempts to make sense of the subject's understanding of their own situation and experiences (Pietkiewicz & Smith, 2014). The methods within IPA are predominantly focussed on cognitive processes and IPA draws on the subject's narrative, their thoughts and their emotional experiences (Smith & Osborn, 2003).

The researcher sought to document and understand the experiences of transgender women through narratives elicited in an interview. The study did not intend to explain the behaviour of the participants, but rather to understand what it was that they experienced and how their responses had shaped the way they coped with those experiences and challenges.

Eight participants were selected purposely (Pietkiewicz & Smith, 2014) as the sample size was small (n=8), and the intention was to select a homogeneous sample.

Audio-recorded semi-structured interviews were conducted in a relaxed atmosphere to encourage participants to recount their experiences of living as a transgender person. The researcher attempted to elicit a narrative from the participant starting with early recollections of difference and gender diverse behaviour, following through with various experiences in adolescence and adulthood. The questioning followed a cognitive, affective and behavioural enquiry approach. Interviews were approximately sixty to ninety minutes long and were transcribed verbatim into Microsoft Word documents by the researcher, and then edited to remove identifying details.

Characteristics of Participants

(see Table 1 Summary of participant characteristics, page 36)

The participants (n=8) ranged in age from 45 to 77 years, and met the inclusion criteria for this study, which was that none had any serious mental health condition or had ever attempted suicide.

All participants were assigned male at birth. All participants regularly cross-dressed (dressed as women) and had presented as women outside of their home. They had disclosed their transgender status to someone close to them in their family (such as their partner or sibling). Two participants had recently made social transitions to living full-time as women; in one case this included a workplace

Table 1 Summary of participant characteristics (n=8)

Participant	Pseudonym	Age	Transitioned	Married/defacto	Sexual Orientation	Children	Notes
S1	Emma	63	N	N	Heterosexual	0	Emma is divorced and lives alone. She has been cross-dressing regularly for the last 3 years, and likes to spend as much time as possible presenting as female.
S2	Julie	56	N	Y	Heterosexual	2	Julie lives in regional Victoria, has cross-dresssed all her life and is highly active in the transgender community
S3	Nicci	59	N	Y	Heterosexual	2	Nicci is married with 2 teenage children, recently came out to her wife and children
S4	Natasha	45	Y	Y	Heterosexual	1	Natasha is separated, has one son and she has recently transitioned to living full time as a woman, including at work, and has told most of her family about her identity.
S5	Jenny	50	N	Y	Heterosexual	2	Jenny is separated with 2 teenage children. Jenny has spent most of her life presenting as a successful man. She has a new partner who is very accepting of her new found identity.
S6	Sarah	77	N	Y	Heterosexual	3	Sarah is married with 3 adult children. Her family have all known about her transgender identity for many years.
S7	Mandy	58	N	Y	Heterosexual	2	Mandy is married with 2 adult children, and only recently disclosed to her wife her gender identity, although she had been out in the community many years ago
S8	Sally	57	Y	N	Heterosexual	0	Sally is widowed, lives alone, and only started exploring her identity in the last few years, she has socially transitioned and is taking hormones.

transition. These two participants were also taking cross-sex hormones. Neither subject had undergone gender reassignment surgery, although both were considering the option. One other participant was planning some form of workplace transition in the next few years. One participant had established a long-term commitment to her family not to transition, but did maintain a high level of feminine expression (dressed in female clothes most of the time).

All participants identified as heterosexual based on the gender assigned at birth, and had been in at least one long-term (five years or more) heterosexual relationship, or marriage. Four participants were currently in stable long-term relationships, one was divorced, two were separated pending divorce and one was widowed. No participants disclosed having sex with men, although one had pondered the potential for homosexual expression as part of her developing gender identity earlier in life, and one subject had engaged in sex with pre-operative Male-To-Female transsexuals. Six participants were employed in professional occupations, one was retired (also professional) and one was self-employed in retail. All participants had purchased their own homes.

Thematic Analysis

A review of the transcripts was performed by the researcher using IPA (Smith & Osborn, 2003), with annotations added to the transcripts to highlight ideas, topics, and concepts. The analysis details from each transcript were entered into an Excel spreadsheet with a tab for each participant. The details captured

Table 2 Themes and sub-themes

Theme	Sub-theme
1.0 Difference – Entering the closet	1.1 Recognising difference
	1.2 Being different is wrong
2.0 Hiding – in the closet	2.1 The need to hide
	2.2 Views of self

Table 3 Difference - Cognitions, emotions and behaviours

Theme	Sub-theme	Cognitions	Emotions	Behaviours
1.0 Difference - Entering the closet	1.1 Recognising difference	I am different from the others	Shame	Hide self
		I like dressing as a woman	Relief/Joy	Cross-dressing
		I am relaxed and comfortable	Relief/Joy	Cross-dressing
	1.2 Being different is wrong	It is wrong to be different	Shame	Hide self
		I must not let others see I am different	Fear	Hide self
		I shouldn't do this	Shame	Hide self

Table 4 Difference - Coping strategies

Theme	Sub-theme	Coping Strategy	Defences
1.0 Difference - Entering the closet	1.1 Recognising difference	Escape/Avoidance	
	1.2 Being different is wrong	Self control	Denial
		Distancing	Concealment Compartmentalisation

were: theme, sub-theme or context, brief description, index into the transcript, quotations, emotion identified, thought identified, and behaviour identified. Finally, the transcripts were reviewed to identify stressors that were present within the themes and then the coping mechanisms and strategies that were employed by the participants.

The responses of the participants were analysed and the themes and sub-themes identified in their lives prior to coming out are detailed in Table 2 Themes and sub-themes.

THEME 1 - DIFFERENCE

The cognitions, emotions and behaviours associated with this theme are summarised by sub-theme in Table 3 Difference - Cognitions, emotions and behaviours.

SUB-THEME - RECOGNISING DIFFERENCE

For most participants the recognition of difference became apparent early in life. Six participants had experienced a sense of difference from other children by the age of six years, the other two became aware of their difference and that it related to gender around ten years of age.

As Mandy said: "*I realised I was a bit different. And it wasn't just dressing up like kids like to dress up as pirates. I really wanted to be a girl.*"

All of the participants had engaged in some form of cross-dressing before the age of around 12 years, borrowing either their mother's or their sister's clothes.

SUB-THEME - BEING DIFFERENT IS WRONG

All participants reported thinking, at some stage, that their cross gender behaviour was wrong and unacceptable. Only two participants said that they had been given any explicit indication from parents or family that that cross-dressing or being like a girl was unacceptable, but a sign of disapproval can be seen elsewhere. For example, Jenny had a strong recollection of being at preschool when she was 4 years old. It was dress-up time and she rushed to claim the ballerina costume.

"*And then I'd noticed the two female teachers whispering and looking at me, and so kids are smart, straightaway you know that this is not acceptable.*"

COGNITIONS ASSOCIATED WITH THE THEME OF DIFFERENCE

For participants at this stage of recognising their difference, their thoughts consisted of: 'I am different from the others'; 'I am not like the other boys', and 'I don't fit in'. The participants also had thoughts about wanting to cross-dress and recognised that they liked to do that.

The thoughts of being different were followed by thoughts of it not being normal, or believing that they shouldn't be like that or that it is wrong to be different. Along with a sense of difference came a desire to be normal. Two participants expressed the desire to wake up one day and be normal, which in one case meant not wanting to dress as a girl, and in the other case meant waking up and being a girl. Three participants believed that they could be cured, either that they would grow out of it or that, later in their lives, getting married would resolve the problem.

Table 5 Hiding - Cognitions, emotions and behaviours

Theme	Sub-theme	Cognitions	Emotions	Behaviours
2.0 Hiding - In the closet	2.1 The need to hide	I must not been seen	Shame/sadness	Hide self
	2.2 Views of self	I must be a man	Self- loathing	Act masculine
		I am not feminine	Guilt	Lie about self to others
		I wish I was normal	Envy	Wishful thinking

EMOTIONS ASSOCIATED WITH THE THEME OF DIFFERENCE

Emotions experienced by the participants within this theme were contrasted between joy and relief associated with doing something they liked (two participants), and shame and fear once they understood that they were wrong to be like that (all participants).

BEHAVIOURS ASSOCIATED WITH THE THEME OF DIFFERENCE

The main behaviour that all participants displayed at some time or another was cross-dressing. For most of the participants this was something that was kept for times when others would not be around to see. The act of concealing their difference from others, including their family and friends, then became a lifelong behavioural response.

COPING ASSOCIATED WITH THE THEME OF DIFFERENCE

The coping strategies observed in theme Difference are summarised in Table 4: Difference - Coping strategies

The coping strategies observed within the Recognising difference sub-theme were predominantly those of avoidance. The escape/avoidance strategy adopted by all participants included the behaviours of hiding and concealment; wishing that things might be different, along with the cross-dressing behaviours that satisfy the participants' desires to express their identity and escape to a different life. Coping with thoughts that 'being different was wrong' focussed more on distancing; so all participants carried on with their lives but were careful to hide and conceal their difference. Self-control also came into play and involved keeping their thoughts to themselves and not telling others about their desires. In addition, there were a number of psychological defenses observed, in particular denial and concealment. These defenses were an attempt to hide the self, as well as satisfy the need for compartmentalisation and a division into two distinct parts; the open and the hidden life.

THEME 2 - HIDING

The cognitions, emotions and behaviours associated with this theme are summarised by sub-theme in Table 5 Hiding - Cognitions, emotions and behaviours

SUB-THEME - THE NEED TO HIDE

All the participants reported feeling that they should hide their difference, especially the cross-dressing behaviour. Six participants had kept secret wardrobes, either hiding clothes in their bedrooms as children, or as adults hiding clothes in or around their homes. Two common hiding places for clothes amongst the participants when adult were in the roof of the house, or in their shed or garage. Sarah went to a lot of trouble to set her shed up, and it was a place her wife never went in to:

> *I still had the clothes but I didn't do a lot of dressing due to lack of opportunity. But it was still the dressing part of it…I had a shed built up at the back, the usual shed. I ended up with a dressing table in there and all sorts of things…I used to be able to go there and put some underwear on, used to wear underwear under my clothes all the time. [I] went round to a little small tub washing machine, and everything, and a line inside.*

Nicci too kept her clothes outside the house in her garage away from her wife and children:

> *…the secret nature of the dressing up continued. The wardrobe this time was in the garage; it wasn't in the house. I collected a few items and sometimes in rash moments I would give them all back to the op shop and then two months later buy another load of clothes. My wife didn't know about the wardrobe.*

And for Mandy, she was aware of the risk of her secret being uncovered:

> *But I didn't part with all my stuff till many years later. I had it stashed in the roof cavity of the house. There was a panic when the electrician came round to rewire the house!*

For these participants there was a secret life, another world where they acted out their desires for feminine expression. The need for secrecy during childhood meant their only opportunity for cross-dressing was at night, when the participant was in their bedroom, or at times when their parents went out. For four participants that resulted in being caught or nearly caught. Mandy stayed away from school one day and was dressed in her mother's clothes, thinking she had lots of free time. Her mother returned unexpectedly and Mandy had to take quick evasive action:

> *…and she came home and there I was sitting in one of her dresses and a nice pair of stockings, and I'm sitting there watching TV when I should have been at school. And her car came in the drive, oh boy did I panic, I hid in the wardrobe.*

SUB-THEME - VIEW OF SELF

The secrecy resulted in six participants having to lie when almost caught or when real life got to close to the secret world. Jenny said that for her 'living a lie' was a real problem:

> *I had to lie to people I love. What else do you do? You are just in this tangled web of emotions that just screws you up, your life up so badly. Because it is so wrong. And you perpetuate the lie through your whole life. And eventually your life becomes a lie.*

Six participants engaged in stereotypical masculine activities in adolescence and adulthood including: martial arts, motor sports and skydiving as well as adolescent risk taking. Four participants reported that this reduced their need to cross-dress as well as reducing their vulnerability to physical intimidation and improving their confidence.

> *I thought if I don't do something I'm going to get sand kicked in my face the rest of my life. So I started boxing.* (Emma)

> *Tae kwon do was totally different for me. When I took it up I took it up for the purposes of self- defence. It also put the cross dressing under control for a few years because I was a zealot with regard to martial arts. I had a sense of purpose and a chance to prove myself as a male.* (Natasha)

All the participants were successful business people or professionals. They had done very well in their careers and reported that they were acknowledged as functional and effective men.

COGNITIONS ASSOCIATED WITH THEME OF HIDING

The thoughts reported in this theme related to keeping a secret. These thoughts included: 'I must hide'; 'I must not be seen', and 'I don't want my father to know'. Initially cognitions were those of not wanting to be seen and the need to conceal oneself, but these thoughts developed later to the need to appear masculine to others: 'I must be a man'; 'I must be masculine', and 'I am not effeminate'.

EMOTIONS ASSOCIATED WITH THEME OF HIDING

Emotions observed in this theme were based on shame and guilt, and it was likely the feelings were a result of the negative self-appraisal of thinking it was wrong to be different. Three participants felt envy and expressed this as a wish to be normal and more like others. One participant felt self-loathing, whilst five participants reported feeling very negatively about themselves and the secret lives they had led.

BEHAVIOURS ASSOCIATED WITH THEME OF HIDING

The Hiding theme was characterised by the tendency to hide in some way. Participants cross-dressed in secret out of view of their family. Participants would take clothes from their mothers or sisters and they dressed when they could. When participants acquired their own clothes they found various ways of hiding them from parents and partners. For some participants the secret cross-dressing was performed as 'underdressing' or wearing female underwear beneath their male clothing. The second sub-theme; 'View of self' involved participants presenting themselves in such a way as to be seen as stereotypically masculine, and engaging in various masculine behaviours including sport.

COPING ASSOCIATED WITH THE THEME OF HIDING

The coping strategies observed in theme Hiding are summarised in Table 6 Hiding - coping strategies and defences

Distancing and self-control were the predominant strategies utilised by seven participants in separating their lives into two distinctive parts. Self-control enabled these participants to keep information to themselves and all seven had lied to others in order to preserve their secrets. As mentioned above, their behaviours reflected a compartmentalisation, in that the two parts of their lives were kept quite separate.

For six participants, a further coping strategy to maintain the hidden selves was to present as strongly masculine. The strategies that were displayed included: self-control and escape/avoidance along with a denial defense to help keep their secrets. Defenses were also apparent and could be explained through: Reaction formation seen in two participants – turning their feminine desires into the opposite masculine desires and behaviours by taking up sports that made them feel more masculine; two subjects exhibited sublimation in refocussing their unacceptable need for femininity into masculine qualities and interests through social conformance with other families, and two participants that used compensation in martial arts to overcome their self-perceptions of weakness because of their gender non-conformance.

Discussion

The discussion follows the themes and sub-themes and examines how participants responded to the various stressors of coming out as transgender.

Stressors and coping mechanisms

THEME 1 – DIFFERENCE

RECOGNISING THE DIFFERENCE

A feeling of difference is a common feature in transgender identity development models (Eliason & Schope, 2007), and is predominant in the narratives within this study. For most participants, the feeling of being different was experienced very early in life, and always by early teenage years. The feeling of difference took the form of not fitting in with same-gender peers; wanting to wear girls' clothes, or wanting to be a girl. However, in contrast to Devor's (2004) report none of the participants openly proclaimed their difference to their families or peers. In the current study participants only came out to parents much later in their lives, if ever. This may reflect the characteristics of the

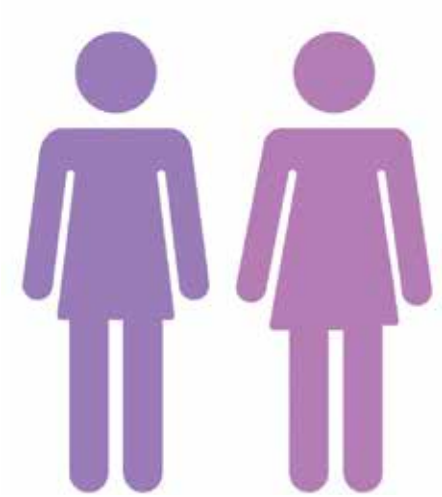


Table 6 Hiding - coping strategies and defences

Theme	Sub-theme	Coping Strategy	Defences
2.0 Hiding - In the closet	2.1 The need to hide	Distancing	Compartmentalisation
		Self control	
	2.2 Views of self	Self control	
		Escape/Avoidance	Sublimation
			Compensation
			Denial
			Reaction formation

participants, as Devor's (2004) included many who transitioned early in life and would have been described as transsexual rather than transgender. Once participants recognised that gender was an issue of difference, shame became the emotion experienced. For some participants the sense of not fitting in meant they felt envious and either wanted to be girl, or be with the girls. The coping strategies in this phase were simple and immature; based on avoidance and consisting of hiding and concealment. Participants tried to avoid being seen as different, or wished they were not different.

BEING DIFFERENT IS WRONG

Levitt and Ippolito (2014b) reported that a sense of difference and the need to conform could result from peer pressure, such as harassment or ostracism. No participants in this study reported gender based harassment; two participants experienced bullying at school but they did not attribute that to their sense of gender difference. From an early age participants had an innate sense of 'wrongness', all but one participant denied being told appearing or behaving in a feminine way was wrong for a young boy. In four cases participants either noted subtle signals from their mother, or more direct statements about not cross-dressing in their mother's clothes. It seems likely that a sense of wrongness about expressing an alternative gender was derived from conditioning resulting from distal social pressures including the media, schools, churches and other institutions, and proximal pressures from family and peers (Levitt & Ippolito, 2014b). Under the pressure of felt stigma (Herek et al., 2015) to conform to gender norms, the participants' shame and fear became the dominant emotion and the universal response was to hide the self. The coping mechanisms were avoidant, but for many the behaviours continued. Their desires to cross-dress persisted and this was accompanied by distancing and concealment along with elements of compartmentalisation as defences.

THEME 2 – HIDING

THE NEED TO HIDE

The sense of difference experienced universally led to hiding and concealment behaviours which are consistent with the findings of Levitt & Ippolito (2014b) who named a theme "Hiding or ignoring my true self" (p. 1736). Devor (2004) also highlighted the trend towards hiding, and attributed that to the impact of "social and psychological realities" (p. 49).

Along with the need to hide was the fear of being caught, or of having one's secret exposed. Cross-dressing at home during childhood / teenage years whilst family members were out of the house was common. The risks of exposure were significant, with participants either being caught (or nearly caught) in the act of cross-dressing, or their mother's noticing that clothes had been disturbed and worn. The participants' mothers appeared to have been the ones to catch their children in the act of cross-dressing. Where a participant's secret had been uncovered by their mother, the subsequent fear was that their father would be told. The threat of discovery was a significant stressor for those with something to hide as explained by Pachankis (2007). The early hiding behaviours continued into adulthood. For example, some participants wore women's underwear under their male clothes, and hid their secret stash of women's clothes from their partners. The risks of exposure remained, and some participants led a double life where their feminine expression was compartmentalised and separated by secrecy and lies.

VIEWS OF SELF

The early childhood private cross-dressing, the later concealing of clothes and the pursuit of masculine activities aligned with the behaviours reported in Levitt & Ippolito's (2014b) theme of hiding. As also described by Devor (2004) individuals will try harder to meet society's expectations for their behaviour and will attempt to conform towards their assigned gender. Exhibiting stereotypical masculine behaviours was believed to affirm their ability to appear male, and allowed them to hide in plain sight. This appeared to be an adaptive coping mechanism, although seemingly an avoidant response, for participants utilised mature defences such as sublimation and compensation, and participants maintained emotional stability and led successful lives. The participants found ways to manage their needs and still meet familial and societal expectations of their outward gender presentation. This is in contrast to the findings of Budge et al. (2013) where pre-disclosure coping behaviours seen were avoidant and maladaptive and included negative metaphors such as being unable to see where they fitted in the picture of their lives, suicidal ideation, and substance abuse; behaviours not observed in the participants in this study.

Conclusion

All participants in this study had found ways of coping throughout their lives; they had managed to successfully conceal their difference and either sublimate or compensate for it. Most participants had all formed long-term relationships with intimate partners whilst concealing their transgender identity and this may

have contributed to strong family and social bonds which gave them necessary support. Under the minority stress model the major stressors include discrimination and isolation, and it is understood that social connectedness provides a buffer and resilience against those stressors. Family connections can provide strong social supports. This study group had emotional, financial and physical security along with living within a relatively open and accepting society with regards to diversity.

The results of this study could assist therapists working with transgender clients. An awareness of the range of common behaviours and coping strategies used may help therapists to acknowledge, understand and support individual clients who are seeking help with exploring their gender identity. Clients may feel more comfortable talking about these deeply personal experiences with a therapist who has a knowledge and understanding of these issues.

Future research could include the examination of the importance of family support on coping mechanisms and outcomes. In addition, it would be useful to explore the experiences of partners of transgender people and how they cope through the coming out process and beyond.

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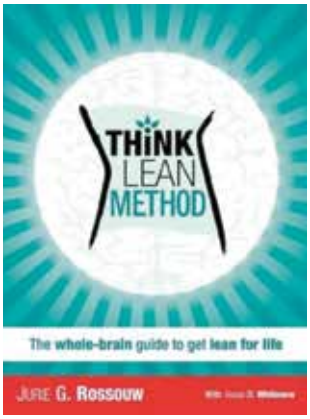
Grace Lee is a counsellor working in private practice in Melbourne and focuses primarily on transgender and gender diverse clients. Her clients are at various stages of identity exploration and expression. Grace is one of only the few openly transgender counsellors in Melbourne. Her research has a unique perspective on her clients' issues and how to support them and their mental health.

Think Lean Method



Review by Philip Armstrong FACA

This is not a book about diets nor is it about food, which is why I agreed to review it, it is about the brain and how it works and the relationship between food, weight and our brains. This book discusses the neuroscience of nutrition, something that is very relevant to all counsellors. Our client's physical health is an important part of mental health and with that, we need to understand the gut-brain axis. Although this book is not about the gut-brain axis, it looks at the neuropsychotherapy of eating and food and how we can change the brain and improve mental health.

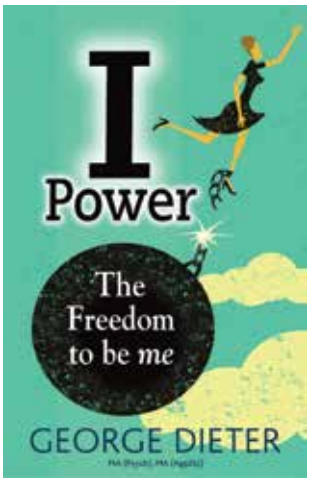
The book starts out by looking at nutrition and its fundamentals giving the reader a strong foundation from which to approach the second part of the book. The strength of this book is that it only uses evidence-based strategies that are embedded in science. The book then moves into the second part which looks at three key areas; Automatic Calorie Management, Boost the Brain and Think Lean. The book includes several very important appendixes covering vitamins, minerals and food, a must if you wish to understand nutrition and its impact on the brain. The book even has a few handy healthy recipes to help the reader get started.

Although this book was written for the person looking to transform their life, I highly recommend this book for counsellors who work with clients who may need to consider life changes about health, weight and mental health. It will give you the necessary knowledge and understanding of what your clients need to do and how you can help them and better understand the connection between mental health and what we eat.

For further information on this excellent book go to www.thinkleanmethod.com

Philip Armstrong FACA is CEO of the Australian Counselling Association and Director of Optimise Potential (OP). He is the designer and facilitator of professional development workshops delivered by OP. He developed and continues to facilitate a Certificate of Attainment in the Professional Supervision Course which is delivered by OP. Philip sits on curriculum development boards for both vocational and higher education providers from Diploma to Masters level. He advises government in relation to standards and training and is highly sort after by government and industry sectors for consultation on industry and training issues. Philip also regularly conducts media meetings, and works tirelessly with consumer groups. He is the founder and continues as the current editor of the peer reviewed journal Counselling Australia since its inception in 1999. Philip is the co-founder of the "Healthy Weight Programme" and now specialises in weight issues.

I Power: The Freedom to be me



Review by Tom Parker, ACA ILO

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I Power: The freedom to be me
George Dieter MA (Psych), MA (AppISc)
ISBN: 978-1-921966-83-5
This book can be purchased at many leading retailers across Australia. For information, please go to:
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Tom Parker is the Industry Liaison Officer with the Australian Counselling Association. Tom comes from a background of therapeutic support and business development; in his role, Tom engages with many key stakeholders to raise the profile of counselling in Australia.

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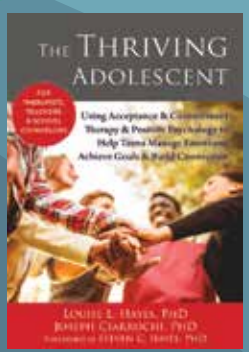

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Valerie Holden	PEREGIAN SPRINGS	0403 292 885	Upon Enquiry	FTF
Anne-Marie Houston	BUNDABERG	0467 900 224	Upon Enquiry	FTF
Beverley Howarth	PADDINGTON	0420 403 102	Upon Enquiry	FTF/PH/WEB
Kim King	YEPPOON	0434 889 946	Upon Enquiry	FTF
Kaye Laemmle	HELENSVALE	0410 618 330	Upon Enquiry	FTF
Jodie Logovik	HERVEY BAY	0434 060 877	Upon Enquiry	FTF/PH
Sharron Mackison	CABOOLTURE	07 5497 4610	Upon Enquiry	FTF/PH/GRP/WEB
Maggie Maylin	WEST END	0434 575 610	Upon Enquiry	FTF/PH/GRP/WEB
Neil Roger Mellor	PELICAN WATERS	0409 338 427	Upon Enquiry	FTF
Tracey Milson	ARUNDEL	0408 614 062	Upon Enquiry	FTF
Ann Moir-Bussy	SIPPY DOWNS	07 5476 9625 or 0400 474 425	Upon Enquiry	FTF/GRP/PH/WEB
Diane Newman	BUNDABERG WEST	0410 397 816	Upon Enquiry	FTF/PH

ACA SUPERVISOR COLLEGE LIST		Medium key: FTF: Face to face | PH: Phone | GRP: Group | WEB: Skype		
Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
SOUTH AUSTRALIA				
Gary Noble	LOGANHOLME DC	0439 909 434	Upon Enquiry	FTF
Colin Palmer	KALLANGUR	0423 928 955	Upon Enquiry	FTF
Lyn Patman	BROWNS PLAINS	0415 385 064	Upon Enquiry	FTF
Penelope Richards	CHAPEL HILL	0409 284 904	Upon Enquiry	FTF
Brian Ruhle	URANGAN	0401 602 601	Upon Enquiry	FTF
William James Sidney	LOGANHOLME	0411 821 755 Or 07 3388 0197	Upon Enquiry	FTF/PH/GRP
Deborah Stevens	KINGAROY	0411 661 098	Upon Enquiry	FTF
Frances Taylor	REDLAND BAY	0415 959 267 or 07 3206 7855	Upon Enquiry	FTF
Robyn Brownlee	NANANGO	0457 633 770	Upon Enquiry	
Ligia Emmel Barnett	EMERALD	0419 954 984	Upon Enquiry	FTF/PH/WEB
Jenny Endicott	MT GRAVATT EAST	0407 411 562	Upon Enquiry	
Annie Cornish	HENLEY BEACH	0407 390 677	Upon Enquiry	FTF
Beverley Dales	GOLDEN GROVE	08 8289 0556 / 0413 303 576	$50	FTF
Susan Turrell	BLAKEVIEW	0404 066 433	$55	FTF/GRP/WEB
Rachael Cassell	TORRENSVILLE	0434 570 992	$80 1 hour : $120 1.5 hours	FTF
Carol Moore	OLD REYNELLA	08 8297 5111 bus Or SMS 0419 859 844	Grp $35, Indiv $99	FTF/PH/GRP/WEB
Deborah Green	BLACKWOOD	0474 262 119	Indiv $75: Groups $45	FTF/GRP/WEB
Richard Hughes	WILLUNGA	0409 282 211	Negotiable	FTF/PH/WEB
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon Enquiry	FTF
Adrienne Jeffries	STONYFELL	08 8332 5407	Upon Enquiry	FTF/PH/WEB
Maxine Litchfield	GAWLER WEST	0438 500 307	Upon Enquiry	FTF
Pamela Mitchell	WATERFALL GULLY	0418 835 767	Upon Enquiry	FTF
Ellen Turner	HACKHAM WEST	0411 556 593	Upon Enquiry	FTF
Kerry Turvey	TANUNDA	0423 329 823	Upon Enquiry	FTF
Laura Wardleworth	ANGASTON	0417 087 696	Upon Enquiry	FTF
Anthony Gray	ATHELSTONE	08 8336 6770/0437 817 370	Upon Enquiry	
Carol Kerrigan	ENGLFIELD	0410 567 479	Upon Enquiry	
Barry White	PORT ADELAIDE	0488 777 459	Upon Enquiry	FTF/PH
Jane Oakley-Lohm	BLACKSTONE HEIGHTS, LAUNCESTON	0438 681 390	$110 GST inclusive, $80 for new students of one ye	FTF/PH/GRP/WEB
Pauline Mary Enright	SANDY BAY	0409 191 342	$70 per session: Concession $60	FTF/PH/WEB
David Hayden	HOWRAH NORTH	0417 581 699	Upon Enquiry	FTF
Benjamin Donald Turale	HOBART	0409 777 026	Upon Enquiry	FTF/PH/WEB
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Deborah Cameron	BRIGHTON	+65 9186 8952 Or 0447 262 130	Upon Enquiry	FTF/GRP/WEB
Graeme John Riley	GLADSTONE PARK	03 9338 6271 or 0423 194 985	$85	FTF/WEB
Sandra Brown	FRANKSTON/MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB

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VICTORIA				
Derek Goodlake	SANDRINGHAM	0403 045 800	$110	FTF/PH/WEB
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Joanne Ablett	PHILLIP ISLAND/ MELBOURNE METRO	0417 078 792	$120	FTF/GRP/PH/WEB
Angeline Crossin	ASCOTVALE/ESSENDON	0451 010 750	$100 F/F, $90 Skye,$50 Group, $70 Students	FTF/GRP/WEB
Jo-Ellen White (specialises in Autism Spectrum Disorder)	BLACKBURN SOUTH	0414 487 509	$100 ind. $50 Group. Stu Dis $80	FTF, PH, GRP, WEB,
Sandra Robinson	MANSFIELD/BENALLA	0403 175 555	$110 individual 1 hour session. $50 - group per hr	FTF/WEB
Melissa Harte	PAKENHAM/SOUTH YARRA	0407 427 172	$132 to $143	FTF
Lynda M Carlyle	EAST MELBOURNE, SPRINGVALE SOUTH, RIPPON LEA	0425 728 676	$135 per hour	FTF/PH/WEB
Kathleen (Kathy) Brennan	NARRE WARREN	0417 038 983	$35 Grp, $60 Indiv	FTF/GRP/PH/WEB
Helen Wayland	ST KILDA	0412 443 899	$75 Indiv	FTF/PH/GRP/WEB
Gayle Stapleton	BERWICK	0459 075 284	$100 p/h Negotiable	FTF/GRP/PH/WEB
Rosemary Petschack	DIAMOND CREEK	0407 530 636	$80 p/h	FTF/PH
Bridget Pannell	MELBOURNE	0423 040 718	call to discuss	FTF/GRP/PH/WEB
Matt Glover	CROYDON HILLS, EAST DONCASTER	0478 651 951	Conc: $70, Full: $90 Group: $30/hour	FTF/GRP/PH/WEB
Rosslyn Wilson	KNOXFIELD	03 9763 0772 Or 03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
Rosie Barbara	SYDENHIAM/WYNDHAM	0433 277 771	Ind:$110/Grp:$50 each min of 4 hours	FTF/PH/GRP/WEB
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Sandra Hatton	KEW	0425 722 311	Indiv. $80/hour; sml group $80/2hours	Individual, FTF/GRP
Stephen O'Kane	BLACKBURN	0433 143 211	To be discussed with client	FTF, GRP
Danielle Aitken	SOUTH GIPPSLAND/ MELBOURNE METRO	0409 332 052	Upon Enquiry	FTF/GRP/PH/WEB
Anna Atkin	CHETLENHAM	0403 174 390	Upon Enquiry	FTF
Nyrelle Bade	EAST MELBOURNE/ POINT COOK	0402 423 532	Upon Enquiry	FTF/GRP/WEB
Marie Bajada	BALLARAT	0409 954 703	Upon Enquiry	FTF
Judith Beaumont	MORNINGTON	0412 925 700	Upon Enquiry	FTF/PH/GRP/WEB
Zohar Berchik	SOUTH YARRA	0425 851 188	Upon Enquiry	FTF
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Sheryl Brosnan	CARLTON NORTH/ MELBOURNE	03 8319 0975 Or 0419 884 793	Upon Enquiry	FTF/GRP/PH/WEB
Anne Meredith Brown	COLDSTREAM	(02) 6026 6141	Upon enquiry	FTF/PH/GRP
Molly Carlile	INVERLOCH	0419 579 960	Upon Enquiry	FTF
Lehi Cerna	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF/WEB
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF

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VICTORIA *CONTINUED*				
Debra Darbyshire	BERWICK	0437 735 807	Upon Enquiry	FTF
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
Petra de Kleijn	TATURA	0413 824 073	Upon Enquiry	FTF/PH/WEB
Lisa Derham	CAMBERWELL	0402 759 286	Upon Enquiry	FTF/WEB
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon Enquiry	FTF, GRP, WEB
Sara Edwards	DINGLEY	0407 774 663	Upon Enquiry	FTF/WEB
Karen Efron	NORTHCOTE	0432 391 887	Upon Enquiry	FTF
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon Enquiry	FTF
Maurice Grant-Drew	ELWOOD	0412 331 301	Upon Enquiry	FTF
Batul Fatima Gulani	MELBOURNE	0422 851 536	Upon Enquiry	FTF
Graham Hocking	PARK ORCHARDS	0419 572 023	Upon Enquiry	FTF
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Beverley Kuster	NARRE WARREN	0488 477 566	Upon Enquiry	FTF
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF
Barbara Matheson	MELBOURNE	03 9703 2920 or 0412 977 553	Upon Enquiry	FTF
Marguerite Middling	NORTH BALARAT	0438 744 217	Upon Enquiry	FTF
Paul Montalto	THORNBURY	0415 315 431	Upon Enquiry	FTF
Andrew Reay	MOORABBIN	0433 273 799	Upon Enquiry	FTF
Patricia Reilly	MOUNT MARTHA/ GARDENVALE	0401 963 099	Upon Enquiry	FTF
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
Karen Seinor	WODONGA	0409 777 116	Upon Enquiry	FTF
Gabrielle Skelsey	ELSTERNWICK	03 9018 9356	Upon Enquiry	FTF/PH/WEB
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon Enquiry	FTF
Natalie Wild	BORONIA	0415 544 325	Upon Enquiry	FTF
Cas Willow	WILLIAMSTOWN	03 9397 0010 Or 0428 655 270	Upon Enquiry	FTF/PH/WEB/GRP
Jacquie Wise	ALBERT PARK	03 9690 8159	Upon Enquiry	FTF
Michelle Wood	MANSFIELD	0497 037 436	Upon Enquiry	FTF/PH/GRP/WEB
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260/03 9786 8006	Upon Enquiry	FTF
Joan Wray	(MOBILE SERVICE)	0418 574 098	Upon Enquiry	FTF
Sandra Clough	TRARALGON	0412 230 181	Upon Enquiry	FTF/GRP/WEB
Tra-ill Dowie	PORT FAIRY	0439 494 633	Upon Enquiry	
Belinda Hulstrom	WILLIAMSTOWN	04714 331 457	Upon Enquiry	
Tabitha Veness	FERNTREE GULLY	0400 924 891	Upon Enquiry	
John Dunn	COLAC SW AREA/MT GAMBIER	03 5232 2918	By Negotiation	FTF/GRP/WEB
Brian Whiter	CARLTON, MOORABBIN	0411 308 078	$100	
Sophie Lea	MORNINGTON PENINSULA	0437 704 611	Individual $100/hour	Face to Face, Phone, Skype

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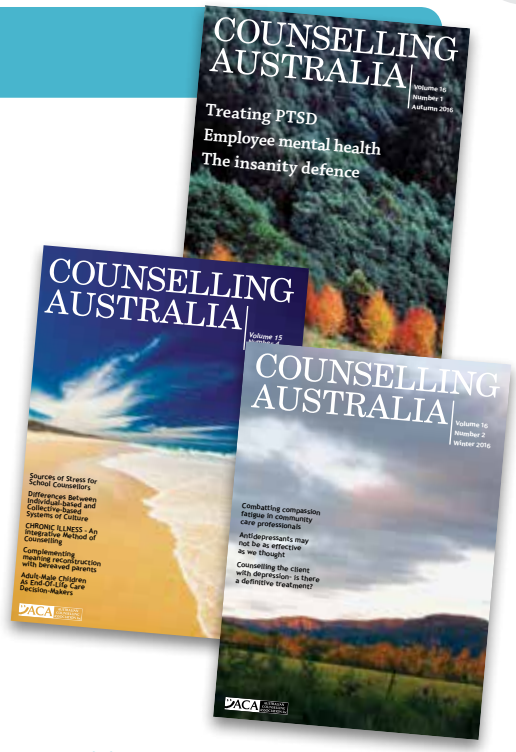
WESTERN AUSTRALIA				
Julie Hall	YANCHEP/BUTLER/ JINDALEE/JOONDALUP	0416 898 034	$100	Face to face, Phone, Skype
Dr. Patricia Sherwood	PERTH/BUNBURY	0417 977 085 or 08 9731 5022	$120	FTF/PH/WEB
Eva Lenz	SOUTH FREMANTLE/ COOGEE	08 9418 1439 Or 0409 405 585	$85, concession $70	FTF/PH/GRP/WEB
Sharon Vivian Blake	FREMANTLE	0424 951 670	Indiv $100, Grp $65	FTF/PH/GRP/WEB
Carolyn Midwood	DUNCRAIG	08 9448 3210	Indiv $110, Grp $55	FTF/GRO/PH/WEB
Trudy McKenna	NEDLANDS	0438 551 210	Indiv $120, Grp $50 Concess $30	Face to Face, Phone, Group, Skype
Genevieve Armson	CARLISLE	0412 292 999	Upon Enquiry	FTF, GRP, PH, WEB
Marie-Josee Boulianne	BEACONSFIELD	0407 315 240	Upon Enquiry	FTF
Lynette Cannon	CAREY PARK	0429 876 525	Upon Enquiry	FTF
Karen Heather Civello	BRIDGETOWN	0419 493 649	Upon Enquiry	FTF
Cindy Cranswick	FREMANTLE	0408 656 300	Upon Enquiry	FTF
John Dallimore	FREMANTLE	0437 087 119	Upon Enquiry	FREMANTLE
Alan Furlong	WINTHROP	0457 324 464	Upon Enquiry	FTF
Merrilyn Hughes	CANNING VALE	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
Lillian Wolfinger	YOKINE	08 9345 0387 or 0401 555 140	Upon Enquiry	FTF/PH/WEB
Fiona McKenzie	GERALDTON	0427 928 505	Upon Enquiry	
INTERNATIONAL				
Dina Chamberlain	HONG KONG	+852 6028 9303	Upon Enquiry	FTF
Pui Kuen Chang	HONG KONG	+852 9142 3543	Upon Enquiry	FTF
Fiona Man Yan Chang	HONG KONG	+852 9198 4363	Upon Enquiry	FTF
Viviana Cheng	HONG KONG	+852 9156 1810	Upon Enquiry	FTF
Polina Cheng	HONG KONG	+852 9760 8132	Upon Enquiry	FTF
Eugnice Yiu Sum Chiu	HONG KONG	+852 2116 3733	Upon Enquiry	FTF
Wing Wah Hui	HONG KONG	+852 6028 5833	Upon Enquiry	FTF
Cary Hung	HONG KONG	+852 2176 1451	Upon Enquiry	FTF
Giovanni Ka Wong Lam	HONG KONG	+852 9200 0075	Upon Enquiry	FTF
Yuk King Lau	HONG KONG	N/A	Upon Enquiry	FTF
Winnie Wing Ying Lee	HONG KONG	N/A	Upon Enquiry	FTF
Lap Kwan Tse	HONG KONG	+852 9089 3089	Upon Enquiry	FTF
Barbara Whitehead	HONG KONG	+852 2813 4540	Upon Enquiry	FTF
Yat Chor Wun	HONG KONG	+852 264 35347	Upon Enquiry	FTF
Frank King Wai Leung	HONG KONG	+852 3762 2255	Upon Enquiry	FTF
Deborah Cameron	HONG KONG	+65 9186 8952 Or 0447 262 130	Upon Enquiry	FTF/GRP/WEB
Jeffrey Gim Tee Po	SINGAPORE	+65 9618 8153	$100.00	FTF/GRP/PH/WEB
Eugene Chong	SINGAPORE	+65 6397 1547	Upon Enquiry	FTF
David Kan Kum Fatt	SINGAPORE	+65 9770 3568	Upon Enquiry	FTF
Su Keng Gan	SINGAPORE	+65 6289 6679	Upon Enquiry	FTF
Saik Hoong Tham	SINGAPORE	+65 8567 0508	Upon Enquiry	FTF
Natalie Chantagul	MALAYSIA	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