COUNSELLING AUSTRALIA

Volume 17
Number 1
Autumn 2017

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ISSN 1445-5285

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PEER REVIEWED ARTICLE

A profile of psycho-social issues and mental health concerns among the female commercial sex workers (csw) in Guwahati, Assam (India)

By Bristi Barkataki

Abstract

In the recent past, a lot of focus has been given to the effects of high risk behavior in sex-workers of India. Guwahati, the capital city of Assam, gateway for all other north-eastern states in India sees very high vulnerability to high risk behavior with 4,251PLHIV (mostly contacted the virus through promiscuous sex) yet the state is not categorized as a high risk region. Studies only highlight the issues of HIV and social issues among CSWs while mental-health have not received much attention. The study aims at profiling the sex-workers in Guwahati and highlights the psycho-social and mental-health issues which often go unnoticed.

Key Words

Commercial Sex Workers (CSW); Guwahati (Assam); Mental Health

Background and Introduction

Vulnerability of sex workers towards sexually transmitted infections has paved way for research relating to their physical health in India (Nair & Verma, 2002). Due to the nature of the practice of sex work in India, commercial sex work in the Indian scenario presents specific mental health concerns (Chudakov, 2002). However, there has been very little systematic effort on investigating the mental health aspects despite the fact that the hostile circumstances in which they operate and try to survive has more than obvious mental health implications (Nair & Verma, 2002).

Prostitution is explained as the provision of sexual services by one person, the 'prostitute' or 'sex worker' for which a second person provides money or other markers of economic value. Exchange of sex for food, clothing, and shelter - known as 'survival sex' is also a part of prostitution" (Alexander, 1998). There are estimated 2.3 to 8 millions women sex workers in India (Murthy, 1999; Nag 1994). Assam is a major state of north-east India where the problem of HIV has emerged as one of the major public health concerns mainly because of its strategic location near the Golden Triangle as it shares common borders with other north-eastern states like Manipur, Nagaland, Mizoram and countries like Bangladesh, Burma, Nepal and Bhutan. It is also vulnerable to day labour invasion from the neighbouring countries like Bangladesh. Guwahati, the capital city of Assam, as the gateway for all other north-eastern states hence rates very high vulnerability to high risk behaviour and spread of HIV.

The scenario of sex work in Guwahati (Assam) is highly complex as there are no segregated red light area in the city and the trade functions as non brothel-based sex workers who are street-based, floating, or mobile sex workers who operate near highways, industrial areas, tourist spots, railway stations, bus stations, and in lodges, hotels, bars and residential areas. Studies only highlight the issues of HIV and social issues among CSWs in the area while mental-health have not received much attention.

Methodology

Based on the literature reviewed, the present study was undertaken with the aim of comprehensively profile the commercial sex work scene in the city of Guwahati, Assam regarding four main parameters, namely;

- Socio demographic characteristics of the sex workers in the city of Guwahati;
- Background and initiation to the profession;
- Health behavior pattern;
- Overall mental health concerns among the female commercial sex workers (FCSWs)

Hypothesis

There will be a high co-morbidity rate of mental health concerns as well as HIV among the CSWs owing to the stressful life style and the practice of high risk behaviour which often go unnoticed.

The design of the study was entirely exploratory in nature as exploratory studies are said to be a valuable means of finding out 'what is happening' and also helps researchers to seek new insights.

The present sample consists of interviews of only 20 FCSWs who gave their consent to participate in the study and who gave complete information on the study parameters were included in the study. These FCSWs were from different

geographical localities within the city as well as from neighbouring states and countries (as they come to the city to earn their wages) and belonged to different age groups ranging from 12 years to 50 years. For supportive evidence 3 peer educators of the sex workers; and health care providers including a counsellor and a doctor associated with the AIDS Prevention Society (Guwahati) were also interviewed as they primarily operate in that area for AIDS prevention. It might be mentioned here that as a part of the exclusion criteria for the study CSWs already diagnosed as having any psychiatric disorder, CSWs showing resistance; study participants who haven't been able to give complete information on all parameters and male CSWs were not included in the present sample data.

Few of the sex workers were reached with the help of the contacts database of sex workers as maintained by AIDS Prevention Society in Guwahati while the rest were peer referrals from the sex workers themselves. The total data was collected from 3 main sources; the sex workers – the primary unit for analysis; the peer educators and the health providers – who helped in providing supportive evidence.

The data was collected through in-depth unstructured face-to-face interviews with the sex workers, the peer educators, and health providers. The data obtained from the CSWs has been used as the primary unit of analysis while that of the peer educators and the health providers were used as supportive evidence for discussion in this present study. The analysis performed was mostly qualitative and the data was compiled and classified into theme-based matrices related to the abovementioned parameters for analysis and discussion.

Profiling

As per the colloquial classification of sex workers, the entire population of sex workers in Guwahati is divided into 5 broad classes based on the socio-economic standing of their profession;

- **a.** High class workers also known as escorts who operate for high class business officials and are difficult to find (out of realm of the collected histories in this present study).
- **b.** Home-based sex workers who either call clients to their residence (which usually keeps changing from time to time to keep away from bad name) or they go to their clients' residence.
- **c.** Illegal Brothel-based sex workers
- **d.** Floating or mobile sex workers who operate near highways, industrial areas, tourist spots, railway stations, bus stations, and in lodges, hotels, bars and residential areas
- **e.** Street based sex workers.

The data related to demographic profile can be compiled under the following heads;

Age

The range of age is extremely wide, 12 years to 50 years. While the younger age group (40per cent); i.e., 12 to 20 years is mostly street children or children of sex workers or children from deprived households, the higher age group (40per cent), i.e., 21 to 35 years comprises of married women, some of them with grown-up children while the older (20per cent), i.e., 36 to 50 years comprises of illegal brothel owners and a few married women who have been into the business for long. Maximum of the sex workers are in the age group of 15 to 35 years.

Domicile, Migration, Housing: Although majority of the sex workers reside in Guwahati, only few of them originally belong to the city. A large number of them (60per cent) belong to other districts and small towns or villages in Assam, who had come to the city for higher studies or work. Some sex workers (30per cent) also commute daily from their home towns/villages to the city for their work.

Migration from nearby areas has also added to the population of sex workers in the city. The migrant population is usually observed to be mobile and of extremely low SES. The standard of housing also differs drastically among sex workers. 35 per cent of CSWs live alone as tenants in residential areas, 15 per cent live with their landlords/landladies who act as pimps and madams, while in certain others the pimps pose as husbands/brothers of the sex workers. 40 per cent live with families where in most of the times the family is unaware of the CSWs profession →

as they ostensibly go for part time work in factories, tailoring shops, etc. while 10 per cent of the population stays in hostels or stay with their friends in private apartments.

Education

The differences in educational levels of the sex workers vary from illiteracy to graduation. While the migrants from rural areas are mostly illiterate women (45per cent), or women who have studied till the primary level (25per cent), the socio-economically well-off women are matriculate (25per cent) or even graduates (5per cent). Some women are into clerical level jobs, while some are students enrolled in colleges in the city. However, majority of the sex workers have not attained high levels of education or are illiterate and this fact adds to their powerlessness and ignorance.

Family Life & Support System

45per cent of the CSWs interviewed are single, 35per cent married and 20per cent are separated/divorced and among them only 35per cent of the CSWs as mothers while most of the times the family is not aware of the CSWs profession.

Most of the sex workers do not have any contact with their families of origin. Some of them left home due to economic needs and send money home to their parents regularly, but do not visit them. Majority of the sex workers conceal their professional lives from their children and husbands (in cases where the husband himself is not involved in sex work). The only support system that they have includes other sex workers who function in the same geographical area as them. Even in this case, they hardly share their emotional and social problems with each other, as they are all pressed for time and 'have to maintain a certain image in front of others'. The sex workers rarely let their real selves show in social or professional situations. A number of them reported that they feel at ease with their peer sex workers (70per cent) or with their owners (30per cent) as they can share their problems with them. Not only do they go through social stigma, harassment from the police (45per cent), clients (25per cent), family/husbands (15per cent) and societal ethics and morals (15per cent) goes beyond unwarranted arrests and often involves extortion of money and brutal physical violence.

Social Behaviour

This parameter includes social behaviours manifested by the sex workers like work hours, support systems available to them, contact with family, social stigma/ discrimination and harassment from police, clients, society, etc. faced by them. A trend characteristic of sex work in the city of Guwahati is that 70 per cent of the times it takes place during the day and not at night, contrary to popular belief. In fact, most of the sex workers have 'regular' work hours from 10 a.m. to 5 p.m. and go home in the evening. These timings make it easier for them to conceal the true nature of their work, telling their families that they hold jobs in offices or that they are part-time domestic workers and this helps them deal with the stigma.

Profile of Clients

Clients range from men of varied age and socio-economic groups. While some are extremely well off professionals and businessmen, others might be rickshaw pullers, auto-rickshaw drivers, or young college-going students. The age group varies from around 20 years to 65 years among clients.

Depending on the profile of the clients, the place of work or purchase of the sex workers' services also vary. While the older and economically well off clients take sex workers to up market hotels or even out of the city to nearby tourist locations and hill stations, the younger men and the clients from a lower economic strata visit the sex workers at her residence in the city, or a place (hotel, lodge, etc.) designated by the CSWs.

Average/day Income

Due to the indeterminate nature of the number of clients serviced by each sex worker in a month, their fixed income per month cannot be estimated with certainty. Added to this is the fact that the same sex worker charges different amounts from different clients, depending on the client's economic status and the scarcity of resources faced by the sex worker at that point of time. The range of minimum to maximum charges from one client may vary from as low as 10INR to as high as 5000INR. The average income is dependent on the area of operation, profile of clients and age of the sex worker. While a young sex worker with a better SES may easily earn up to 5000INR a day, a street side worker might just manage only a 10INR. Various factors contribute to this wide range wherein the entire income is spent on survival needs and personal grooming. The higher the socio-economic status of the sex worker, higher is the

70 percent of the CSWs reported that that they do not go for regular health check-ups so as to avoid the societal stigmatization

amount of money she charges from her clients. Also, educated women receive clients from a higher socio-economic stratum, who in turn are ready to pay higher charges. Age of the sex worker also determines the amount of money she can charge or the number of clients she can get. Young girls and women till around 20 years of age are known to receive more money and more number of clients than older women. Old women belonging to lower income migrant populations in commercial areas are the least paid. Besides the low payments, a large percentage of their incomes are paid to madams, pimps, landlord/landladies and other helpers to get the contact of the client to the sex worker. The amount received by the sex worker, therefore, is extremely minimal.

Initiation into the Profession

This parameter includes the factors responsible for pushing the woman into sex work. This attempts to trace incidences of trafficking of children and women. From the data collected, it was found that child trafficking exists in the city. Girls are brought from rural areas in the pretext of working as domestic workers in the city and are sold to pimps/madams for sex work.

The principal factor behind initiation into the profession among majority of the CSWs is economic sustainability. Extreme poverty leads to migration from rural areas to the city and involvement of the women in sex work for the lack of other economic opportunities. Unemployment and underemployment among women as well as low levels of education often are the reasons initiating them into sex work.

While some women are forced by their husbands into the profession (20per cent), some are forced by others in authority like police officials, relatives, etc. (35per cent) while the rest are misled in the pretext of job offers. Street children of lowly paid sex workers often get initiated into the profession painfully after sexual abuse and repeated rapes.

Health Behavior

This parameter consists of behaviours related to the health of the sex workers. Common health problems faced, health seeking behaviours, awareness about STI/HIV/AIDS, contraception, myths, etc., substance abuse, attitudes towards PLWHA/self would be discussed under this head. They often visit quacks operating in their neighbourhoods or resort to home based remedies. Unwanted pregnancies are common among the sex workers, and they are either burdened with more dependents to feed or they risk their health through unsafe abortions. None of the CSW participants of the study, when tested for HIV with ELISA by APS were found reactive. This could be attributed to the effective awareness of HIV by APS, death of co-workers due to HIV and free supply of condoms in most of the conspicuous areas of the city.

HIV/AIDS Awareness

Owing to interventions initiated by APS, the community (60per cent) is relatively aware about the health hazards that they are prone to in their profession. 70per cent of the CSWs reported that that they do not go for regular health check-ups so as to avoid the societal stigmatization. The rate of condom-use is extremely poor with only 40per cent using condoms regularly mostly because of the denial by customers or lack of assertiveness in the CSWs. This is to a large extent due to the lack of bargaining power on part of the sex workers. They get paid less or lose clients when they insist on safe sex practices. Although female condoms are now being made, they are not readily available and are extremely expensive for the sex workers to afford. Their attitudes towards PLWHA (People Living with HIV/AIDS) are not too negative due to their interactions socially and professionally with sex workers with HIV continue to be the same. However, the PLWHA do not disclose their sero-positive status for fear of losing clients.

Substance Abuse

As mentioned above, the rate ethanol and nicotine abuse is very high (60per cent) among the sex worker population. Due to the innumerable stressors in their lives they resort to substance abuse, the most common being nicotine/local cigarettes called bidis (30per cent), chewing tobacco (also known as ‘Gutka”) and beetle nut (10per cent), and alcohol (20per cent). All of which poses serious physical and mental health repercussions. Due to complete lack of support systems and disgust with their lives, sex workers often become victims of alcoholism. Once they become addicted, their work and personal lives suffer, pushing them further into poverty.

Mental Health concerns

The mental health needs among the population of sex workers is very high. In the present study, around 65per cent of the sample exhibited anxiety symptoms among which 5 per cent reported severe

anxiety. Suicidal ideation is commonly observed among the sex workers with 15per cent seen to have had a history of self-harm which is high in lethality as well as intentionality. Somatoform disorders are also commonly seen among sex workers with 65per cent reporting of numerous aches and pains without any specific cause. Affective symptoms such as lack of interest in pleasurable activities, low mood, sleep disturbance and change in appetite was reported by 90per cent of the study sample. About 10per cent of the sample also reported of visual and auditory hallucinations. Thus the prevalence of mental illnesses is quite common, including anxiety disorders, major depressive disorder, bipolar affective disorder, dissociative and conversion disorders, delusional and in some rare cases even psychosis. This is mainly because the sex workers suffer a sense of identity-loss and experience severe traumatic events in their lives. The lack of support systems and a constant struggle for subsistence, stigmatisation from society and acute physical violence add to the list of etiological factors of their psychological disorders. Although psychiatric morbidity is suggestive, there is complete lack of insight into the issue. However no gross sub-normalities or major psychosis was found in the CSW sample.

Discussion

Although a lot of attention is paid to the CSWs of Calcutta and Bombay, researches in the past have paid less attention to the unorganized nature of prevailing sex work in the city of Guwahati where the mode of functioning are very different from the ones invariably commonly noticed in other cities. The studies done in the recent past only highlight the issues of HIV however, qualitative, socio-economic and mental health issues have not been seen to be the prime area of productive research work.

From the results, it is evident that stress and quality of life is highly associated with the psychiatric problems. The emergence of young college girls and married women from low SES getting into the profession is also seen to be on the rise. While it is seen that sex workers who do not have proper socio-economic support and are new to the trade but are not associated with any state intervention programmes have poor mental health compared to their counterparts (Nair & Verma, 2002). Consistent with previous researches, depressive symptoms among these workers was recorded to be the predominant psychological symptom in the study sample along with other undiagnosed psychopathologies with anxiety, insomnia and somatic complaints (Simon, 1992; El-Bessel, 1997; Alegría et al, 2002; Romans, 2001). Another crucial and major issue in managing emotional stress and depression among sex workers is the associated stigma and life of the fear of violence and arrest (Priscilla, 1999). Job conditions and related mental stress is known to be detrimental to the mental health of workers (Krasek, 1979). These women belong to very lower strata of the society which in itself has its intricate social as well as economic problems. Owing to the low socio-economic status (SES) and the need to earn their living these women get into the sex work business/profession. Many are married women seeking to supplement meagre household incomes for family survival (Amin, 2004). Due to the stigma associate with the trade, the sex workers do not directly indulged in sex work and rather disguise it in the name of other works like construction work, pickle making, factory work, road-side store vendors, pavement sellers, etc. Most of the women who are indulged in sex work in the present sample came from either remote rural areas of Assam for seeking daily work or are migrants from nearby borders states and countries.

Therefore, the present study sample highlights that sex workers in Guwahati have a poor quality of life in the domains of physical health, psychological health, social relationship and environment. Although in Guwahati (Assam), there is non-brothel based sex work, but where these sex workers gathered regularly to seek their daily work, the surroundings people of that location are usually wary of their operation, hence sex workers have to face stigma, shame and lack social support.

The study concludes that the unorganized nature of the profession of sex work in the city of Guwahati, as well as the diversity distinctly found in the profile of sex workers and their clients could pose complications in developing support programs for sex workers. The disempowered status of the sex workers, social stigma faced by them, lack of support systems, violence from police personnel and clients, as well as a plethora of underserved mental health needs have been identified as important contributors to the prevailing psychological distress by the study.

HIV though hypothesized to be high among the CSW was found to be reasonable controlled. This could be due to the active involvement of the government's AIDS Prevention Society. However, owing to the small sample size and less availability of willing participants in the border areas of functioning HIV could be underrepresented in the sample and thus generalization cannot be made.

Thus, the study summarizes that besides the characteristic features of sex work in the city there is enormous diversity prevalent in this profession and among the sex workers. Since there is no specified red light area in the city of Guwahati, the residence and work places of the sex workers are varied and scattered. The locations range from up market residential areas to commercial areas. The unorganized nature of the profession adds to the non-availability of appropriate resources to help the community with medical and psychological interventions. The various problems faced by the sex workers have been documented in the study.

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Recommendation

To even out disparities and to accelerate the awareness process in general, strategic interventions related to community organization of the sex workers, formation of self-help groups for social, psychological and economic support of the sex workers, mental health services, vocational training and adult literacy courses can go a long way in empowering the sex workers and alleviating their problems. However, a radical change in the attitudes of the society and the state towards sex work and sex workers is what is required for these victims of human right violations to lead a fulfilling life.

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PEER REVIEWED ARTICLE

Food addiction – an overview

By Vanessa Kredler

Summary

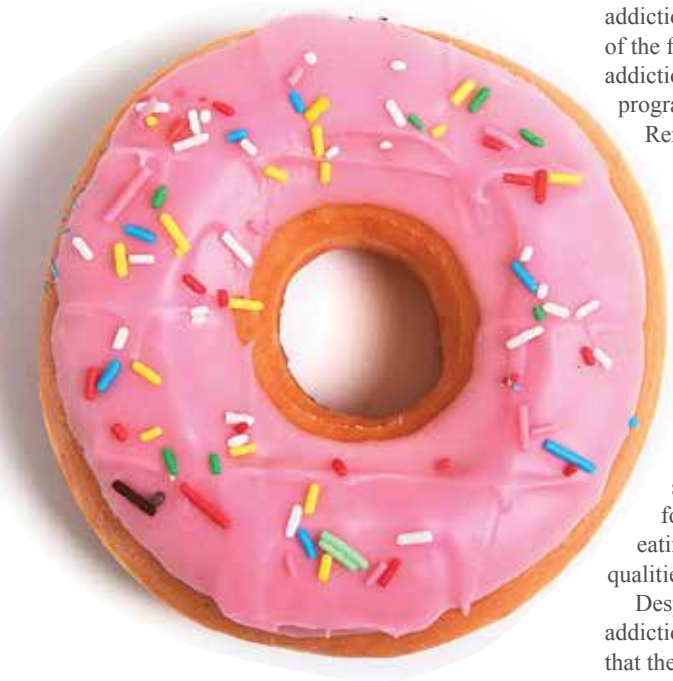
This article provides an overview of food addiction. It outlines several critical milestones in the birth of the concept of food addiction in the field of psychology, medicine and science, provides a description of the symptoms of food addiction, how it may be diagnosed and what the broad treatment parameters are. It concludes that as the interest in the as of yet still controversial concept of food addiction increases, this will have far reaching implications for a variety of factors, including diagnostics, treatment options and health insurance, as well as the food industry and associated government policy.

The concept of food addiction is well established in popular culture, with terms such as 'chocaholic', 'sweet fix', and 'sugar addict' being commonly used. In particular, the addictive qualities of refined sugar have recently gained a foothold in popular culture (*That Sugar Film*, 2014). While in a day to day setting people frequently make reference to 'withdrawal' and 'cravings' in relation to food, in the clinical environment it has been observed that people affected by issues such as obesity, eating disorders and binge eating habits often use terms of addiction to describe their relationship with food (Brownell and Gold, 2012).

The interest in food addiction in the fields of science, medicine and psychology has seen a recent increase (Brownell and Gold, 2012), yet food addiction is not a new phenomenon.

As early as 1960, an overweight woman who believed that her eating was similar to her friend's addiction to gambling founded the 12-step group *Overeaters Anonymous* (Rozanne S: 1996). In 1975 William Dufty wrote the book *Sugar Blues*, which argued that sugar is an addictive substance akin to heroin, opium and morphine (Dufty, 1975). The 1980s saw the opening of a rehab centre in the US that was specifically addressing food addiction rehab as a sister program to drug and alcohol rehab (Tarman, 2014).

In 1993, US-based mental health counsellor and eating disorders specialist Kay Sheppard wrote what is now considered a groundbreaking book on the



subject, *Food Addiction – the Body Knows*. Herself a food addict, Sheppard continues to be considered a pioneer in the field of food addiction and was one of the first in developing a food plan and recovery fellowship for people with food addiction. In 1996, addictions counsellor Judi Hollis published some of the first academic findings on food addiction in her book *Fat is a Family Affair: How Food Obsessions Affect Relationships* (1996), in which she compared her own food issues to the drug and alcohol dependence of her clients. In 2005, the then Director of US-based National Institute on Drug Abuse (NIDA) highlighted studies that linked dopamine levels in compulsive overeaters and cocaine addicts (Volkow, 2005).

In 2010, the former commissioner of the US Food and Drug Administration, Dr David A Kessler published *The End of Overeating: Taking Control of the Insatiable North American Appetite*, in which he shared his own experience with food addiction as well as the role the food industry played in producing 'hyperpalatable foods' (Kessler, 2010). In 2011, the American Society of Addiction Medicine (ASAM) redefined the nature of addiction itself as no longer a matter of poor emotional coping strategies but as a brain disorder. ASAM has proclaimed that any substance or behaviour can be addictive, food included (Tarman, 2014).

In 2014, Dr Vera Tarman published the book *Food Junkies – The Truth About Food Addiction*, which provides a detailed account of the condition. Dr Tarman, a medical practitioner with a specialty in addictions medicine, spearheaded one of the first residential programs for food addiction, complete with a menu and program of relapse prevention tools at Renascent rehab centre in Toronto.

A number of works written by individuals suffering from the condition have been published in recent years (Epstein: 2013, McCarty: 2012, Nodrstrand: 2010, Praeger: 2010, Sheppard: 2000). The topic has also gained a foothold in Australia, where Dr Tracy Burrows, as part of her research on food addiction at the University of Newcastle recently surveyed young Australians and found that around 15% displayed eating tendencies with addictive qualities (Burrows and Pursey, 2015).

Despite these references to food addiction over the past 60 years, it seems that there is ongoing controversy over the concept of food addiction and to what extent it exists (Ziauddeen and Fletcher, 2013). Food addiction is not recognised as a disease in the medical world and is also not listed in the DSM-V. Nonetheless, key food addiction specialists have described it in detail as a disease of physical, emotional, mental and spiritual dimensions.

Kay Sheppard, in her nominal book *Food Addiction – The Body Knows* (1993), describes food addiction as involving 'the compulsive pursuit of a mood change by engaging repeatedly in episodes of uncontrolled eating despite adverse consequences' (Sheppard, 1993: 3). She states that food addiction is a metabolic, biochemical imbalance of the brain and body that creates craving for refined foods. A food addict is obsessed with food, preoccupied with weight and body image and progressively loses control over the amount of food they eat (ibid).

In her book *Food Junkies – The Truth About Food Addiction* (2014), Dr Vera Tarman describes food addiction as a condition where many, particularly highly processed foods, cannot be eaten without developing strong physical cravings and mental obsessions about food. In addition, Tarman describes that those suffering from food addiction can be addicted not only to specific foods, but also to quantity. This often pushes them into cycles of binge eating and causes constant mental stress trying to stop their compulsion to eat. According to Tarman, people with food addiction often develop eating disorders such as binge eating disorder, bulimia or anorexia in an effort to control excessive food intake and manage weight. Tarman makes a clear distinction between food addiction and eating disorders, which can, but do not always, occur simultaneously (Tarman, 2014).

How food addiction can lead to an eating disorder is well described by Sheppard: 'Obsession with food creates constant eating, resulting in concern about weight gain…As the disease progresses, the fear of obesity places the addict in a no-win dilemma. The addiction condemns one to eat, acting in direct opposition to the desire to be slim and attractive. This discrepancy between the obsession with slimness and compulsive eating results in crazy ways of dealing with this problem' (Sheppard, 1993: 5).

The 'crazy ways' of dealing with this problem can include fasting, purging through vomiting, using laxatives or overexercising, or not eating at all for fear of not being able to stop. Weight loss and exercise programs as well as other slimming methods are sought in the hope to regain control. People with food addiction, ashamed of their inability to control their food consumption, often eat in secret, and after bingeing feel a sense of guilt, remorse and self-contempt, with a firm resolution to never binge again. Yet, the combination of the physical craving and the mental obsession drives the addict into the next binge, setting off a new

cycle of binge eating leading to even greater despair (Kim G, 2015).

Sheppard states that 'food addiction is a chronic, progressive and ultimately fatal disease. It is chronic because the condition never goes away, progressive because the symptoms always get worse over tie and fatal because those who persist in the disease will due an early death due to its consequences' (Sheppard, 1993: 3).

As the addiction progresses, more time is required to manage it, including food shopping, preparing food, hiding traces of binges, vomiting or using laxatives, exercising, or recovering from the physical discomfort of a binge. In many cases, the person addicted to food gives up any attempts to control their food, leading to rapid obesity. A snowball effect of compounding problems such as financial strain, loss of employment due to absenteeism, health issues and social problems often accompany the addiction (Tarman, 2014).

It is unknown how many people suffer from food addiction. Tarman estimates that 10-30% in any given Western population are living with food addiction at varying stages, and that food addiction is a chief cause of the global obesity epidemic (Kredler, 2016). Others have argued that food addiction may be a key contributor to the global obesity epidemic (Commonwealth Club, 2016, Part 1). Brownell and Gold for example state that 'the full implications of work on food and addiction are difficult to predict, as the field is moving rapidly. It is our belief, however, that the way the world deals with issues such as obesity could be heavily affected by this concept and the work surrounding it' (2012: xxiv).

As with all forms of addiction, and due to the lack of diagnostic tests, food addiction in the first instance is determined through questions and observations. The most comprehensive questionnaire for determining food addiction is the Yale Food Addiction Scale. This scale includes the following 25 questions eliciting the patient's thoughts, feelings and actions in relation to food (Gearhardt et al: 2009).

1. I find that when I start eating certain foods, I end up eating much more than planned
2. I find myself continuing to consume certain foods even though I am no longer hungry
3. I eat to the point where I feel physically ill
4. Not eating certain types of food or cutting down on certain types of food is something I worry about
5. I spend a lot of time feeling sluggish or fatigued from overeating
6. I find myself constantly eating certain foods throughout the day
7. I find that when certain foods are not available, I will go out of my way to obtain them. For example, I will drive to the store to purchase certain foods even though I have other options available to me at home.
8. There have been times when I consumed certain foods so often or in such large quantities that I started to eat food instead of working, spending time with my family or friends, or engaging in other important activities or recreational activities I enjoy.
9. There have been times when I consumed certain foods so often or in such large quantities that I spent time dealing with negative feelings from overeating instead of working, spending time with my family or friends, or engaging in other important activities or recreational activities I enjoy.
10. There have been times when I avoided professional or social situations where certain foods were available, because I was afraid I would overeat.
11. There have been times when I avoided professional or social situations because I was not able to consume certain foods there.
12. I have had withdrawal symptoms such as agitation, anxiety, or other physical symptoms when I cut down or stopped eating certain foods. (Please do NOT include withdrawal symptoms caused by cutting down on caffeinated beverages such as soda pop, coffee, tea, energy drinks, etc.)
13. I have consumed certain foods to prevent feelings of anxiety, agitation, or other physical symptoms that were developing. (Please do NOT include consumption of caffeinated beverages such as soda pop, coffee, tea, energy drinks, etc.)
14. I have found that I have elevated desire for or urges to consume certain foods when I cut down or stop eating them.
15. My behaviour with respect to food and eating causes significant distress.
16. I experience significant problems in my ability to function effectively (daily routine, job/school, social activities, family activities, health difficulties) because of food and eating.
17. My food consumption has caused significant psychological problems such as depression, anxiety, self-loathing, or guilt.
18. My food consumption has caused significant physical problems or made a physical problem worse.
19. I kept consuming the same types of food or the same amount of food even though I was having emotional and/or physical problems.
20. Over time, I have found that I need to eat more and more to get the feeling I want, such as reduced negative emotions or increased pleasure.

21. I have found that eating the same amount of food does not reduce my negative emotions or increase pleasurable feelings the way it used to.

22. I want to cut down or stop eating certain kinds of food.

23. I have tried to cut down or stop eating certain kinds of food.

24. I have been successful at cutting down or not eating these kinds of food

25. How many times in the past year did you try to cut down or stop eating certain foods altogether?

The critical question that follows for the counselling profession is how to assist clients seeking help with food addiction. While there are treatment plans and modalities for clients with eating disorders, there is no such treatment path for food addiction. However according to Burrows (2015) eating disorders are not always present in people suffering from food addiction. According to Tarman, treatment for food addiction and eating disorders in many cases warrant different treatment trajectories. This is complicated by the fact that often, food addiction does present with other eating disorders. This is not normally fully assessable until treatment has commenced (Tarman, 2014).

In the absence of the formal medical recognition of food addiction, as well as the lack of diagnostic tools and established treatment trajectories, self-help groups often are the only help available for those with food addiction. Globally there are a number of different twelve-step fellowships for food addiction recovery, including Overeaters Anonymous, OA-How, 90-Day Meetings, Grey Sheet, Food Addicts Anonymous, Compulsive Eaters Anonymous-HOW, Food Addicts in Recovery Anonymous, and Grey Sheeters Anonymous (Werdell, 2012). While there are some variations in approach, all fellowships operate according to the same structure as other twelve step addiction recovery fellowships such as Alcoholics Anonymous and Narcotics Anonymous. These programs suggest for the individual to attend group meetings, 'work the twelve steps' with a 'sponsor', make outreach calls to fellow group members, read relevant literature, maintain anonymity and participate through service commitments.

One key aspect of food addiction recovery is abstinence. While the notion of abstinence exists in most addiction recovery fellowships, this concept is extremely complex in the case of food addiction recovery. Unlike other addictive substances, food cannot be given up entirely. Hence a major challenge for the person with food addiction is to learn to live with their drug of choice. As cravings and obsessions can result from specific foods and eating behaviours, it is necessary for the individual to identify them and abstain entirely.

Often, it is found that sugar, flour and quantity are highly triggering. Most food addiction recovery groups suggest that the food addict adopt a food plan that avoids these and other personal trigger foods and behaviours. Some groups and practitioners suggest specific food plans and emphasise the necessity to weigh and measure amounts (CEA-How, 2012; Sheppard, 1993; Werdell, 2015). While weighing and measuring seems restrictive to normal eaters, it is considered a relieving and empowering practice for people with food addiction as it provides clear boundaries and calms the ongoing mental noise around food. A weighed and measured food plan is described as a physical as well as a spiritual tool. It is physical in that it provides a practical everyday tool for adequate nutrition and mental peace, and it is spiritual because the individual has surrendered a battle they cannot win, and is willing to seek help. While diets are considered control, the abstinent food plan is considered a daily spiritual practice reaffirming one's surrender and continued openness and willingness to maintain 'sobriety' (Werdell, 2015).

To remain abstinent, the person who has food addiction must learn to eat for nutrition only rather than for recreational purposes. 'Eating three meals a day with nothing in between' is a common guideline provided in recovery groups. Any recreational food must be declined even in situations that are culturally →

To remain abstinent, the person who has food addiction must learn to eat for nutrition only rather than for recreational purposes. 'Eating three meals a day with nothing in between' is a common guideline provided in recovery groups.

and socially obliging, for example cake at birthday celebrations, excessive meals for holidays such as Thanksgiving and Christmas, or religious ceremonies.

Most people with food addiction have developed an early dependence on food to regulate their emotions. In the recovery process they learn how to manage their emotions without excess food, and to deal with potential issues around social/cultural exclusion as a result of not partaking in 'recreational eating'. A food plan becomes a way to separate the food from the feelings and enables the person to let go of the need for excess food so that emotions can be allowed to surface and worked through (CEA How, 2012).

As addiction is said to be a chronic disease, addiction treatment cannot be acute (Mathe, 2010). Rather, to be effective it must focus on management through daily recovery actions. To avoid switching to other addictions, such as alcoholism, drugs, or workaholism, it is important to maintain a daily commitment to recovery activities (Tarman, 2014). In the context of a disease where a substance or behaviour has been pursued to progressively worsening extremes, the notion of balance is of essence (Overeaters Anonymous: 2011). A popular concept is HALT, reminding the individual to take precautionary action to avoid getting too Hungry, Angry, Lonely, or Tired (Overeaters Anonymous: 1995). Fellowship with other food addicts is considered a critical tool to maintain recovery through accessing peer support (Overeaters Anonymous: 2011).

Relapse can occur as soon as recovery management actions are neglected. The consequences of relapse are life threatening either as a result of rapid weight gain and obesity-associated diseases or mental deterioration to the point of suicidality. Once the 'first compulsive bite' has been taken, the person has no control over stopping the relapse, which may take days or years (Kim G, 2015).

Food addiction is a known concept both in the popular and clinical worlds, yet it remains an under-researched and controversial topic without formal medical recognition. The increasing interest in this phenomenon in the fields of medicine, psychology and science is likely to have a significant impact on wide-ranging areas including diagnostics, treatment options and health insurance, as well as the food industry and associated government policy.

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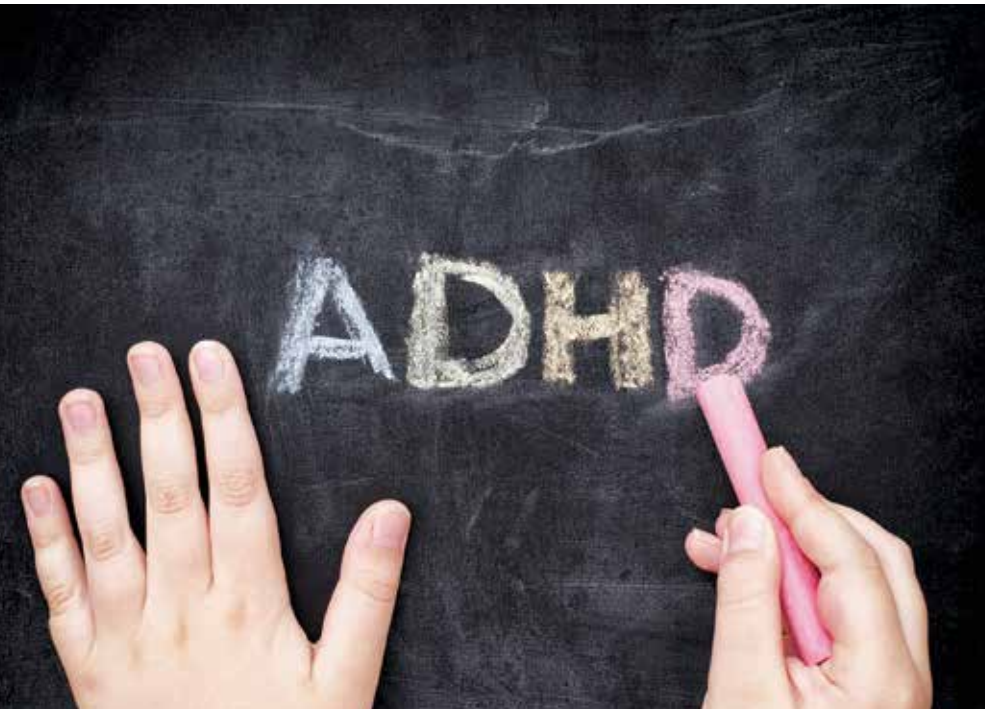
Vanessa is a life coach and counsellor with focus on food addiction and compulsive eating. Several years ago she hit bottom with her lifelong struggle with food addiction and binge eating. On her path of recovery she explored countless therapies, self-help groups, books and programs and traveled to healing retreats around the globe. Her experience inspired her to help others suffering from distress around food and eating. She combines coaching and counselling to help people transform their relationship with food and discover life beyond food. She's a passionate speaker on the topic of food addiction. Vanessa is a member of the Australian Counselling Association and the International Coach Guild. She is also an official Ambassador of *That Sugar Film*.

Youngest in class twice as likely to take ADHD medication

By Martin Paul Whitely, Suzanne Robinson



If ADHD is a neurobiological disorder, a child's birthdate or gender should have no bearing on their chances of being diagnosed. New research has found the youngest children in West Australian primary school classes are twice as likely as their oldest classmates to receive medication for Attention Deficit Hyperactivity Disorder (ADHD).

Published in the Medical Journal of Australia, the research analysed data for 311,384 WA schoolchildren, of whom 5,937 received at least one government subsidised ADHD prescription in 2013. The proportion of boys receiving medication (2.9%) was much higher than that of girls (0.8%).

Among children aged 6–10 years, those born in June (the last month of the recommended school-year intake) were about twice as likely (boys 1.93 times, girls 2.11 times) to have received ADHD medication as those born in the first intake month (the previous July).

For children aged 11–15 years, the effect was smaller, but still significant. Similar patterns were found when comparing children born in the first three months (July, August September) and the last three months (April, May, June) of the WA school year intake.

The ADHD late birth date effect was fist demonstrated in four large scale studies conducted in the US, Canada and Taiwan. The prescribing rate for children in the WA study was 1.9%, slightly larger than that reported in the Taiwanese study (1.6%). The late birth date effects identified in WA and Taiwan were of similar strength to those in the three North American studies, where the reported prescribing rates were much higher (4.5%, 5.8% and 3.6%).

We need further research on the ADHD late birth date effect in other Australian states, which unlike WA, allow greater flexibility for parents in deciding when their child starts school. It could be that allowing parents to decide when their child is ready for school prevents misdiagnosis. Alternatively, the greater age range within a class that occurs when there is increased flexibility could exacerbate the late birth date effect.

Why does birth date effect ADHD diagnosis?

A likely cause of the late birth date effect is that some teachers compare the maturity of their students without due regard to their relative age, resulting in higher rates of diagnosis among younger class members. Of course, teachers don't diagnose ADHD; that can only be done in most Australian states by a paediatrician or child psychiatrist.

But research has demonstrated in many cases that teachers are the first to suggest a child may have ADHD. Even when they don't encourage parents to have their child assessed for ADHD, teachers still play a central role in the diagnostic process by providing information about a child's behaviour compared to "age appropriate standards".

In the majority of cases teachers are the first to suggest a child may have ADHD. Questioning ADHD as a diagnosis. The late birth date effect is not the only factor creating unease about ADHD. Multiple studies, including the WA study, have established boys are three to four times more likely to be medicated for ADHD. If, as is routinely claimed, ADHD is a neurobiological disorder, a child's birthdate or gender should have no bearing on their chances of being diagnosed.

Other risk factors for receiving medication for ADHD include race, class, postcode and clinician, teacher and parental attitudes; none of which have anything to do with a child's neurobiology. In addition, sleep deprivation, bullying, abuse, trauma, poor nutrition, toxins, dehydration, hearing and eyesight problems, giftedness (boredom), intellectual disadvantage (frustration) and a host of other factors can cause the impulsive, inattentive and hyperactive behaviours central to the diagnosis of ADHD.

Another common criticism of ADHD as a pathological condition is that the diagnostic criteria "medicalise" normal - if somewhat annoying - childhood behaviours. Critics contend teacher

A likely cause of the late birth date effect is that some teachers compare the maturity of their students without due regard to their relative age, resulting in higher rates of diagnosis among younger class members

and parent reports of children "often" fidgeting, losing toys and pencils, playing loudly, interrupting, forgetting, climbing or talking excessively, being disorganised and easily distracted, failing to remain seated, and being on the go (as if driven by a motor) should not be construed as evidence of a psychiatric disorder best treated with amphetamines.

Proponents counter that stimulant medication for ADHD children is like "insulin for a diabetic" or "eyeglasses for the mind". There is no doubt low dose stimulants often make rowdy children more compliant. However, a 2010 WA Health Department study found ADHD diagnosed children who had used stimulants were 10.5 times more likely to fail academically than children diagnosed with ADHD but never medicated.

As evidenced by rapidly increasing child ADHD prescribing rates in Australia and internationally, ADHD proponents seem to be winning the very public and ongoing ADHD debate. But history has taught us that as societal values change, definitions of mental illness change. It wasn't long ago that the inventors of ADHD as a diagnostic entity, the American Psychiatric Association, classified homosexuality as a disease treatable with electric shock and other forms of aversion therapy.

Perhaps in the future playing loudly, talking and climbing excessively, fidgeting and disliking homework will no longer be regarded as evidence of a psychiatric disorder, best treated with amphetamines and similar drugs.

https://theconversation.com/youngest-in-class-twice-as-likely-to-take-adhd-medication-71331

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DISCLOSURE STATEMENT

Bio: Martin Paul Whitely is affiliated with the Health Consumers' Council (WA) employed as an advocate and researcher. I am a former Member of State Parliament of Western Australia (2001-13 Labor). Suzanne Robinson receives research funding from WA State and Commonwealth Governments; Healthways

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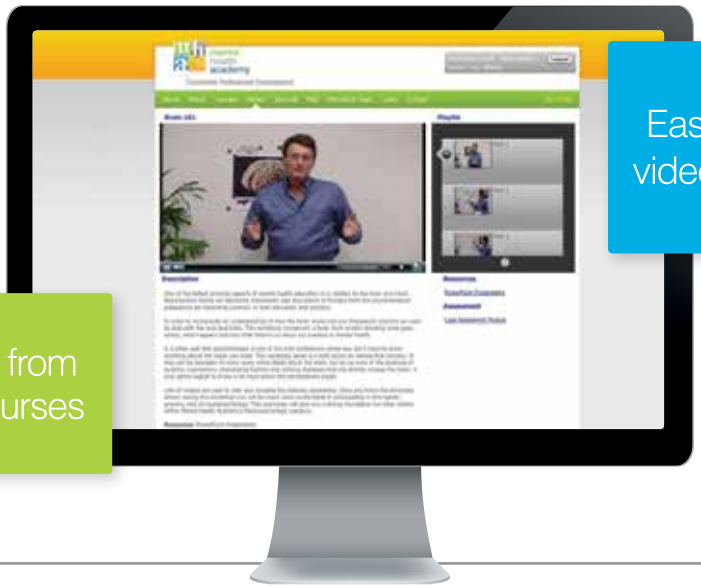

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Brief Counseling: The Basic Skills

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

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Physical health ignored in people with mental illness

By Simon Rosenbaum, Katherine Samaras, Scott Teasdale

The physical health of people with schizophrenia and bipolar disorder is often overshadowed by their mental health issues. Australians with serious mental illness are living on average for 10-32 years less than the rest of the population, mainly due to preventable and treatable diseases like diabetes. No wonder, these early, preventable deaths have been described as a scandal.

Clearly, people with mental health issues like depression, schizophrenia and bipolar disorder are not benefiting from advances in the treatment and prevention of physical disease the rest of society enjoys.

A double whammy

People living with serious mental health issues are significantly more likely to be obese, have impaired blood sugar levels (diabetes) and high cholesterol, risk factors collectively referred to as metabolic syndrome. There are several reasons behind this high rate of physical disease, many of which can be modified.

Medications used to treat mental illness, although an essential part of treatment, can affect people's physical health. Some medications can lead to significant weight gain, particularly in the first two years of treatment, (typically around 7kg within 12 weeks).

Increased hunger and reduced physical activity associated with some medications are also major contributors to gaining weight. These medications have direct metabolic effects including changes in blood sugar levels, likely due to alterations in hormones such as glucagon. Understandably these serious physical side effects can lead to people not taking their medication.

People with mental illness are more likely to smoke, with one third of all cigarettes smoked in the US smoked by someone with a mental illness. People with mental illness are more likely to smoke, have a poor diet and don't tend to exercise, all of which can be addressed. from www.shutterstock.com/jarareab

Having a mental illness is associated with unhealthy eating, including excessive energy intake and a poor diet high in processed foods and sugary drinks. This contributes to obesity, heart disease and diabetes.

Mental illness is also associated with low levels of physical activity, increased sitting time and poor fitness. It's difficult enough to motivate the general population to take regular exercise and choose a healthy diet. But in people living with mental illness, where poor motivation can be an inherent part of the illness, these barriers to a healthy lifestyle are compounded.

Another key issue is the significant social disadvantage often associated with mental illness, which makes a healthy lifestyle even more challenging. This clearly requires a whole-of-government response, to ensure adequate support, infrastructure and funding to make a healthy lifestyle a reality.

Integrating mind and body

Mental health professionals usually focus on psychiatric symptoms, and often feel unqualified to deal with physical health issues. This may lead to physical health problems being overshadowed and inadequately treated. Efforts are underway to ensure the mental health workforce is competent and confident in screening for physical health issues and routinely delivering evidence-based interventions.

Addressing the burden of poor physical health among people with mental illness is no longer a knowledge gap, rather it is a failure of implementation. In 2015 the Royal Australian and New Zealand College of Psychiatrists released a report outlining why psychiatrists and psychiatric services must think about the whole person, their overall health and the relationship between body and mind.

This includes improving dietary habits, increasing physical activity and reducing smoking. This cultural shift has seen the successful integration of lifestyle programs including exercise physiologists and dietitians into mental health teams.

This world first Australian program uses a multidisciplinary team to help address physical health issues for young people with serious mental health problems. A world first initiative is Sydney's Keeping the Body in Mind program, where nurses, dietitians and exercise physiologists are part of mental health teams.

A critical next step to promoting long-term change is ensuring health professionals receive appropriate undergraduate and postgraduate training that prepares them to provide real world interventions for this vulnerable population.

For example, dietitians and exercise physiologists should receive training in psychopathology, while medical students need to be exposed to principles of lifestyle interventions and the interrelationship between mind and body.

Modern mental health treatment goals include a key focus on improving quality of life for people living with mental illness. Surely the first priority in achieving this goal must be achieving equality of life expectancy to start with.

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DISCLOSURE STATEMENT

Simon Rosenbaum receives funding from Society For Mental Health Research.

Katherine Samaras and Scott Teasdale do not work for, consult, own shares in or receive funding from any company or organisation that would benefit from this article, and has disclosed no relevant affiliations beyond the academic appointment above.

https://theconversation.com/physical-health-ignored-in-people-with-mental-illness-69040

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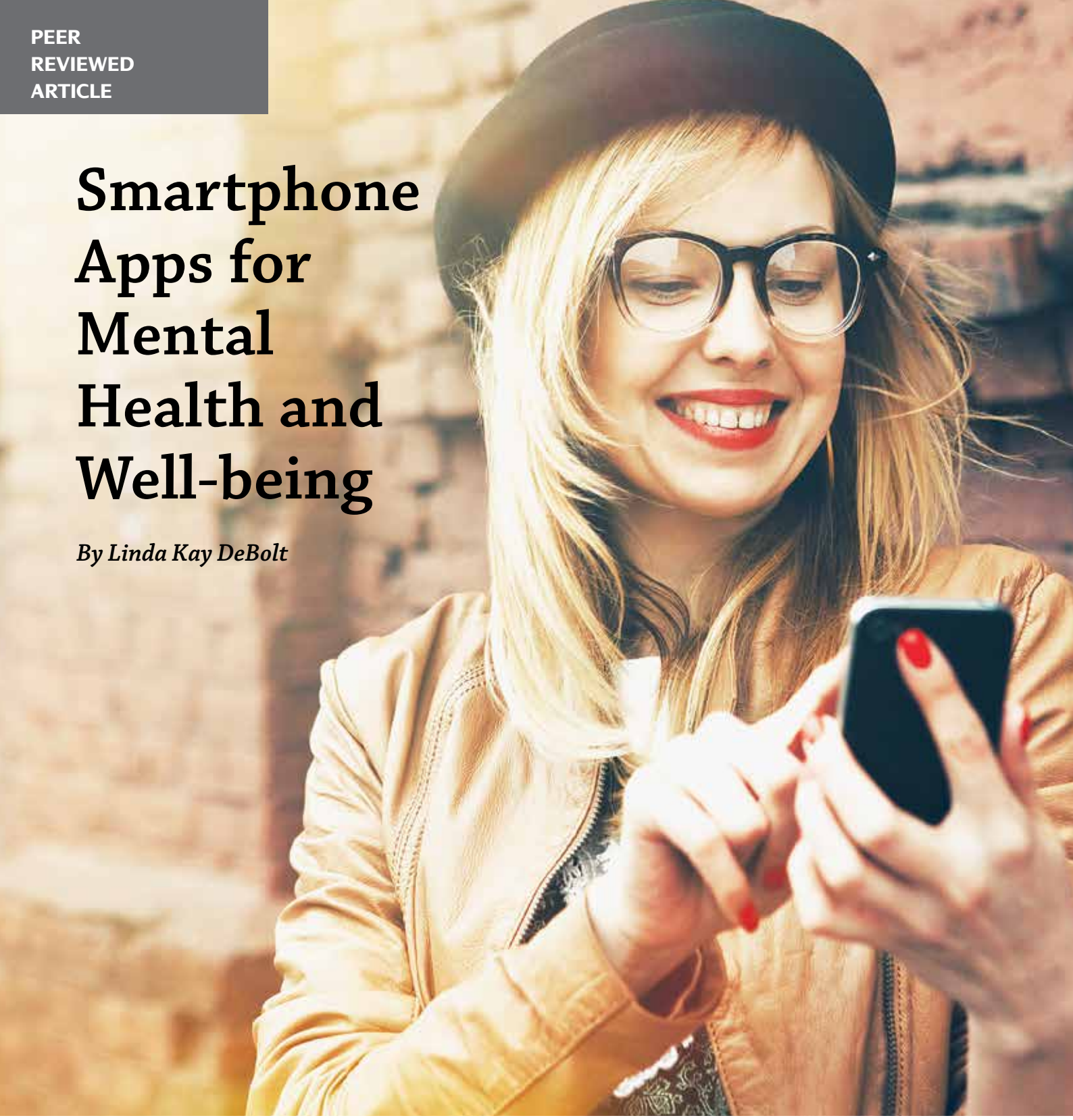
PEER REVIEWED ARTICLE

Smartphone Apps for Mental Health and Well-being

By Linda Kay DeBolt



Research Question

What information is important to facilitate informed decision making when choosing mental health and well-being apps and which of those apps offer the benefits of neuroplasticity?

Abstract

Technology is changing the way we do things. App technology is finding a niche market in its ability to provide easily accessible, regularly updated technology that can deliver programs from a Smart phone. My interest in this paper lies in apps that support mental health and well-being. Research demonstrates that there is a burgeoning array of mental health and well-being apps available but they can range from helpful to harmless to bordering on fraudulent (Kiume, 2013). Educating the public about what to look for in an app for mental health or well-being issues can foster informed decision making with the potential to empower individuals with the means to manage minor mental health and well-being issues (Bakker, Kazantzis, Rickwood, & Rickard, 2016). Consensus is building on the benefits of a central e-hub that provides a list of evidence-based, professionally reviewed mental health and well-being apps (Australian National University; Leigh & Flatt, 2015). Neuroplasticity, a new science that is demonstrating how the brain can change and create new neural pathways based on positive experiences, can be assisted with app technology (Bambling, 2014). Ongoing research is needed to monitor the experience of those who use these apps and what evidence-based modalities work best in the app environment.

Introduction

The use of app technology is becoming more widely accepted and integrated into mainstream society. The Australian government website (Australian Government), lists apps that are available for download to access Australian government resources 'from the palm of your hand'. Chrome Apps encourages users, saying, 'web apps offer functionality similar to programmes that you'd install from a CD, but they're always up to date with the latest web technology' (Chrome). So, it would seem that apps are available to manage your Medicare claims, public transport, classroom education support, entertainment, health and fitness and mental health, to mention just a few. Mental health and well-being apps that are evidence-based and peer reviewed offer the consumer confidence in the product. This paper will seek to inform the general public, as well as psychotherapists and counsellors, of important elements to consider when choosing mental health and well-being apps and to explore some of the diverse benefits that come from them.

Report

Describe the evidence for and against mental health and well-being apps.

Associate Professor of Psychology at Swinburne Online, Nikki Rickard, suggests that apps will provide a valuable adjunct to psychological therapy, contribute positively to motivation for treatment, raise awareness and reduce stigma surrounding mental health (Nulty, 2016). However, Triple J, a popular ABC radio station and website, also quoting Nikki Rickard, put forward that she cautions us to be wary of apps created simply for commercial gain with no link to evidence-based therapies (Stockwell, 2015). This is the challenge facing the mental health sector in steering the public towards apps that support mental health and well-being.

The Sydney Morning Herald published an article in 2015, interviewing a young adult who discussed her lived experience of mental health concerns; not understanding how to help herself or others and dealing with the associated stigma (Francis, 2015). Thankfully, she was able to find great support through the ReachOut website. The article legitimises her concerns, referring to Dr Carr-Gregg, a renowned children's psychologist, and the mental health website ReachOut, both of which emphasised the need for technology to deliver convenient, immediate, anonymous, evidence-based therapies from mobile devices.

The emerging consensus of the need to link the potential of this mental health tool to evidence-based practice is gaining momentum. Research conducted by Lattie et al (2016, p. 153) on mental health apps, concluded that quality control through a central hub would assist in meeting the criteria for evidence-based practice. The Australian National University's e-hub is providing a similar central point of access for evidence-based self-help tools (Australian National University). Apps can complement existing therapy, be used by therapists as homework tasks and empower clients to explore behaviours and beliefs outside of therapy (Bakker, et al., 2016, p. 5; Price et al., 2014, p. 4). However, reviews of mental health apps indicated that only five were found to have evidence-based efficacy (Bakker, et al., 2016, p. 4; Boschert, 2014). The Mobile App Rating Scale (MARS) has recently been developed to assist clinicians in what they choose to recommend, but the public is advised to look at reputable sites such as ReachOut.com (Hides, 2014). So, while there is growing awareness that mental health apps need to be evidence-based, there is still work to be done in this field in order for consumers to have confidence in the products they are accessing (Anthes, 2016; Price, et al., 2014, p. 10).

Availability and accessibility are other advantages for mental health apps. Advantages are immediate availability of help and information from a Smartphone (Anthes, 2016, p. 4; Hides, 2014; Lattie, et al., 2016). This not only provides psycho-education information for those in therapy but also can normalise the importance of mental health and provide support for people who are not diagnosed but have mental stress from time to time (Bakker, et al., 2016, p. 7). It is opening up the pathways of empowering people with information and tools that may, in the long run, reduce the reliance on professional help for mild conditions (Bakker, et al., 2016, p. 2). The immediacy of help through apps is being recognised as having a significant role to play in →

PTSD, particularly for military veterans, as well people with suicidal ideation (Anthes, 2016; Melvin & Gresham, 2016). Therefore, it is becoming apparent that mental health apps have a significant role to play as they are available at anytime, for a minimal cost.

Aboriginal and Torres Strait Islander Australians experience mental health issues within their own unique cultural boundaries. A study of the potential of mental health apps was conducted and results show similar themes of other Australians in that these apps reduce stigma, are accessible and available from a Smartphone, can increase motivation to be well, and awareness of mental health issues. However, the addition of culturally appropriate content, emphasis of a purposeful journey and meaningful language increased acceptability and demonstrated respect for their cultural values and belonging (Povey et al., 2016).

Finally, all mental health professionals are bound by a code of ethics (PACFA, 2011). For mental health apps to gain legitimacy not only do they need to be evidence-based and have development input from professionals in the field, they also need to conform to ethical guidelines. The American Psychological Association put forward four ethical principles that they feel should apply to the use and development of mental health apps (Jones & Moffitt, 2016, p. 5):

- Beneficence and non-maleficence
- Responsibility
- Justice
- Respect for People's Rights and Dignity.

They highlight the need to include information on privacy, confidentiality, limits to confidentiality, the need for password protection, and possible costs associated with use. A warning should also be included regarding the extent of help the app can provide and recommending professional help or a crisis support line if their symptoms become unmanageable.

What apps are available?

Mental health apps are available from many organisations, and can be divided into help for specific mental health issues, personal wellbeing and growth, and brain exercises under the banner of neuroscience. Typing 'mental health apps' into your Search engine brings up a plethora of choices, but how do you decide which are reputable? Our discussion in the previous section revealed a strong consensus among academics that people need to use evidence-based, peer reviewed apps that are recommended by reputable organisations (Leigh & Flatt, 2015).

One of the sites listed in this search is http://www.mindhealthconnect.org.au/ , a site sponsored by the Australian Government. This site lists apps within the mental health condition you are seeking information about and I found it easy to navigate. Looking at four basic mental health issues, anxiety, PTSD, panic attack and depression, the *Breathe* app is represented in three. They also have *High Res* and *Smiling Mind f*or PTSD. ReachOut.com, an organisation for young people to provide mental health services online, offers app choices for depression, anxiety and panic attacks, with Breathe featuring in two. Looking at the

Sydney Morning Herald article titled 'Ten apps to help you beat the blues' (Francis, 2015), most of the apps listed in the above sites were listed in this article. If you are looking for an app for a specific complaint, going to a site like ReachOut or www.mindhealthconnect.org.au will steer you to information on relevant apps as well as more in-depth fact sheets and online help. Searching for a mental health app through professional sites such as these as opposed to simply going to the Apple App Store will give you the reassurance of evidence-based apps that have gone through at least some scrutiny (Anthes, 2016).

'Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community' (World Health Organization, 2014). Evidence suggests that balanced, resilient cognitions can lead to behaviours and emotions that are more in line with ones values (Huppert, 2009, p. 139). Therefore, as apps are immediately accessible from a Smartphone, they can provide a means to keep us in equilibrium when we are noticing we are not coping as well as we would like. The added benefit comes from something known as Self-determination theory (SDT) which emphasises the importance of self-

Smiling Mind app

direction and choice which nurtures self-efficacy (Bakker, et al., 2016, p. 5). Apps that assist with this are included in the sites reviewed earlier, however I have chosen the Medibank be, 10 Best Mental Health Apps article, for this section of my report (Medibank, 2015).

Smiling Mind, for mindfulness meditation, Breathe, focusing on the breath, *Worry Time*, taking control of those upsetting thoughts and *Deep Sleep*, a guided meditation to help you relax and get to sleep, all look to offer exercises that engage the user in practical ways to help them achieve well-being. Linking these to evidence-based modalities reveals the use of progressive muscle relaxation, mindfulness meditation and Cognitive Behavioural Therapy (CBT) (Bakker, et al., 2016, p. 5; Lattie, et al., 2016, p. 153). I take this opportunity to point out the warning at the end of this article which states that these apps should not take the place of professional help. Care should also be taken to be in a safe place when using these apps as you will be concentrating on relaxing.

Crisis support has been another area that mental health apps have made inroads into. While there are several organisations with websites that provide online support, like Lifeline, Kids Helpline, Mensline, QLife and the Suicide Call Back service (Australian National University), the benefit of an app is immediate access, familiarity and engaging with the choice to keep oneself safe. There is international interest in suicide prevention, with a corresponding selection of apps from

different countries; however BeyondNow is an app developed by an Australian organisation, Beyondblue (beyondblue, 2016). Comprehensive support is provided from this webpage, how to download the app, what safety planning is, and other crisis support information. It suggests, 'the BeyondNow app puts your safety plan in your pocket so you can access and edit it at any time', and encourages, 'You can also email a copy to trusted friends, family or your health professional so they can support you when you're experiencing suicidal thoughts or heading towards a suicidal crisis.' (beyondblue, 2016). Empowering and encouraging someone who has suicidal thoughts to keep themselves safe is worth every available resource and this app seems to link all of these supports into one accessible tool.

This brings us full circle, looking at mental health not only as an absence of disorder but also through the lens of well-being, in which an individual can cope with the normal stresses of life (World Health Organization, 2014). Apps that provide support for either a particular mental health diagnosis or to maintain well-being therefore have the add-on benefit of minimising the potential of escalating mental health issues. Bringing people into a space in which they are more understanding and in control of their emotional triggers allows them to metaphorically step back and see life from a new, more empowered perspective, which leads us to the subject of neuroplasticity.

Explain neuroplasticity in mental health and well-being.

Neuroscience provides a biological and environmental basis for the concept of changing the structure and organisation of the brain (Bambling, 2014). Neuroplasticity describes the changes in the brain through experience and that it is possible to choose positive, life enhancing experiences/thoughts/emotions to create positive, enduring change in neural pathways which then benefits mental health and wellbeing (Cramer et al., 2011, p. 1595; Hanson, 2013, p. 10). The benefits of neuroplasticity for biological ailments as well as psychological health is gaining ground with this realisation that the brain is 'plastic' and changeable; the linking of brain and body for a holistic health approach; and how a person's perception or understanding of their difficulties or ailments impacts on health (Peterson, 2012, p. 2; Rose, 2016, p. 98).

The idea that our perceptions, which come from the mind, can profoundly impact on our quality of life and how we deal with the ups and downs of life is the focus of neuroplasticity for positive change; what we give attention to alters the brain (Begley, 2007). The concept that internal thought processes can have lasting effects on the structure of our brain is often linked to Buddhist philosophy and teachings and this has resulted in a rise in interest in meditation (Begley, 2007; Hanson, 2009). Monks with a tradition of meditation and compassion were shown to have increased gamma waves impacting on perception, problem solving and consciousness, even when not meditating (Begley, 2007). Conversely studies have also demonstrated that child abuse, post-institutionalised children who were not adopted at an early age and those children continuously exposed to maternal depression experienced a negative impact on their brain structure (Davidson & McEwen, 2012, p. 692). These studies provided evidence of structural change in the developing brain with increased amygdale volume and a decrease in sectors of prefrontal cortex. Therefore not only can mental training contribute to enduring brain traits, but experiences also impact on brain structure, both positively and negatively (Begley, 2007; Davidson & McEwen, 2012).

Dr Allen Ivey puts forward that science is now able to support the benefits of counselling through the research in neuroscience. The process of the therapeutic relationship with an emphasis on active listening, empathy and building on strengths and wellness creates changes in the organisation of the brain, a way of nudging awareness to a new way of thinking (Ivey & Zalaquett, 2011, p. 104). This engagement supports a resilient polyvagal system. The polyvagal theory, as put forward by Dr Stephen Porges, describes three vagal complexes; the social nervous system (social engagement), the sympathetic nervous system (fight or flight), and the parasympathetic nervous system (freeze) (Porges, 2001, p. 144). When someone perceives the environment as dangerous, there is a degrading of the function of social engagement and hence an increase in fight/flight/freeze response (Porges, 2001, p. 143). Are there apps that can assist with increasing our neuroplasticity and understanding of our polyvagal systems, thus contributing to our mental health and well-being?

Breathe app

How can neuroplasticity be enhanced through the use of apps? What is available?

We have three aspects of neuroplasticity to look at in an app: how attention can change our perception; breathing or meditation increases our gamma waves which has an influence on our problem solving skills and consciousness; and that these can change our brain which in turn provides us with a structure that is more conducive to following a path of a meaningful life (Begley, 2007). We can further understand these concepts through the functions of the polyvagal system; the influences of the social nervous system, the sympathetic nervous system and the parasympathetic nervous system, and the impact of focusing on the breath has on these systems (Porges, 2001). This consensus among researchers on the physical and mental benefits of focusing on mindfulness, relaxation, meditation and compassion to bring us into what is known as our Window of Tolerance; the place where we manage the ups and downs of life with some sense of resiliency can be supported by apps (Begley, 2007; Corrigan, Fisher, & Nutt, 2011; Ivey & Zalaquett, 2011) While what we have discussed about the brain may sound very technical, it shows us that our

Worry Time app

experiences and attention changes our brain.

Existing apps that may assist with this, and that we have covered in this article, are *Breathe, Worry Time, and Smiling Mind*. These all use simple techniques that can calm us into a more relaxed and coping state and conform to the neurplasticity principles in that they change our thinking by empowering us to notice and choose to direct our mental state in a more healthy direction (Ivey & Zalaquett, 2011; Porges, 2001). The *Breathe* app monitors your breath and heart rate through your smart phone while you take slow regular breaths. Putting your attention onto your breath is a mindfulness technique and the slow, steady breaths bring oxygen into your body. The *Worry Time* app gives you the opportunity to reflect on what is worrying you, write it into the app and then choose a time to consider these worries. You are therefore allowing yourself to step back and not focus on your worries until the time you have chosen. This gives permission to give attention to all the other things going on in your life, that may be empowering and worthwhile to grow, that have been overshadowed by your worries. Once again, neuroplasticity will benefit by consciously choosing what you will give attention to. Then there is the *Smiling Mind* app, which is a body scan meditation app. Once again, the benefits are that you choose to use this app and you tailor it to how you are feeling as well as the actual meditation.

There are a couple of resources that I would like to see put into an easily accessible app format. The MATES Resource program teaches a set of simple, practical exercises that can help you self-regulate back into your Window of Tolerance (Abeles & Souza). These steps can be used by anyone, whether you are managing a mental health issue or are a busy parent or professional. They engage you in focusing on the thought (Mind), the breath (Air), a grounding exercise (Tree), and becoming aware of your emotional state (Express). This program comes with training and psycho-education but has not, at this stage, simplified the concepts into an app. However, I feel the benefits of making this tool accessible through app technology would be worthwhile.

Russ Harris has also created some awareness around neuroplasticity through his Acceptance and Commitment Therapy (ACT) work (Harris, 2009). He has created an app for therapists, called the Happiness Trap, but I was not able to find one for everyday people to access for themselves. There are YouTube clips that inform people about the brain and how it works with our mind (Harris, 2016), but after seeing how helpful mental health and well-being apps can be in providing something that anyone can access and benefit from, I would really like to see him develop an app that encapsulates the concepts of ACT into a simple self-help tool.

Conclusion

App technology is becoming a familiar tool that we use in a variety of areas of our lives, from transport to Medicare, entertainment to health and fitness. Mental health and well-being apps are in their infancy and a consensus is emerging of the need to monitor them for an evidence-based practice approach. Some have suggested this is best done through a central e-hub backed by input from mental health professionals and research on efficacy (Australian National University). Neuroplasticity, seen as the ability to change one's mind and brain through what we choose to pay attention to, is also in its infancy (Bambling, 2014). However, there is solid proof that it underlies the process of counselling in which people are empowered to be the best they want to be (Begley, 2007; Ivey & Zalaquett, 2011; Porges, 2001). Apps that already exist that support this process, in my view, are the Breathe, Worry Time, and Smiling Mind apps.

My position as a writer and angle on the question

My position as a writer is from a mental health professional perspective, researching mental health and well-being support options for therapists, clients and the general public. While I was able to find a wealth of information on the use of apps for mental health and well-being support, bringing this all together in a report allowed me to include information on not only the apps, but how they measure up to evidence-based modalities, quality control considerations, ethics, cultural considerations, and elaborate on my angle of neuroplasticity. Neuroplasticity is a new science and linking it in this report to evidence-based mental health and well-being apps can be a helpful way to introduce this area of knowledge.

How I picture the reader and my aim in addressing them

It seems that everyone has a Smartphone. You only need to walk down a street or ride on public transport and you will most probably see the majority of the general public using their Smartphones. Within these Smartphones is access to not only communication but the internet and now, increasingly, apps. Therefore I am assuming my reader will have an affiliation, skill and interest with some sort of app technology. Whether or not they have used a mental health or well-being app remains to be seen and it is hoped that by the time they have read this report, their interest will have been piqued to explore what is on offer.

My aim is to expand on the interest most people have in their health and well-being by providing information on new resources that can facilitate their personal growth. Reducing stigma, increasing self-directed mental health and well-being support, exercises to enhance neuroplasticity, learning more about mindfulness and the linking of eastern and western philosophy all within app technology are additional areas of possible interest. These tools are also increasingly used by therapists as they seek to empower their clients not only through in-between counselling session's homework tasks but also as an opportunity for their clients to choose to seek out ways of achieving their goals of mental health.

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BIOGRAPHY

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PEER REVIEWED ARTICLE

Is There a Direct Correlation Between Substance Abuse and Social Phobia?

By Sandra Sweetman

Introduction

This paper will investigate the relationship between social phobia and substance abuse and delineate a hypothesis whether a correlation exists between this in young people. Past research substantiates social phobia as being more prevalent and debilitative than once thought (Curtis, Kimball & Stroup, 2004) and that greater understanding of this disorder is needed (Hudson & Rapee, 1997). The following three research questions will be investigated. Firstly whether there is a direct correlation between substance abuse and social phobia. Secondly if a direct correlation can be substantiated: would the early detection of social phobia in school students prevent the use of substance abuse later on. Thirdly is the use of substance abuse in young people used to 'mask' social phobia inadequacies and finally if a direct relationship can be authenticated what is the extent of the correlation? The thinking behind the hypothesis recognizes that the use of substances may allow a young person with social phobia to 'mask' the phobia.

During the last decade Australia and most overseas countries have seen a significant increase in the availability and use of illicit substances and efforts to curb this have had little marginal effect (Farrell, 1998). In November 1998 the Australian Government, due to concern over illicit substances, established the National Drug Strategic Framework (NDSF) based on harm minimisation to deal with the problem. The NDSF assisted government and non-government organisations in the development of strategies and allocation of resources for the prevention and reduction of the harmful effects of substance abuse on Australian society. The NDSF was instigated due to the rising high cost of illicit drugs in both economic and social costs to the Australian community. The Framework developed drug education strategies to reduce harm minimisation such as: national protocols for schools to respond to drug issues in schools, school information and education resources, supporting materials for local school/community drug summits (NDSF, 1998-04).

The Australian Federal Police Drug Harm Index (AFP, 2004) cites substance abuse as a major contributor to breakdown in families and relationships, suicide, crime, violence and other negative impacts upon Australian society. Collins and Lapsley (2002) estimated that the economic costs associated with illicit drug use in 1998–99 amounted to $34.5 billion and social costs were $6,075.8 million. Along with these statistics the Australian Institute of Criminology (2007) released a comprehensive study that estimated the cost of drug initiated crime was $1,960 million per annum.

Research estimates that between 37 and 52 percent of drug offenders reported a direct causal link between their drug use and criminal activity (Collins and Lapsley, 2002). The focus over the years has been on drug education not in investigating the underlying issues as to why substance abuse was instigated. If an underlying issue could be ascertained this would alleviate the use of illegal substances to 'mask' the problem and would reduce the escalating costs that illicit substance cause.

Social phobia, an overview

Social phobia, categorised as Social Anxiety Disorder in DSM-IV-TR 300.23 is a debilitating psychiatric condition which, although treatable, often remains undetected and untreated. It could be said that there is shyness: mild social anxiety on one side of the spectrum, social phobia in the middle and avoidant personality disorder at the other end: severe social anxiety. For example, Curtis, Kimball & Stroup (2004) state that this debilitating psychiatric disability is treatable but often remains undetected and untreated. Without treatment, sufferers are at risk of complications such as reduced quality of life, poor relationships, difficulties in daily functioning and poor job performance even to the point of finding life not worth living so that suicide eventually occurs.

It could be said that the debilitating symptoms of social phobia occur during formal and informal interactions with others and the problem typically begins during school years as noted by Valente (2002). In addition Hudson & Rapee (1997) state that an alternative way to approach the question of age onset of social phobia is to examine the age at which the child first develops social-evaluation concerns or becomes self-conscious, with the age onset usually confirmed as adolescence or early adulthood although they state that this could be a much earlier age. Key findings from the National Survey of Young Australians 2007 endorse this with the resulting research statistics stating that 'body image' was the top key concern followed by school or study problems for those aged 11 to 19 years (MA, 2007).

Social development deliberates that specific factors occurring during a young person's development influence the degree which they will then gain strong social bonds,

School phobia which can be defined as anxiety and fear associated with going school and each year schools are faced with many students who refuse to attend.

particularly at school. These can be seen as protective factors against behaviours that violate socially accepted standards which could be attachment: a positive emotional link and commitment: a personal investment the young person makes to the group, both components of the bond (Hawkins, Catalano, Kosterman, Abbott & Hill, 1999). Hudson & Rapee (1997) validate this as comprising of four major components: genetic, family, environmental and developmental factors all of which are critical to a child's development. It can be argued that children will escape from what they perceive as aversive social situations and even refuse to attend school (Place, Hulsmeiser, Davis Taylor, 2000). It could be argued that social phobia in students will then lead them to avoid certain situations but it has not yet been analysed whether, in order to cope with the avoided school social situations, students will then 'mask' the disability with substance abuse in order to alleviate or lessen the phobia.

Social phobic linkage to school phobia

School phobia which can be defined as anxiety and fear associated with going school and each year schools are faced with many students who refuse to attend. These students, due to this specific phobia have difficulties in remaining in school and exhibit extreme anxiety and physical illness (Tyrell, 2005). Fremont (2003) expounds this by stating that if left untreated, school phobia can lead to the development of panic disorders and psychiatric illness that will affect the student throughout their life. Mcshane, Walter and Rey (2004) categorise school phobia as anxiety disorder, social phobia or specific phobia depending on the cause of the anxiety or fear. Mcshane et al state this as a persistent and potentially serious emotionally disability with long term effects if left unresolved. Left untreated this leads to academic failure, school drop out, employment difficulties and increased risk of adult psychiatric disorders. It can be argued that this is similar to the outcome of suffering from social phobia although not yet authenticated.

Mcshane et al (2004) explain that high schools are a climate of forced and broad social interaction that is debilitating for any social phobic adolescence and that life becomes a commodity between school refusal and social phobia. Of the 192 adolescences that they researched and accessed for school refusal over 55% had comorbid diagnosis of mental disability, mood disorders, social phobia, anxiety and simply bullying although the impact of the commodity was not adequately examined due to not adequately researching the background of the participants; whether the parents had mental illness that could have been a contributor. It could be argued that there is a need for further research to investigate a correlation between school refusal and social phobia and if a correlation can be substantiated would →

early education and intervention programs based on the development of a student's healthy self image and esteem and building up confidence in social situations help to retain the student in high school. One could then argue this would then alleviate the risk of the students resorting to the use of illicit substances later to 'mask' their social phobic short comings.

Social phobia causes and treatment

Latest government epidemiological data show social phobia affects over 7.1% of the population at any given time and the lifetime prevalence rate i.e. the chances of developing social anxiety disorder at any time during the lifespan stands at above 12.5% which makes it the third most common psychiatric disability after depression and alcohol dependence (TNCS, 1994). About one to two in a hundred men and two to three in a hundred women will suffer from a social phobic disability The course of the disorder is lifelong and unremitting unless treated (Den Boer, 1997). Markway, Carmin, Pollard and Flynn (1992) expound the causes of social phobia as biological factors including genetics, biochemical irregularities and sensitivity to disapproval, environmental factors including negative experiences, misinformation and misconceptions of threat plus cognitive factors, misperceptions of threat and maladaptive coping mechanisms including avoidance, worry and self-preoccupation.

Research reveals that behavioural therapy and pharmacological treatments are effective helping sufferers of social phobia. These include Cognitive Behavioural Therapy (CBT), and Exposure Therapy (ET). Curtis, Kimball and Stroup (2004) quote these as four stages; teaching how to identify and dispute irrational thoughts, role play of fearful situations, cognitive restructuring before and after role playing and assigning homework aimed at confronting fearful situations. Curits et al explain that there needs to be a combination of education and group support therapy. On the other hand Feske and Chambles (1995) argue that exposing people with social phobia to feared situations without proper cognitive restructuring can be counterproductive because people scrutinise themselves negatively after social interactions and if time is not spent beforehand helping them identify and dispute irrational thoughts any exposure will then reinforce their negative thoughts patterns.

Some medications have been found helpful in treating adults with social phobia including phenelzine, paraoetine and other serotonin reuptake inhibitors. Only a few studies have examined the effects of pharmacology in treating children with social phobia (Stein, Liebowitz, Lydiard, Pitts, Bushnell, Gergel, 1998). As social phobia is a chronic, unremitting lifetime disorder that begins between the ages of 13 and 20 only one in four is diagnosed accurately and treated (Valente, 2002). If early screening methods could be implemented in schools to diagnose students prone to this disorder then this would alleviate problems later on. Valente explains that half the people with social phobia drop out of school and 23% become unemployed and rely on welfare with a linkage later on to suicide and alcohol abuse.

Research conducted on students indicated that by the end of secondary school most would have used alcohol and/or other drugs at some stage.

Substance abuse in school students

It could be argued that young people are defined as being between the ages of 12-24 years (AIHW, 2007) and form an identifiable cultural, sociological group in terms of development tasks, leisure, culture and social settings in which they feel comfortable. Adolescence is developmental and can become vulnerable to a number of conditions that include: motor vehicle accidents, suicide, mental health and behavioural problems, teenage pregnancy plus substance abuse: all high risk factors (NSCCMH, 2007). Recent statistics state that 23% of people aged 15-24 years reported using illicit drugs during the last 12 months. 75% of mental health problem and mental disabilities first occur between the ages of 15-24 with only 1 in 4 receiving any professional help (ABS, 2004). The prevalence of mental health problems is high with 12% in the 13-17 group and 27% in 18-24 age group (AIHW, 2007). In 2005-06, there were 11,700 hospital separations related to drug use for young people aged 15-24 years and 12% of suicides in 2005 were accountable to substance abuse (ABS,

2004-05). 27% of young people aged 15-24 years are likely to experience a mental health problem in any 12 month period with the most common being depression, substance dependency or abuse, eating disorder or anxiety (Sawyer & Kosky, 1995). It could be stated that such statistics are alarming and raises public concern over the escalating costs of welfare, hospitals and drug education programs for young people. Between 2005 and 2006 the NSW Government invested an extra $10.9 million in health care (GWAHS, 2005) an increase of 90% between the years of 1993-2005 (NMHR, 2007).

Research conducted on students indicated that by the end of secondary school most would have used alcohol and/or other drugs at some stage. In the 2007 National Drug Strategy Household Survey research stated that at the age of 14 approximately 90% of students reported that they had tried alcohol (AIHW, 2008). Mission Australia's report: Homeless Young Australians: Issues and Responses 2007 identified the reason pertaining to the homelessness of young women and men as either anxiety or depression (MA, 2007). In addition, this has been verified from a recent USA study on homeless youth conducted by Nyamathi, Hudson, Mutere, Christiani, Sweat & Nyamathi (2007) stating that substance abuse was used by homeless youth as a remedy to cope with depression, avoid hurtful relationships or memories and an aid in socialization.

Professor Steve Allsop (2008) stated on ABC radio that 'about 50% of the people who have mental health problems also have drug problems. There's very limited evidence about effective treatment programs for drugs'. National television recently reported that new research estimates that over 100,000 people are homeless every night with a third under the age of 25 and a high number have problem with alcohol and drugs (McLintock, 2008). In view of the above it can be seen that social phobia and substance abuse does affect young people drastically.

Preventative measures for combating substance abuse

It could be viewed that the most common approach for prevention of substance abuse is drug education (AIHW, 2008). One could argue that drug education can only be applicable to students already engaging in substance abuse and that this is not investigating preventative measures such as targeting strategies for students to avoid substance abuse altogether. More over Hawthorne (2001) argues that the difficulty with the harm minimisation approach is the balance of displaying tolerance of those who use and misuse alcohol and other drugs and appearing to condone drug use generally.

The practise of expelling students who have been found to resort to substance abuse can promote further harm such as homelessness, mental health problems and suicide (ABC News, 2008). Young people when deprived of strong peer networks and relationships with teachers often develop harmful drug taking practices. In other words, elucidates Plant & Plant (1999), they are at risk and in more need of a supportive school environment. Due to this escalating dilemma, a drug rehabilitation initiative was developed in 1997 to deal with suspended school substance abusers; the Ted Noffs Foundation Schools Counselling Service. The Ted Noffs Foundation Schools Counselling Service found that 5 out of 10 substance abusers stopped using the drug, 7 out of 10 decreased the use of the drug, and 9 out 10 gained a better understanding of alcohol and other drug related issues. It can be seen that this initiative was successful in decreasing the use of drugs in substance abusers but deals still with the issue after the addiction became the problem and the student has been expelled from school.

Co-morbidity of social phobia and substance abuse

In examining the latest research it is apparent that there are four theories have been elaborated to explain the high rates of concurrence between anxiety disorders and substance abuse dependence. Firstly tension reduction theory states that people suffering from anxiety seek to alleviate their symptoms by 'self-medicating' with alcohol or drugs. Secondly anxiety may be a result of alcohol or drug abuse due to the substance's anxiogenic effects (a substance that causes anxiety or withdrawal syndromes). Thirdly substance abusers incur more pathological and unstable life circumstances making them susceptible to future stress and anxiety and lastly there also may be a genetic susceptibility in some people making them vulnerable to both disorders (Posternak and Mueller, 2001). These four theories cover a wide range of anxiety disorders including generalised, panic, agoraphobia, post-traumatic stress, simple and social phobia and obsessive compulsive disorder plus personality disorders. It can be argued that this covers too wide a range of anxiety disorders without establishing a commodity between specialised individual ones.

Although studies in America (Johnston, O'Malley, Bachman 1999) have linked a strong co-morbidity between social phobia and alcohol disorders such as those with social phobia are two to three times more likely to develop alcoholic dependence that those without it, social situations and internal anxiety symptoms are seen as conditioned cues that signal the onset of drinking and relieve the onset of social anxiety. Stewart, Morris, Mellings & Komar (2004) expand this by stating that prior studies have often failed to recognize that social anxiety is multifaceted and may manifest in many ways such as fear of negative remarks, social avoidance, distress, social interactions, shyness.

Stewart et al (2004) propound that research has failed to consider the →

role of drinking motives which is either valence or source. Valence refers to the type of reward that the person hopes to achieve by consuming alcohol positive or negative reinforcement and source refers to the change in the emotional state or external such as the social situation. In the cross over of these two dimensions four drinking motives then emerge; enhancement motives, drinking to enhance one's emotional state (internal/positive); social motives drinking to achieve social outcomes (external/positive); coping motives (internal/negative) drinking to reduce mood state and conformity (external/negative) drinking to avoid peer pressure. The internal motives are associated with heavier alcohol consumption and both social and coping motives correlated to social phobia. Overall research has not focused on whether substance abuse can be substituted for alcohol, particularly in the younger age set.

A recent study on methamphetamine 'ice' abuse in the USA, substantiated that adolescences used this drug to relieve social inhibitions and improve self-confidence and self-esteem along with feeling happier, being more aware of their surroundings, for sexual enhancement and the ability to think faster (Moss & Tarter, 1993). Overall research has not linked this illicit drug use and the commodity of social phobia as a means of coping with every day stressful social situations.

Where to from here

Overall, given the latest research, it is evident that social phobia and substance abuse impacts individuals socially, emotionally and mentally which then places them at risk of self harm and suicide. To achieve state of the art, up to date intervention programs for young people with substance abuse disorders and implement these in a cost effective manner, governments need to continue to examine various treatment and current drug rehabilitation programs. Due to the high relapse among adolescents with substance abuse disorders and governments focusing on cost saving measures most programs only focus on short term care (Kaminer, 2001). It could be argued that there is a great need for governments and non government organisations to develop a new intervention education program where the underlying issues such as social phobia can be rectified in school age children so that, when they reach adolescence, they have healthy self esteem and strong identity therefore will not resort to illicit substance to 'mask' the problem and cover up societal failings. This would save the government millions of dollars in tax payers' money and alleviate them resorting to welfare cuts.

A study conducted by Makkai and Payne (2005) on illicit drug use and offending histories explains that to reduce the number of new offenders primary prevention strategies are needed. Makkai et al argued that these need to be implemented from an early age due to the drug abuse commencing at an early age when they were a juvenile. Furthermore the study states that the window of opportunity between using the first drug and the first offence was approximately two years. Moreover the study reinforces that interventions must refocus and target the mix factors that premeditate both offending and using illicit substances.

In summary interventions are needed to target school children with the aim of breaking the transmission of crime. The aim of this literature review was to investigate the correlation between social phobia and substance abuse. In conducting the literature review and examining the latest statistics and research it is evident that there is a correlation between school and social phobia in students although the use of illicit substance to 'mask' the former has yet to be substantiated and researched. Current drug education programs and research focus primarily on the substance abuse victims; not the underlying and preventative issues. Therefore, in conclusion, it could be said that preventative meWasures, early detection of social phobia at a young age will then prevent students use of illegal and harmful substances to 'mask' the disability later on.

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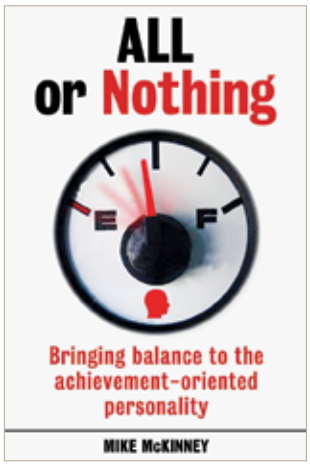
BIOGRAPHY

Sandra is an ACA Level 3 registered ACA Counsellor, individual and Family Therapist specialising in helping clients to heal and resolve current and past emotional pain & move towards a happier life. Sandra has had success helping clients overcome depression, anxiety, and social phobia, past and present trauma, grief and loss plus family and relationship issues. Sandra uses a holistic integrated approach drawing from different methodologies.



All or nothing: Bringing balance to the achievement-oriented personality

McKinney, M. (2016).
Wollombi, Australia:
Exisle Publishing Pty Ltd

Review by Judith R Boyland

Having worked in the field of clinical psychology (in both hospital-based and private practice) for a period of 20+ years, McKinney explains that he became "increasingly intrigued by the potential for an individual's personality-style to enhance or undermine decisions and behaviours in relation to achievement".

In All or nothing, McKinney explores what he terms as the A/N personality style. Beginning with an outline of key aspects and attributes, he invites the reader to consider, "How do I know if I am 'all or nothing'?" and presents a short and succinct reflection task for the purpose of self-identifying. The next two chapters lead the reader into a journey of discovery, posing questions such as, "Where (and why) did this begin?" and "What keeps this all going?"

With the turn of each page from chapter four through to chapter eight, McKinney presents a clear and honest account of the challenges that confront persons whose personality style is identified as 'all or nothing'. Topics addressed include "Avoiding things and then … the 'nothing' ", "The Harsh Internal Critic: an unhelpful passenger", "Striving for perfection, or needing to be perfect?", "Health and well-being", and "New perspectives, achievement and the 'me' ".

McKinney then concludes his work with a glimpse into 'The partner's journey" and invites partners and families to come together and consider six specific challenges or concerns that the A/N approach to life may be presenting. Drawing on all that has been learned through taking a glimpse into the lives of those impacted by living with an A/N personality style and those who are living with one who is living with an A/N personality style, each is invited to take a final moment to consider what life might look like from the perspective of the other.

As the pages are turned, the book is brought to life as the reader engages with a selection of personal stories, such as that of Tessa whose parents were both perfectionists and who expected high levels of commitment and success from their daughter. There is also the story of Terry, an experienced broker who developed a crisis of confidence following his making some not so successful choices and recommendations. Each chapter concludes with a reflective summary accompanied by a section that focuses on 'aspects for reflection', 'options for change' and a 'try this' activity.

All or nothing is recommended to be an excellent read and a valuable resource for the clinician who works with clients whose life is impacted by a dominant personality style.

All or nothing: Bringing balance to the achievement-oriented personality, is available from www.exislepublishing.com.au and wherever good books are sold. For more information, the reader is invited to contact Alison Worrad on (02) 4998 3327 or alison@exislepublishing.com

Judith Borland
Judith is an experienced Counsellor and Professional Supervisor. She has been practising counselling for over twenty -five years and has a professional background in education. She brings an holistic and eclectic approach to Counselling practice, incorporating a variety of therapeutic strategies that support the healing of life stresses and the growth of calmness in the midst of the realities of everyday chaos.

Available for purchase at:
www.exislepublishing.com.au
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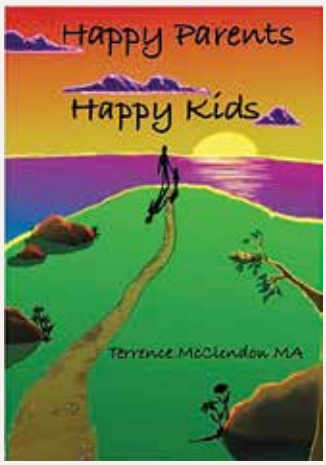


Happy Parents Happy Kids Course

Review by Alison Armstrong

In 2007, Terrence McClendon published the book "Happy Parents Happy Kids". This self-paced course of the same name is designed to complement the book. The course includes a copy of the book, access to 11 videos, a number of worksheets and practice sheets, online assistance from Mr McClendon, and two optional half-hour Skype sessions.

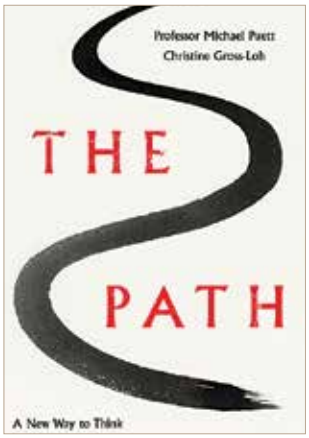
The subtitle of the book, "Words and Actions for Parents and Kids", provides a fitting description of the content of the course, which is based on the principles of Neurolinguistic Programming (NLP). Mr McClendon's expertise in NLP is evident throughout the videos, in which he elaborates on, and provides examples of, the material covered in the comprehensive book. Topics include anchoring, mirroring/matching, and presuppositions, just to name a few. The videos are all under 20 minutes in length, with some far shorter, such that most parents and professionals who work with children will be able to find time to incorporate watching the videos into their busy schedules. As Mr McClendon emphasises, however, the greatest benefit is gained from completing the worksheets to ensure understanding, combined with practising the skills repeatedly. In reviewing the material, I informally practised some of the techniques discussed. Whilst my results were mixed, they may have been different if I had been completing the course formally, and in the prescribed manner, rather than as a reviewer.

Overall, I sense that the strategies covered in this course may work best when applied to specific issues and with some children more than others. Issues addressed in the course include, for

example, motivating children to follow instructions, dealing with bedtime fears, and assisting children to learn to spell. Whilst I am not sure that the course would be the most suitable source of information for a highly-stressed parent, dealing with multiple behavioural issues, it certainly would be a valuable tool for those parents and professionals who wish to gain a deeper understanding of the intricacies of communication and, thus, to enhance relationships within their families and workplaces. The inclusion of personalised feedback and support from Mr McClendon, via email and Skype, allows participants to clarify any material and discuss individual concerns. This feature is a significant strength of the course, maximising learning for all participants.

Alison Armstrong
Alison Armstrong is a registered psychologist with a Masters in Clinical Psychology. She is a member of the Australian Psychological Society and the Australian Counselling Association.

Available for Purchase at:
http://www.nlpaustralia.com.au
Paperback: $30.00



The Path: A New Way to Think about Everything

Review by Glenda O'Sullivan

I highly recommend you take a look at the book by Professor Michael Puett and Christine Gross-Loh called The Path. This easy to read, fascinating book has readers travel through the ancient Chinese philosophies of Confucius, Mencius, Laozi, Zhuangzi and Xunzi, to offer a refreshing 'perspective on how to become a better human being and how to create a better world.'

Puett, a Harvard historian and academic, challenges some of our popular notions such as looking within to find our true selves and suggests instead a path of self-cultivation and moment by moment engagement with the everyday world, as a more practical and powerful way to open up new possibilities and create real and lasting change.

Rather than tackling big philosophical questions like 'do we have free will?' or 'what is the meaning of life?' this book is more interested in how we live our lives on a daily basis. Its focus is the 'here and now' and how we interact with those around us moment by moment.

Pruett and Gross-Loh believe that the interpretations of the philosophers chosen to be examined have in the past been interpreted through a very Western lens and some of their important insights have been missed or misinterpreted. The authors provide their view of what they believe the philosophers in question were saying, by looking at the texts through a historical and cultural lens, rather than a Western philosophical one. I have no expertise in philosophy or ancient Chinese history, but the interpretations of the philosophers ideas, provide plenty of grist for the mill for counsellors and coaches.

The philosophers looked at in The Path all contemplated new and exciting ways to live, and all believed that every person has equal potential to be 'great' and 'good'. According to Pruett and Gross-Loh, Confucious believed that we can all cultivate our emotions to internalize better ways to respond to others. He taught his followers to respond with propriety and civility, to create new more rewarding relationships. He taught people to take on the perspective of others, especially those with whom you had difficulty, to increase your understanding of their position and thus build empathy. Through consciously and repeatedly changing roles and playing with new rituals and ways of seeing and behaving, Confucious believed we can 'slowly develop new ways of interacting and eventually construct a different and far better self'.

Pruett and Gross-Loh claim that Zhuangzi believed we create problems in the world when we believe that our perspective is universal. We can get stuck in our way of seeing and become rigid and dogmatic. When we remember that the world is always in a process of flux and transformation, we can grow and change for the better. We can then live with what he called trained spontaneity, something which sounds like an oxymoron, but instead is somewhat like the magic of the improvisations of highly skilled chefs, musicians or dancers.

I particularly enjoyed Pruett and Gross-Loh's discussion of the writings of Laozi which are the basis of Daoism. The premis is we are most effective when we stop seeing ourselves and the world as separate and distinct. By avoiding false dichotomies of me and you, us and them, we can see the interconnectedness in all things and in all behaviours. We can look at changing the dynamics of relating and over time create deeper understanding with less power struggle and less blame. They claim that Laozi's writings suggest that we can reset the attitude in a room and recalibrate relationships in our lives. Also, we can be creative to connect with others in new ways and smooth over distinctions that had in the past created divisions. And when we recognise that everything we do impacts others and appreciate how paradoxically there is more power in weakness than strength, we understand the workings of influence. An exciting idea indeed; and one which has already changed some of my conversations with clients and family members for the better.

Pruett and Gross-Loh claim that Laozi believed we can free ourselves from the false idea that ambition is opposed to passivity and that the only way to get

ahead is to be competitive and strong. He believed in effective change and provided alternative ways to achieve it. He suggests that silence and quiet responses are more powerful in the long run. His writings suggest we can be more influential through softness not hardness, connection not domination.

There are far too many ideas which inspire and challenge discussed in The Path to mention here, but I would like to close with one that has truly empowered me.

How about abandoning looking for our authentic self and instead start creating ourselves wisely and carefully moment by moment? How about working on ourselves, altering ourselves, constructing ourselves for the benefit of ourselves and those around us, every day? And amidst the everyday messy human stuff we experience, we can effectively cultivate and create a better world. I am thankful that I can keep dipping into The Path regularly to keep pondering the hopeful possibilities, and applying the insights professionally and personally.

Glenda O'Sullivan
Glenda provides Counselling and Coaching to help you move forward with Clarity, Confidence and Creativity. Glenda's background is in performing, writing, and teaching, facilitating as well as counselling and coaching. She is known for her provocative, funny, original cabaret productions, which highlight social justice, gender, as well as personal and professional development and empowerment issues.

Available for purchase at:
www.penguin.co.uk
Kindle: $16.24
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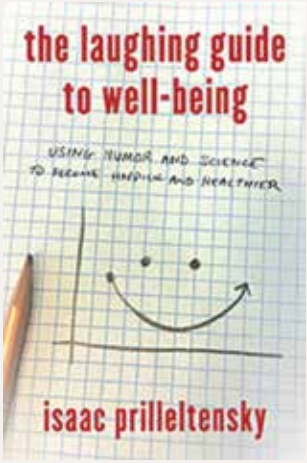

The laughing guide to well-being: Using humour and science to become happier and healthier

Review by Judith R Boyland

Professor Prilleltensky is Dean of the School of Education and Human Development and Vice Provost for Institutional Culture at the University of Miami. Building on a platform that he defines using the acronym, I COPPE (translated as 'I cope'), Professor Prilleltensky addresses six domains of well-being – Interpersonal, Community, Occupational, Physical, Psychological and Economic. Each domain is addressed individually in a concept specific chapter (chapter two through to chapter seven) under the overarching construct of well-being. In Chapter one, Professor Prilleltensky introduces the holistic concept of well-being.

As Chapters unfold, the reader is introduced to 'The Laughing Side' and 'The Learning Side' of each domain. While the structure of 'The Laughing Side' of each chapter varies according to context and content, the structure of 'The Learning Side' of each chapter follows a thematic pattern. Initially, each domain is defined. Then follows discussion around 'fit', 'fitness' and 'fairness' which explores the 'fit' between the person and his/her environment, 'fitness' in relation to skills, values and levels of empowerment relevant to each domain and 'fairness' which the author describes as relating to "the role of justice in mattering and well-being" (p.17). 'The Learning Side' of each domain closes with an invitation to 'Know Yourself, Help Yourself' followed by the challenge to 'Know Others, Help Others'.

Throughout the text, Professor Prilleltensky makes effective use of humour to entertain, enlighten and teach in a manner that is insightful and compassionate: showing a deep and rich understanding of the human condition that defines both that which is shared by all persons and that which marks each and every person as an individual within a common species.

With a focus on resilience and well-being, effective use is also made of a variety of linguistic elements to bridge science and the empirical reality of lived experience as shared in reflective anecdotes sprinkled throughout the text

The laughing guide to well-being is recommended to be an excellent read and a valuable resource for the clinician whose clients' well-being is being negatively impacted by life stressors, whatever domain is presenting with symptoms or demonstrated signs of unwellness. The laughing guide to well-being is also recommended to be an excellent read for the clinician who may need a reminder that the medicinal capacity of laughter is limitless. The laughing guide to well-being: Using humour and science to become happier and healthier is available from www.rlpgbooks.com and is also currently available in both hardback and softback through www.fishpond.com.au and www.bookdepository.com A kindle edition is available through www.amazon.com.au . For more information, the reader is invited to contact Suzanne Wheatly and Katherine Sloggett (Roman & Littlefield Publishing group) on reviewsintl@rowman.com.

Judy Boyland
Judy is an experienced Counsellor and Professional Supervisor. She has been practising counselling for over twenty -five years and has a professional background in education. She brings an holistic and eclectic approach to Counselling practice, incorporating a variety of therapeutic strategies that support the healing of life stresses and the growth of calmness in the midst of the realities of everyday chaos.

Available for purchase at:
http://www.thelaughingguide.com/
Kindle: $18.95
Paperpack: $32.90
Hardcover: $41.91

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Jane Oakley-Lohm	BLACKSTONE HEIGHTS, LAUNCESTON	0438 681 390	$110 GST inclusive, $80 for new students of one year	$110 GST inclusive, $80 for new students of one year

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TASMANIA *CONTINUED*				
Pauline Mary Enright	SANDY BAY	0409 191 342	$70 per session: Concession $60	FTF/PH/WEB
VICTORIA				
Shivon Barresi	ROXBURGH PARK	0413 568 609	Ind. $80 ph, Group $60ph	FTF/PH/GRP/WEB
Angeline Crossin	ASCOTVALE/ESSENDON	0451 010 750	$100 F/F, $90 Skye,$50 Group, $70 Students	FTF/GRP/WEB
Rosemary Petschack	DIAMOND CREEK	0407 530 636	80 p/h	FTF/WEB
Bettina Revens	NEWPORT/ WILLIAMSTOWN	(03) 9397 7075: 0432 708 019	$120 individual	FTF/WEB
Derek Goodlake	SANDRINGHAM	0403 045 800	$110	FTF/PH/WEB
Gayle Stapleton	BERWICK	0459 075 284	100 p/h Negotiable	FTF/GRP/PH/WEB
Rosie Barbara	SYDENHIAM/WYNDHAM	0433 277 771	Ind:$110/GRP:$50 each min of 4 hours	FTF/GRP/PH/WEB
Petra de Kleijn	TATURA	0413 824 073	Upon Enquiry	FTF/PH/WEB
Sophie Lea	MORNINGTON PENINSULA	0437 704 611	Individual $100/hour	FTF/PH/WEB
Dorothy Dullege	RINGWOOD NORTH	0433 246 848	Upon Enquiry	FTF/GRP/PH/WEB
Batul Fatima Gulani	MELBOURNE	0422 851 536	Upon Enquiry	FTF
Karen Seinor	WODONGA	0409 777 116	Upon Enquiry	FTF
Anna Atkin	CHETLENHAM	0403 174 390	Upon Enquiry	FTF
Lynne Rolfe	BERWICK	03 9768 9902	Upon Enquiry	FTF
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Joan Wray	(MOBILE SERVICE)	0418 574 098	Upon Enquiry	FTF
Tra-ill Dowie	PORT FAIRY	0439 494 633	Upon Enquiry	FTF
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon Enquiry	FTF
Barbara Matheson	MELBOURNE	03 9703 2920 or 0412 977 553	Upon Enquiry	FTF
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, GRP $40 (2 hours)	FTF
Debra Darbyshire	BERWICK	0437 735 807	Upon Enquiry	FTF
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Melissa Harte	PAKENHAM/SOUTH YARRA	0407 427 172	$132 to $143	FTF
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260 Or 03 9786 8006	Upon Enquiry	FTF
Beverley Kuster	NARRE WARREN	0488 477 566	Upon Enquiry	FTF
Patricia Reilly	MOUNT MARTHA/ GARDENVALE	0401 963 099	Upon Enquiry	FTF
Molly Carlile	INVERLOCH	0419 579 960	Upon Enquiry	FTF
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Claire Sargent	CANTERBURY	0409 438 514	Upon Enquiry	FTF
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF

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VICTORIA *CONTINUED*				
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Gaye Hart	BITTERN 3918	0409 174 128	Upon Enquiry	FTF
Belinda Hulstrom	WILLIAMSTOWN	04714 331 457	Upon Enquiry	FTF
Paul Montalto	THORNBURY	0415 315 431	Upon Enquiry	FTF
Marie Bajada	BALLARAT	0409 954 703	Upon Enquiry	FTF
Tabitha Veness	FERNTREE GULLY	0400 924 891	Upon Enquiry	FTF
Kaye Allison Jones	CAMBERWELL	0417 387 500	Upon Enquiry	FTF
Marguerite Middling	NORTH BALARAT	0438 744 217	Upon Enquiry	FTF
Zohar Berchik	SOUTH YARRA	0425 851 188	Upon Enquiry	FTF
Natalie Wild	BORONIA	0415 544 325	Upon Enquiry	FTF
Andrew Reay	MOORABBIN	0433 273 799	Upon Enquiry	FTF
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon Enquiry	FTF
Brian Whiter	CARLTON, MOORABBIN	0411 308 078	$100	FTF
Jenny Anne Field	UPPER FERNTREE GULLY	0404 492 011	On Request	FTF/GRO/PH/WEB
Paola Gina Salvagno	DONCASTER; TEMPLESTONE; BALWYN	(03) 9812 7520; 0430 157 857	$120 p/h $100 - students enroled in counseling	FTF/PH/WEB
Simon PHilip Brown	WATSONIA	03 9434 4161	Upon Enquiry	FTF/PH/GRP
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon Enquiry	FTF/GRP/WEB
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF/WEB
Stephen O'Kane	BLACKBURN	0433 143 211	Negotiable	FTF/GRP
Sandra Hatton	KEW	0425 722 311	Indiv. $80/hour; sml group $80/2hours	FTF/GRP
Danielle Aitken	SOUTH GIPPSLAND/ MELBOURNE METRO	0409 332 052	Upon Enquiry	FTF/GRP/PH/WEB
Michelle Wood	MANSFIELD	0497 037 436	Upon Enquiry	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
Kathleen (Kathy) Brennan	NARRE WARREN	0417 038 983	$35 GRP, $60 Indiv	FTF/GRP/PH/WEB
Sandra Brown	FRANKSTON/MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Joanne Ablett	PHILLIP ISLAND/ MELBOURNE METRO	0417 078 792	$120	FTF/GRP/PH/WEB
Bridget Pannell	MELBOURNE	0423 040 718	call to discuss	FTF/GRP/PH/WEB
Jacquie Wise	ALBERT PARK	03 9690 8159 or 0439 969 081	By Negotiation	FTF/GRP/PH/WEB
Rosslyn Wilson	KNOXFIELD	03 9763 0772 or 03 9763 0033	GRP $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Nyrelle Bade	EAST MELBOURNE/POINT COOK	0402 423 532	Upon Enquiry	FTF/GRP/WEB
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Anne Meredith Brown	COLDSTREAM	0428 221 854	Upon Enquiry	FTF/PH/GRP
Lehi Cerna	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB

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VICTORIA *CONTINUED*				
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
Sandra Clough	TRARALGON	VIC	0412 230 181	Upon Enquiry
Judith Beaumont	MORNINGTON	0412 925 700	Upon Enquiry	FTF/PH/GRP/WEB
Jo-Ellen White	BLACKBURN SOUTH	0414 487 509	$100 ind. $50 Group. Stu Dis $80	FTF/PH/GRP/WEB Specialising is Autism Spectrum Disorder
Gabrielle Skelsey	ELSTERNWICK	03 9018 9356	Upon Enquiry	FTF/PH/WEB
Lynda M Carlyle	EAST MELBOURNE, SPRINGVALE SOUTH, RIPPON LEA	0425 728 676	$135 per hour	FTF/PH/WEB
Cas Willow	WILLIAMSTOWN	03 9397 0010 Or 0428 655 270	Upon Enquiry	FTF/PH/WEB/GRP
Sara Edwards	DINGLEY	0407 774 663	Upon Enquiry	FTF/WEB
Lisa Derham	CAMBERWELL	0402 759 286	Upon Enquiry	FTF/WEB
Graeme John Riley	GLADSTONE PARK	03 9338 6271 or 0423 194 985	$85	FTF/WEB
Sandra Robinson	MANSFIELD/BENALLA	0403 175 555	$110 individual 1 hour session. $50 - group per he	FTF/WEB
John Dunn	COLAC SW AREA/ MT GAMBIER	03 5232 2918	By Negotiation	FTF/GRP/WEB
WEST AUSTRALIA				
David Fisk	NORTH LAKE	0412 781 865	$100 (neg) Upon Enquiry	FTF/GRP/WEB
Allison Lord	CLARKSON	0403 357 656	Upon Enquiry	FTF/PH/GRP
Trudy McKenna	NEDLANDS	0438 551 210	Indiv $120, GRP $50 Concess $30	FTF/GRP/PH/WEB
Julie Hall	YANCHEP/BUTLER/ JINDALEE/JOONDALUP	0416 898 034	$100	FTF/PH/WEB
Narelle Williams	MIDLAND, PERTH	0429 000 830	Individual $100 :Students $85	FTF/WEB
PHillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
Fiona McKenzie	GERALDTON	0427 928 505	Upon Enquiry	FTF
Marie-Josee Boulianne	BEACONSFIELD	0407 315 240	Upon Enquiry	FTF
Cindy Cranswick	FREMANTLE	0408 656 300	Upon Enquiry	FTF
Lynette Cannon	CAREY PARK	0429 876 525	Upon Enquiry	FTF
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
Karen Heather Civello	BRIDGETOWN	0419 493 649	Upon Enquiry	FTF
Alan Furlong	WINTHROP	0457 324 464	Upon Enquiry	FTF
Genevieve Armson	CARLISLE	0412 292 999	Upon Enquiry	FTF/GRP/PH/WEB
Jenna Trainor	BEDFORD	0431 817 807	Upon Enquiry	FTF/GRO/PH/WEB
Carolyn Midwood	DUNCRAIG	08 9448 3210	Indiv $110, GRP $55	FTF/GRO/PH/WEB
Merrilyn Hughes	CANNING VALE	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB
Sharon Vivian Blake	FREMANTLE	0424 951 670	Indiv $100, GRP $60	FTF/PH/GRP/WEB
Eva Lenz	FREMANTLE/COOGEE	08 9418 1439 Or 0409 405 585	$85 concession $65	FTF/PH/GRP/WEB
Dr. Patricia Sherwood	PERTH/BUNBURY	0417 977 085 or 08 9731 5022	$120	FTF/PH/WEB

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WESTERN AUSTRALIA (CONTINUED)				
Lillian Wolfinger	YOKINE	08 9345 0387 /0401 555 140	Upon Enquiry	FTF/PH/WEB
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
INTERNATIONAL				
Yat Chor Wun	HONG KONG	+852 264 35347	Upon Enquiry	FTF
Yat Chor Wun	HONG KONG	+852 264 35347	Upon Enquiry	FTF
Polina Cheng	HONG KONG	+852 9760 8132	Upon Enquiry	FTF
Cary Hung	HONG KONG	+852 2176 1451	Upon Enquiry	FTF
Dina Chamberlain	HONG KONG	+852 6028 9303	Upon Enquiry	FTF
Giovanni Ka Wong Lam	HONG KONG	+852 9200 0075	Upon Enquiry	FTF
Fiona Man Yan Chang	HONG KONG	+852 9198 4363	Upon Enquiry	FTF
Frank King Wai Leung	HONG KONG	+852 3762 2255	Upon Enquiry	FTF
Wing Wah Hui	HONG KONG	+852 6028 5833	Upon Enquiry	FTF
Joyce Chan	HONG KONG	(+852) 92507002	$AU90, HKD 550	WEB
Su Keng Gan	SINGAPORE	+65 6289 6679	Upon Enquiry	FTF
Eugene Chong	SINGAPORE	+65 6397 1547	Upon Enquiry	FTF
David Kan Kum Fatt	SINGAPORE	+65 9770 3568	Upon Enquiry	FTF
Saik Hoong Tham	SINGAPORE	+65 8567 0508	Upon Enquiry	FTF
Jeffrey Gim Tee Po	SINGAPORE	+65 9618 8153	$100.00	FTF/GRP/PH/WEB

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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.

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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

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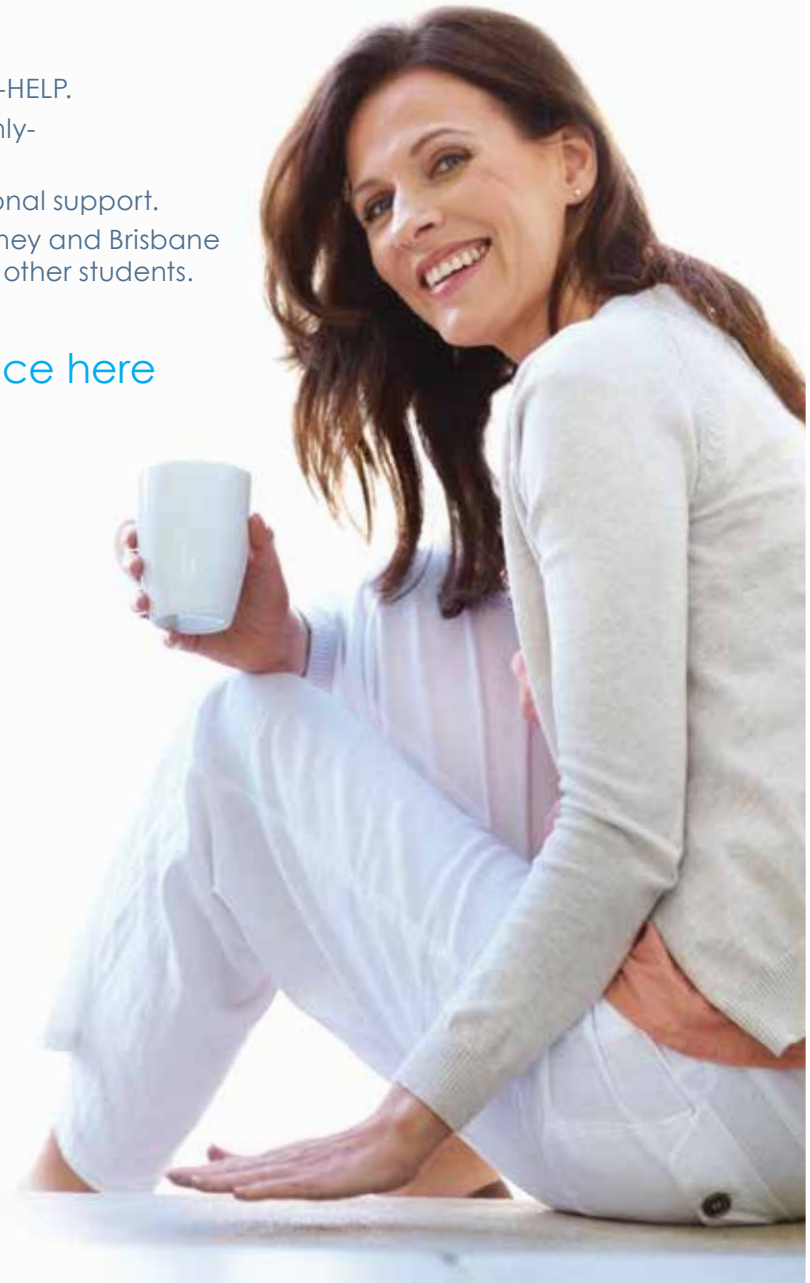

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Regional NSW	|	1800 625 329
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