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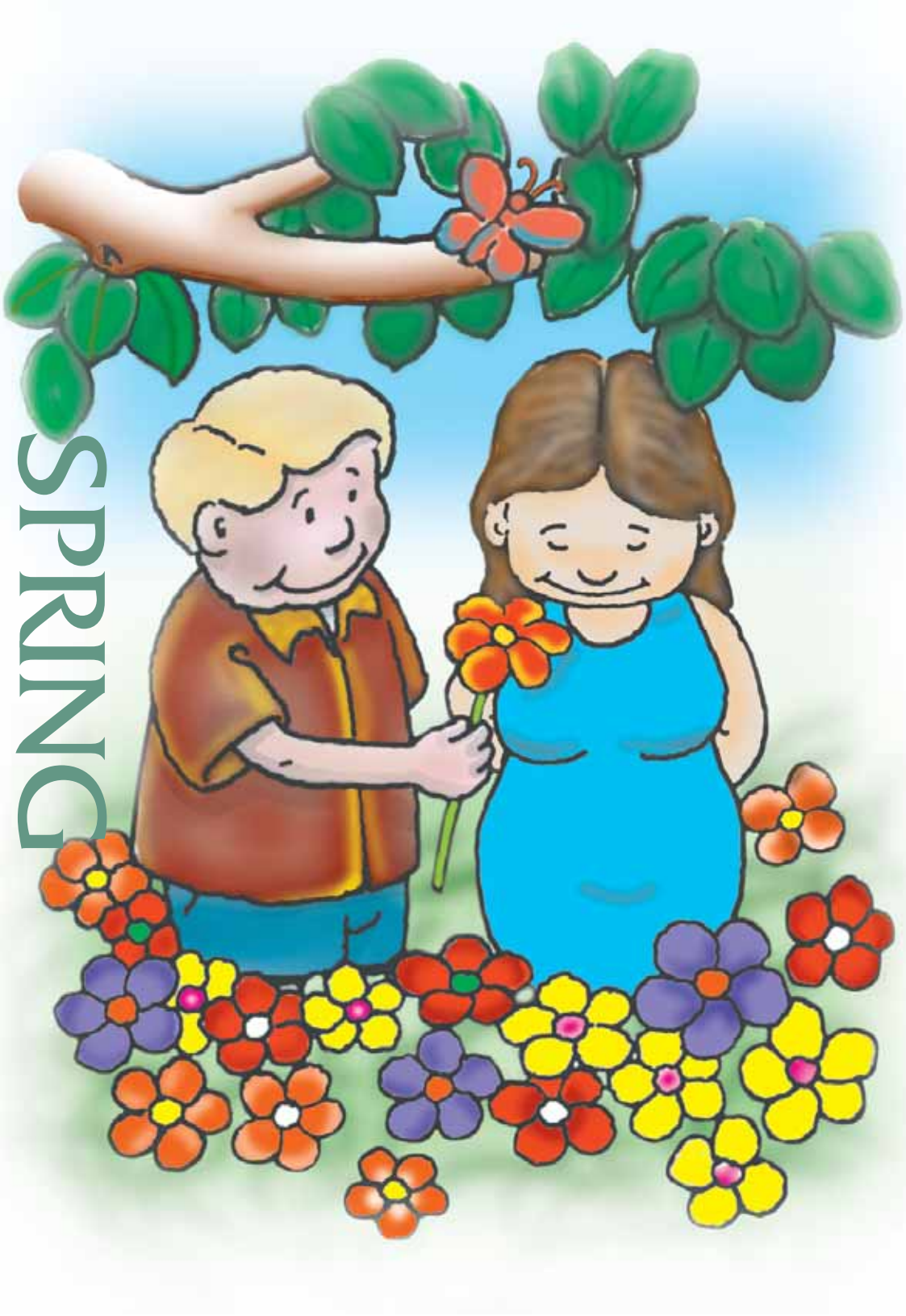

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Editorial By Phillip Armstrong

There have been several important events happen over the last few months. The introduction of the Australian Register of Counsellors and Psychotherapists (ARCAP), the Inaugural Asia Pacific Rim Conference in July and the raising of the Asia Pacific Rim Confederation of Counsellors Ltd.

ACA was a leader in each of these events and heavily involved in the evolution and development of each event. From an Australian perspective ARCAP has been the most significant achievement for the counselling and psychotherapy industry for the last 10 years. The joint ACA/PACFA working party has been working hard on implementing ARCAP as an independent National Register for all counsellors and psychotherapists in Australia. Both organisations have been running workshops on the establishment of ARCAP and what it means to the industry. I have run workshops on ARCAP in Perth, Adelaide, Brisbane, Melbourne and Hong Kong. Other workshops have been run across Australia. The most impressive outcome of ARCAP is that ACA and PACFA have worked together in a collegial manner on the concept and constitution. The boards of both associations have approved the current constitution although further work is still needed before the concept is adopted in whole.

The most impressive outcome of ARCAP is that ACA and PACFA have worked together in a collegial manner on the concept and constitution.

ARCAP is extremely important in the fight for recognition by the industry for recognition for private provider numbers from Private Health Insurance providers, GST exemption and Medicare rebates. Representation by one body ensures consistency of messages and dialogue. It also ensures resources are not wasted through repetition and are focussed appropriately on important matters. Although the working party has been successful in introducing ARCAP it will only be successful if it is embraced constructively by counsellors and psychotherapists through out Australia. ARCAP is vehicle for representation, registration and credentialing at a national level.

July saw ACA in partnership with our New Zealand and Hong Kong colleagues hold the Inaugural Asia Pacific Rim Conference in Hong Kong. The conference was a resounding success with presenters coming from all over the world. The 2 day conference will become biennial event with the next conference being held 2010. There is a six page spread in the middle of this edition of Counselling Australia that outlines the great time had by all.

One of the consequences of the conference was rhe raising of a new regional body, Asia Pacific Rim Confederation of Counsellors Ltd. This new body has representatives from Australia, Singapore, Hong Kong, China, South Korea, New Zealand and Malaysia as the founding bodies. Dr Catherine Sun from Hong Kong was elected as the inaugural President and I was fortunate enough to be elected as the first Secretary General (SG). Australia was represented by Adrian Hellwig (President of Clinical Counselling Association) and Ed Riley a member of ACA and the AGCA. Dr Colin Benjamin was appointed as the under-secretary to the SG. Membership will be open to all counsellors within the Asia Pacific Rim area soon. The association is still finding its feet and has a lot of work to do. Part of the association's agenda is to set up a regional Disaster Management Team to respond to natural and man made disasters in the region in relation to trauma issues. I will ensure you are all kept update with the associations progress through Counselling Australia.

I hope to see many of you at the Self Harm conference in Brisbane in November.

Regards

Philip

ACA

A Virtuous Process-Experiential Emotion-Focused Therapist Part 2 By Caroline McDougall

(Part 1 was published in the June 08 edition)

4. Case Study Dilemmas

Virtue ethics in challenging PEEFT moments

PETER

The dilemma:

How do I maintain a commitment to a genuine, collaborative relationship with Peter, a long-term client, who is entrenched in a cycle of depression?

(Collaboration refers to an internal therapist attitude of interested engagement and equality with the client)[1].

Peter is an intelligent, introspective and articulate man with depression. I have had a close working relationship with him for several years. In retrospect I realize that much of my work with him has transpired unconsciously within a virtue ethical framework. He has learnt, over time, to share his inner experience with me in a profound and honest way. This has been difficult for him, but there has been a strong commitment from us both to work on his issues of trust. Trusting is difficult for a man who has lost everything: family, friends, a successful career, hope for a wife and children, health, self-esteem, sanity. Along with his untold losses and no support, his parents (in denial) perpetuate his sense of hopelessness and self-stigma.

His life is extremely painful on a daily basis, for, as he is overwhelmed with shame and guilt, he is also desperate to regain some of what he has lost. For him to trust me, I must be worthy of his trust: I must be trustworthy. He needs constant reassurance of discretion and confidentiality. When he feels confident of this he is more self-disclosing and we can make progress.

Work with Peter is not encapsulated in predictability. It is a fragile process, and so it is vital that I do not betray this trust, albeit unwittingly. Maintaining this bond is crucial to his survival, as it is with vulnerable clients in general. I also trust him to continue being honest, to tell me *his* truth (unlike many who say what they think others want to hear: a legacy of the institutionalized).

He has learnt, over time, to share his inner experience with me in a profound and honest way.

With a commitment to the virtue of honesty, and to the PEEFT collaborative relationship, it is sometimes extremely challenging to remain committed to a client with whom change is almost non-existent. I also have issues with self-care as I have a tendency to lose objectivity with vulnerable clients like Peter. He battles with suicidal ideation and has attempted suicide several times. He is in and out of hospital. He is on a treadmill of medication and medicos. His arbitrary flirtations with transient, recycled dreams and goals are, it seems at times, all he has to keep 'hope' alive. As he travels through cycles of 'wellness' his goals elevate, and tend to become unrealistic. This inevitably

1 According to Elliott et al (1994): 'PE therapists think of themselves as equals with clients and as fellow human beings who struggle with many of the same issues' (p78). PEEF therapists therefore aim to enter into a mutual collaborative relationship in which they are partners with their clients.

A Virtuous Process-Experiential Emotion-Focused Therapist Part 2 (Continued)

leads to pressure, and results in a downward spiral of disappointment, depression and hospitalization.

The cycles can be frustrating and draining for me as well as Peter. He is often on my mind. I worry that he will finally reach 'the end of his tether' and succeed in ending his life. Within this slow and at times tortuous process, I sometimes struggle with feelings of helplessness (beyond the boundaries of the therapeutic hour) in the wake of his despair. In feeling his suffering, my work encompasses the affective virtue of empathy. But sometimes I feel impatient and even angry, losing the sense of empathy which I hold so close, and which is intrinsic to humanistic work. I must, in these moments focus on the virtue of *loyalty*. *Loyalty* allows me to maintain independence of judgment, and reminds me of the importance of not allowing personal dislike, disapproval or other negative reactions, to affect the quality of therapy. It reminds me (and this has been my own personal challenge with Peter) to not get too personally involved. It is important at these times, to also ask myself what I may need in terms of self-care. Being too involved affects my ability to make objective discernments, and may impact my professional/moral *competence*, such as being confident regarding what type of task or intervention is the right 'fit' in the moment.

Within a virtue ethics framework, my integral honesty, or genuineness in PEEFT terms, may be challenged.

Competence, as a virtue, is closely related to *benevolence*, described by Cohen and Cohen (1990) as: 'to do good for others when reasonably situated and to do no harm', this concern for the welfare of others 'for its own sake' (p90).

So to maintain *loyalty* and all its related virtues, I cannot share with Peter, my fears or frustrations regarding his situation. I wonder if, in this sense, the collaborative nature of our relationship is in jeopardy. Within a virtue ethics framework, my integral honesty, or genuineness in PEEFT terms, may be challenged. Genuineness, as it is closely linked to *honesty*, is a value central to the PEEF therapeutic relationship.

According to Elliott et al (2004):

> Genuineness consists of … a) wholeness is having integrity and being coherent; it includes having a friendly relationship with oneself and being willing to approach one's own painful emotions; and b) authenticity is being what claims to be: natural, congruent, honest, real; being aware of one's own experiencing, including painful emotions… Genuineness translates into presence in the form of being open or transparent with the client, including, where appropriate, being self-disclosing and 'up front'. (p75).

The genuineness central to the PEEF relationship encourages transparency, even self-disclosure. Genuineness working with people with mental illness requires careful management as they are often very lonely, and alliance ruptures are a high risk. It is therefore an ongoing necessity and challenge to keep clear boundaries, whilst remaining committed to a 'collaborative PEEFT trust-establishing paradigm'.

In terms of working with the vulnerable and marginalized, I believe that genuineness and *honesty* are appropriate insofar as their application advances the person's interests and doesn't violate other

relevant ethical principles. Use of these virtues in the therapeutic relationship must have a curative value, and perhaps should be considered as a technique to be utilized appropriately as well as a virtuous character trait.

According to Jordan and Meara (1990): 'Genuineness includes both a principle-oriented guide to proper action (to tell the truth) and a virtue-oriented characteristic (integrity or trustworthiness)' (p143). In practice, these two admonitions may be independent of each other. For example, to maintain trust, 'measured deliberateness' may inform the practice of 'speaking the truth'. In doing so I acknowledge the importance and application of the virtue of *discretion*.

Jordan and Meara state (1990): 'Not speaking, or speaking with care and discretion can be just as critical to maintaining integrity and trustworthiness of the therapist as speaking out (p143). A 'genuine' therapist therefore must use experiential wisdom, as well as balance the virtues of *honesty* and *discretion* to assist with making professional judgments. Transparency, honesty and genuineness may therefore be used appropriately within the 'moment-be-moment' process central to PEEFT.

I reflect upon my own need for resilience, that I cannot always 'make a difference' in the often unchartered waters of mental illness, that I can never underestimate the magnitude of Peter's problems. When he speaks to me of suicide intent I understand that this evolves from a pervading sense of hopelessness. I utilize *loyalty* in that I am willing to listen, to take him seriously and communicate a deep sense of care. I do what I can to let him know that at least one human being shows him *loyalty*. I remind him of the progress he has made in terms of the fact that he can now speak openly of his feelings; he can now recognize and express his core emotions.

According to Pope and Vasquez (1999): 'Providing this degree of availability gives the client evidence of caring when that caring is absolutely necessary to convince that client that life is both livable and worth living… the overwhelming priority is to help the client stay alive' (p246). Although it is challenging to maintain positive feelings when Peter is angry, suicidal and depressed, through PEEFT, his expression of these emotions and conditions allows a connection with life. He can also connect, albeit briefly, with another person, outside of the confines of his exploding inner world.

Through all the 'twists and turns' of this work with Peter, I practice *candor* in every step of the therapeutic process. I explain for example, when and how I identify a marker for the PEEFT interventions. In doing so, Peter is always aware of, and ready for the experiential emotional nature of the interventions.

Virtue ethics help me to remain genuinely *loyal*, to maintain trust in the process of change. I also use *diligence* to avoid assumptions. For example, I cannot assume that if Peter's presentation improves, that the suicide risk is gone. I must keep checking. I hope that, in demonstrating this level of concern, or *diligence*, this may be enough to convince him of my genuineness and *loyalty*, and that another day of breathing is a preferable alternative to self-annihilation.

A 'genuine' therapist therefore must use experiential wisdom, as well as balance the virtues of honesty and discretion to assist with making professional judgments.

A Virtuous Process-Experiential Emotion-Focused Therapist Part 2 (Continued)

PAUL

The dilemma:

When Paul asserts his self-determination in a way that may involve potential for harm, how do I juggle his right to self-determination and my duty of care? What is my responsibility to Paul in this process?

Honesty, in turn, requires some degree of genuineness from participants under the assumption that honesty as opposed to deception is attached to the actual person' beliefs

Paul is a strong-willed, outgoing person with schizo-affective disorder. He generally has a positive outlook and holds several achievable goals. A common theme is his wish to reduce and self-monitor his medication despite onset of psychotic episodes and subsequent hospital admissions when reduction/self-monitoring has occurred in the past. Of course, this is not my decision to make, however I can explore with Paul what lies beneath this desire for a sense of ownership over an aspect of his life, which has the potential to endanger his existence. I am bound to respect Paul's personal freedom, providing this does not involve harm. Dryden poses the following question regarding the vital issue of therapist responsibility (1985): '… to what degree should they (therapists) take responsibility for their clients' welfare or to what extent should they respect clients' autonomy and ability to make informed decisions about their own lives?' (p3).

This is a common theme in mental health: finding the balance between what will cause least harm and what will achieve the greatest good in the process of maximizing opportunities to implement personal choices.

According to Hazler and Barwick (2001):

> A degree of *honesty* on the parts of client and therapist seems to be one key general ingredient necessary to maintaining connection to the reality of the client's problems and to the realities of the therapeutic relationship. Honesty, in turn, requires some degree of *genuineness* from participants under the assumption that honesty as opposed to deception is attached to the actual person' beliefs (p103).

More questions emerge: How do I maintain *honesty* as a virtue when, even in mild psychosis, Paul's reality is very different from my own? Do Paul and I understand each other in relation to this dilemma? Are we able to remain connected in relationship through this dilemma? What maximizes the opportunities for us both to implement our preferred choices?

Within the counselling process, I often utilize focusing (a PEEFT experiencing task). This intervention can evoke a deep connectedness whereby Paul and I are able to explore the core emotions behind his need to self-determine/self-destruct. It is important to mention, at this point, the use of *candor* as a virtue, to maximize Paul's self-determination. That is, I inform him about matters related to the counselling process consistent with what he would reasonably want to know. Regarding PEEFT, I explain the tasks and interventions, and am highly transparent regarding why each is chosen. I use language that he will understand, to avoid paranoia and misunderstandings.

In all aspects of intervention, a conscientious application of candor is vital, and assists the virtue of *honesty*, to challenge Paul's self-beliefs and maintain connection to the reality of the therapeutic relationship, despite the impact of mild psychosis.

Through focusing, Paul and I regularly find a core emotion of shame attached to his need for self-determination regarding his medication. He is ashamed of his need for medication, as he has great difficulty accepting his illness. Paul, like many others amongst this marginalized population, is riddled with self-stigma. Through long-term work on his emotion scheme in all its complexity, we are able to challenge and work to unravel his self-stigma. In doing so we are heading towards Paul finally accepting his mental health status.

As we explore this core, new needs may emerge and I may have to question if I can provide for this need.

For example, some time ago I recognized clear signs of imminent 'unwellness'. PEEFT is a deep therapy and such signs may emerge in the counselling setting, where there is no 'hiding'. I did not speak openly of my concerns (reserving *honesty*), but through exploration, assisted Paul to realize that he was becoming unwell. As a mark of his self-determination, he was foremost in making the decision to be admitted to hospital. This was a turning point for him. PEEFT (framed in the virtues of *diligence*, *loyalty* and *competence*) assisted Paul in realizing that self-determination may be utilized in many different ways. The flexible nature of PEEFT is evident in this example of productive work with a client. PEEFT, like virtue ethics, is not 'rule-based', and it allows for ever-changing goalposts in the counselling process.

I embrace the virtue of *diligence*, as it is vital in mental health, where maintaining understanding, rapport and trust is paramount. It means reliable counselling, carefully geared towards genuine caring. Relying upon efficient application of knowledge and ability to help, the clients' welfare is the overriding consideration. As a diligent counsellor, I cannot be forgetful or negligent. I genuinely care about Paul's welfare, and gear the counselling process carefully towards accomplishing the goal of balancing his wellness and his self-determination. In providing reliable, careful counselling I maximize the opportunity to remain connected, when imminent 'unwellness' presents its unique challenges.

Working within an umbrella of PEEFT bound by an ethic of *diligence*, Paul and I can be more carefully guided in relationship through challenging moments. Incorporating the virtue ethics into my practice encourages reflection on my personally formed character to provide the basis for professional judgment, especially in challenging situations. In other words, it enables me to reflect on 'who I shall be' in a given situation.

As we explore this core, new needs may emerge and I may have to question if I can provide for this need.

A Virtuous Process-Experiential Emotion-Focused Therapist Part 2 (Continued)

Another theme in Paul's self-determination is his fixation on one day living the lifestyle of his sister. She is independently wealthy, and is highly successful in both her personal and professional life. When the theme arises of this unachievable goal, I am aware that to tell the truth will devastate Paul. I will not reinforce the death of his dreams. I therefore refer to practical wisdom (phronesis) to resolve the conflict. Preston (2001) asserts: 'Truthfulness (honesty)…. signifies an intention to be someone who is not deceptive, and whose actions reflect an integrated, ethical view that life is valuable, trust is important and that fair dealings are necessary' (pp93-94).

Filled with shame and guilt about not being able to work, his self-critic is hard at work.

Although the intention is to be honest, *fairness* as a virtue is also at the heart of trust. *Fairness* is defined by Cohen and Cohen (1990) as: 'providing services of equal quality and magnitude consistent with maximizing the promotion of the welfare in each client (p102). In the interests of Paul's welfare, *honesty* is in conflict with *fairness* and *discretion*, so I choose to allay *honesty* in the interests of maintaining the trust and rapport we have built over a long time. My strategy is, draw our awareness back to the present moment, which tends to reinstate a fresh sense of reality and enjoyment of 'where he is' at the time.

Without a consideration of the interplay (and potential conflict) between the trust-establishing virtues in complex situations with complex individuals, the 'person who I shall be' is not reflecting an integrated being who values the virtue of *nonmaleficence*. This is the virtue of causing no harm; to safeguard the welfare of others through preventing pain and suffering.

In practicing *nonmaleficence*, I hold a moral responsibility to use knowledge and power that is consonant with Paul's welfare in these situations. I also take time to reflect about what may help or hinder this process. Therefore if *honesty* leads to greater harm, especially in working with psychotic clients, then 'dishonesty', or a 'softer version of the truth' may be justified. Too much insight may be overly painful and even devastating where there is potential for unpredictable consequences.

Despite conservative use of *honesty* at times when nonmaleficence is paramount to balancing duty of care and self-determination, there have been major turning points in Paul's self-sabotaging behaviour. For example, despite significant barriers, Paul has, for the past few years, applied independently for work rather than join a 'disability employment agency'. This has resulted in an ongoing barrage of disappointment. For 10 months we have worked on his core shame to challenge the self-stigma driving many of his actions and choices. As a PEEF therapist I have refrained from advising him on what to do, but instead worked with great *diligence*, and attention to *nonmaleficence* to actively challenge his irrational belief concerning his determination to persist with mainstream employment applications.

Paul is filled with shame and guilt about not being able to work, and his self-critic is hard at work. A diligent and patient approach using PEEFT tasks and interventions has helped us to address the core issues

which perpetuate his self-stigma. The central issue is to focus on his feelings about how he *thinks* people perceive him. Through focusing and other PEEFT interventions, we explore a deeper understanding of his beliefs about the person he wants to be, and we use the emerging evidence to challenge his fundamental beliefs. These tasks help Paul to look at the truth and consequence of his own beliefs, without the use of overt *honesty*, which in this case, would be too confronting and cause him unnecessary pain.

As a result, Paul has recently accepted what will work better for him in the long-term. He has now joined an appropriate agency and he is very comfortable with this choice. He also has a better understanding as to why he made these choices in the past, and what will benefit him in the future.

Attendance to *nonmaleficence* therefore assists me to be mindful that certain approaches, techniques and tasks are appropriate for some situations but not others. *Candor* determines the use of negotiation in the choice of different techniques, tasks and interventions. *Diligence* helps me to maintain ongoing vigilance to be aware that each hour or minute spent in relationship is unique and therefore requires unique consideration. This virtuous approach truly reflects the person-centred core of PEEFT and the importance of anticipation within the moment-by-moment process.

5. Implications for Future Practice

According to Preston, (2001, p62) the practical virtues of a virtue ethics framework include:

- An emphasis on character-building which can be useful in everyday morality
- An applicability to a professional role and professional ethics
- A check on the excessively cognitive style of other approaches, allowing a place for feelings, roles and relationships in line with an ethic of care
- A tool to assist identifying core community values in pluralist societies

As I reflect on these 'positives' I believe that, as a virtuous therapist, I will be more accountable for my mistakes; and demonstrate moral responsibility (mindfulness) and emotional competence when the unforeseen occurs. As a virtuous therapist I aspire to being honest, candid, discreet, benevolent, diligent, loyal and fair. However, being a virtuous therapist is not always simple. Sometimes, as is apparent in the case studies the virtues will be, or will seem to be, in conflict with one another. For example, the use of *honesty* in working with people with mental illness will often conflict with other virtues, and must be used with *discretion*.

> Pope and Vasquez (1998) assert that:
> Emotional competence reflects therapist's acknowledgement and respect for themselves as unique, fallible human beings. It involves self-knowledge, self-acceptance, and self-monitoring. Therapists must know their own emotional strengths and weaknesses, their needs and resources, their abilities and limits (p62).

I believe that, with this greater knowledge of my ability to affect outcomes *ethically*, I will work with improved 'balance' between self-care and the courage required

Reflecting on these 'positives' I believe that, as a virtuous therapist, I will be more accountable for my mistakes; and demonstrate moral responsibility (mindfulness) and emotional competence when the unforeseen occurs.

A Virtuous Process-Experiential Emotion-Focused Therapist Part 2 (Continued)

to promote and safeguard clients' welfare (even by challenging the systems which may work against them). It will assist me in not only helping clients through their problems but to do so competently.

This ethical approach resonates with both my theoretical approach and my personal 'self'. I am drawn to both PEEF therapy and virtue ethics because 'I am me'; because I consider these approaches offer guidance through complex situations. I embrace virtue ethics within practicing PEEFT because it emphasizes the importance of context, relationships, and the notion of self in a greater context. I also appreciate the notion of personal character around 'who we ought to be' rather than 'what we ought to do'. I believe I have unconsciously practiced virtue ethics for years, but now the process is conscious. Perhaps this framework resonates because it is familiar, because it reflects my intrinsic approach to life. According to Bersoff (1996): 'Character traits, though potentially malleable, are developed as a result of genetic endowment and life experiences' (p146).

Therapeutic relationship embodies a new sense of moral complexity and accountability in the practice of understanding (and walking alongside) those who choose, with courage, to reveal the inner parts of 'self'.

The 'virtue' focus on moral qualities encourages reflection on the following:

'Will this ethical response be consistent with the kind of person (character or disposition) I aim to be?'

'Am I imposing my own systems of values/virtues on my clients?'

'Do I have the character traits which will enable me to achieve these ideals?'

'Can these character traits be taught?'

As an ethical imperative in counselling, this framework evokes new awareness of all that must be considered when a dilemma arises in the context of the therapeutic relationship. I have a heightened awareness throughout all stages of the counselling experience, adding layers to the skeleton of theory, and richness to the therapeutic process. This more integrated, global, and holistic approach brings with it a sense of moral accountability and heightened reflection; and a sense of personal congruence between self in therapy and self in a well-lived life. It keeps my approach fresh, and keeps alive the privilege of sharing the personal challenges and victories of others, within my personal vision of growth and excellence. I now consider not only questions about how to resolve a specific problem, but also deeper questions about how I live and the person I wish to be. Therefore there is external gain: virtues in terms of their value for clients; and internal gain, as virtues are of value in themselves. The therapeutic relationship embodies a new sense of moral complexity and accountability in the practice of understanding (and walking alongside) those who choose, with courage, to reveal the inner parts of 'self'.

6. Conclusion

Hillman (1999) says:

Some of what I mean by 'force of character' is the persistence of the incorrigible anomalies, those

> traits you can't fix, can't hide, and can't accept… We are left realizing that character is indeed a force that cannot succumb to willpower or be reached by grace… Character forces me to encounter each event in my peculiar style. It forces me to differ. I walk through life oddly. No one else walks as I do, and this is my courage, my dignity, my integrity, my morality, and my ruin (p181).

In the final analysis, I reflect upon the trust-establishing virtues, including patience, as both a valuable moral beacon for life, and for building and maintaining a trusting therapeutic alliance. Without trust we are formless beings, and we stand alone in bleakness. To elaborate upon Hillman's poignant ramblings: Alone or in relationship, we are human, you and I, he and she, each one unique. Perhaps we all, along with the vulnerable and marginalized, struggle as we walk through life oddly.

I willingly embrace a brilliant theory, and enclose it within a meaningful and resonant ethical framework. I aspire to being a 'virtuous therapist'. It is, with a sense of loyalty … my favorite virtue (or is it a character trait), that I bear witness to the battles, the pathos, the torture inherent in relentless mental illness: all this… but walking proudly alongside 'those others', whose virtues breathe *inherently* with a profound sense of universal applicability: courage, dignity, integrity.

Caroline holds a Master of Counselling and Human Services, Bachelor of Social Work, Bachelor of Education, Diploma of Community Services.

7. Bibliography

Bersoff, D.N. (1996). The virtue of principle ethics. *Counselling Psychologist*, 24, 86-91.

Caputo, J.D. (2003). 'Against Principles: A sketch of an ethics without ethics', in *The Ethical*. Wyschogrod, E. and McKenny, G.P. (eds.). Blackwell: Oxford.

Cohen, E.D. and Cohen, G.S. (1997). *The Virtuous Therapist: Ethical Practice of Counseling and Psychotherapy*. Brooks-Cole: Belmont/USA.

De Certeau, M. (1986). *Heterologies: Discourse on the Other*. University of Minnesota Press: Minneapolis.

Dryden, W. (1985). *Therapists' Dilemmas*. Sage: London.

Elliott, R., Watson, J.C., Goldman, R.N., Greenberg, L.S. (2004). *Learning Emotion-Focused Therapy – The Process-Experiential Approach to Change*. American Psychological Association: Washington, D.C..

Hazler, R.J.and Barwick, N. (2001). *The Therapeutic Environment*. Open University Press: Birmingham.

Hillman, J. (1999). *The Force of Character and the Lasting Life*. Random House: New York.

Jordan, A.E. and Meara, N. M. (1990). Ethics and the professional practice of psychologists: The role of virtues and principles. *Professional psychology: Research and Practice*, 21, 107-114.

Pope, K.S. and Vazquez, M.J.T. (1998). *Ethics in Psychotherapy and Counselling* (2nd Ed.). Jossey-Bass Publishers: San Francisco.

Preston, N. (2001). *Understanding Ethics*. The Federation Press: Leichhardt, NSW.

Sands, A. (2000). *Falling for Therapy: Psychotherapy from a Client's point of view*. Macmillan: London.

Venerable Traleg Rinpoche (Winter, 2002). How does Buddhism deal with religious pluralism? *Australian Buddhist Review*.

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First Aid Strategies That are Helpful to Young People Developing a Mental Disorder: Beliefs of Health Professionals Compared to Young People and Parents

By Anthony F Jorm; Amy J Morgan; Annemarie Wright

Abstract

Background: Little is known about the best ways for a member of the public to respond when someone in their social network develops a mental disorder. Controlled trials are not feasible in this area, so expert consensus may be the best guide.

Methods: To assess expert views, postal surveys were carried out with Australian GPs, psychiatrists and psychologists listed on professional registers and with mental health nurses who were members of a professional college. These professionals were asked to rate the helpfulness of 10 potential first aid strategies for young people with one of four disorders: depression, depression with alcohol misuse, social phobia and psychosis. Data were obtained from 470 GPs, 591 psychiatrists, 736 psychologists and 522 mental health nurses, with respective response rates of 24%, 35%, 40% and 32%. Data on public views were available from an earlier telephone survey of 3746 Australian youth aged 12-25 years and 2005 of their parents, which included questions about the same strategies.

Results: A clear majority across the four professions believed in the helpfulness of listening to the person, suggesting professional help-seeking, making an appointment for the person to see a GP and asking about suicidal feelings. There was also a clear majority believing in the harmfulness of ignoring the person, suggesting use of alcohol to cope, and talking to them firmly. Compared to health professionals, young people and their parents were less likely to believe that asking about suicidal feelings would be helpful and more likely to believe it would be harmful. They were also less likely to believe that talking to the person firmly would be harmful.

Conclusion: Several first aid strategies can be recommended to the public based on agreement of clinicians about their likely helpfulness. In particular, there needs to be greater public awareness of the helpfulness of asking a young person with a mental health problem about suicidal feelings.

Background

Because of the high prevalence of mental disorders in the community, every person will either develop a disorder themselves or have close contact with someone who does. For this reason, it has been argued that members of the public need some degree of knowledge about the recognition, management and prevention of these disorders - what has been termed "mental health literacy".[1] However, surveys in a number of countries have found deficits in public knowledge, including inability to recognize mental disorders, negative views about some standard psychiatric treatments, particularly medications, and positive views about some non-evidence-based interventions.[2-8]

An important aspect of mental health literacy, which has received comparatively little attention, is the initial response of those in the social network when someone is developing a mental disorder. When a person develops a mental disorder, they will often not receive any professional help or there may be delays before they get this help.[9] Nevertheless, the changes in the person's behaviour and functioning are likely to be apparent to family, friends and others in their social network. Indeed, family and friends are seen as important sources of help for mental disorders by both adults and adolescents.[8,10-12] These people are in a position to provide first aid to the person with the mental disorder and to facilitate professional help-seeking. *Mental health first aid* can be defined as the help provided to a person developing a mental health problem or in a mental health crisis. The first aid is given until appropriate professional treatment is received or until the crisis resolves.

A number of community surveys have examined the mental health first aid skills of the public. In a national survey of Australian adults, Jorm et al.[13] presented participants with a vignette of a person with a mental disorder and asked what they would do if that person was someone they had known for a long time and cared about. The responses to this open-ended question were coded into categories. The most common responses were to encourage professional help-seeking and to listen to and support the person, although significant minorities did not give these responses. Other first aid responses were mentioned by only a minority. Of particular concern was the low percentage assessing the risk of harm for a vignette which portrayed a depressed person with suicidal thoughts.

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More recently, Jorm et al.[14] have reported a similar survey of young Australians aged 12-25 years and their parents. The young people were presented with a vignette and asked how they would respond to a peer with the problem. Parents were given the same vignettes and asked how they would respond if this was their child. Only a minority of young people mentioned that they would encourage professional help, even when the vignette portrayed a psychotic person. However, most parents said they would encourage professional help-seeking, although there was a minority who did not mention it. Only a minority of both young people and parents mentioned listening to the person's problems and few mentioned asking about suicidal thoughts.

In a survey of high school students, Kelly et al.[15] asked how they would respond to a peer portrayed in a vignette of either depression or conduct disorder. Around half the sample gave positive social support as their response, but only a minority would engage the help of an adult such as a parent, teacher or school counsellor. Other research has examined how young adults would respond to a suicidal peer and found that many would not tell a responsible adult about it.[16]

While these surveys indicate that the public's first aid skills may not be optimal, there is a difficulty judging the adequacy of their responses, because there is no

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evidence-base or guidelines on what is appropriate first aid for mental disorders. It is not feasible to carry out controlled trials on first aid responses of the public. In this situation, the best guide is probably expert consensus. Here we report the findings from surveys of a range of health professionals on the likely helpfulness or harmfulness of 10 first aid strategies for young people. These strategies were rated for vignettes depicting four disorders: depression, depression with alcohol misuse, social phobia and psychosis. The vignettes focussed on young people because mental disorders often have first onset during youth.[17] Furthermore, young people show a strong preference for getting initial help from their family and friends[11,18] who are therefore a potential source of first aid. Because health professionals vary in the sorts of disorders they have experience with and in the interventions they are trained to use, we sought the views of a range of professions (GPs, psychiatrists, psychologists and mental health nurses) and looked for consensus across these groups. The consensus views of these professionals can then give guidance on what the public should be advised to do. The questions used in these surveys were also included in an earlier national survey of Australian youth and their parents,[14] allowing an examination of any discrepancies between professional consensus and public beliefs.

Surveys were completed anonymously and separate response cards with identification numbers were used to determine participation or refusal.

Professional Samples

Surveys were posted to all 1710 psychiatrists listed on the Medicare Provider File (Medicare is Australia's national health insurance scheme), a random sample of 2000 GPs listed on the File, all 1628 Australian members of the Australian and New Zealand College of Mental Health Nurses, and a random sample of 2000 psychologists listed in the Victorian Psychologists Registration Board's online database of registered psychologists. Surveys were completed anonymously and separate response cards with identification numbers were used to determine participation or refusal. GPs, psychiatrists and psychologists were sent one reminder letter to encourage participation. Completed surveys were received from 470 GPs, 591 psychiatrists, 522 mental health nurses and 736 psychologists. Response rates were 24.0% (GPs), 35.4% (psychiatrists), 32.3% (mental health nurses) and 40.3% (psychologists).

Youth and Parent Samples

The details of these samples have been previously published,[14] so are only described briefly here. In 2006, a telephone survey was carried out with a national sample of young Australians aged 12-25 years. If the young person lived at home with a parent, then one parent was randomly invited to be interviewed as well. Interviews were completed for 3746 young people out of 6087 who could be contacted and were confirmed as in scope, giving a response rate of 61.5%. There were 2925 youth respondents with a co-resident parent, of which 2005 completed interviews, giving a response rate of 68.5%.

Survey Questions

The survey was based on a vignette of a young person with a mental disorder.[14] Participants were randomly given a vignette describing a 15 or 21 year old with depression, depression with alcohol misuse, social phobia or psychosis. The vignettes were written to satisfy DSM-IV criteria and were validated by asking the professionals in the current study what was wrong with the person described. (Over 80% of each professional group diagnosed the psychosis vignette with schizophrenia or other psychotic disorder, the depression vignette with a mood disorder and the social phobia vignette with an anxiety disorder. However, diagnosis of comorbid substance-related disorder was lower, ranging from 26% up to 60% depending on the professional group and the age of the person in the vignette).[19] Vignettes were matched to the gender of youth participants, whereas professionals received only male vignettes due to the smaller sample size and the fact that previous research had shown that gender of the vignette had very little effect on responses.[20] After being presented with the vignette, professionals were asked a series of questions to assess their recognition of the disorder in the vignette, beliefs about first aid, interventions, and prevention, and sociodemographic characteristics. The present paper presents data only on the first aid questions, so these are described in detail here. Professionals were asked whether it would be helpful if a friend or family member were to do various first aid actions, youth were asked whether it would be helpful if they provided the first aid to someone they knew and cared about, and parents were asked whether it would be helpful if they provided the first aid to their child. The first aid actions were: 'Listen to his problems in an understanding way. Talk to him firmly about getting his act together. Suggest he seek professional help. Make an appointment for him to see a GP. Ask him whether he is feeling suicidal. Suggest he have a few drinks to forget his troubles. Rally friends to cheer him up. Ignore him until he gets over it. Keep him busy to keep his mind off problems. Encourage him to become more physically active.' Participants could respond 'helpful', 'harmful', 'neither', 'depends' or 'don't know'. These 10 potential first aid strategies were based on previous work on what members of the public report they would do to help someone with a mental disorder[13] and strategies that are described as either helpful or not helpful by a mental health first aid training manual.[21]

Previous publications on these data sets have covered young people's and parent's beliefs about help-seeking,[22] treatments,[18] the effect of substance use on mental disorders,[23] mental health first aid strategies,[14] stigmatizing attitudes,[24] and awareness of a national depression initiative.[25] There have also been publications on clinicians' beliefs about treatments for depression and psychosis,[26,27] their recognition of mental disorders in young people,[19] and their beliefs about intervention to reduce smoking in people with mental disorders.[28]

Statistical Analysis

Responses were dichotomized in two ways: helpful versus all other responses, or harmful versus all other responses. For descriptive purposes, the percent rating each strategy as helpful and as harmful was calculated by vignette and professional group. To examine differences in ratings according to profession and vignette, multiple logistic regressions were carried out predicting helpful or harmful ratings in the combined professional sample. The predictors were profession (with GP as the reference category), type of disorder in the vignette (with depression as the reference category) and age group in the vignette (with 15 years as the reference category). Because of the large sample size and the number of comparisons examined, the 99% CI was used for odds ratios.

Data on the youth and parent samples have been reported previously,[14] but are reproduced here to allow comparison with the professional data. The major interest is in how youth and parents rate those first aid strategies about which there is professional consensus on helpfulness or harmfulness. A strategy was classified as recommended by professionals if the mean helpful rating across the four professions and the two vignette ages was >70%. Similarly, a strategy was classified as harmful where the mean harmful rating was >70%. These cutoffs were chosen because they well exceed a majority support for either using or avoiding a first aid strategy. Because of the large sample size of youth and parents, even very small differences in ratings of helpfulness could be statistically significant. Therefore comparisons of public with professionals were made in terms of effect sizes, with medium and large effect sizes noted. Following Rosenthal,[29] a medium effect size was defined as a difference in percentages of at least 18 points and a large effect size as a difference of at least 30 points.

Ethics Approval

Approval was given by the University of Melbourne Human Research Ethics Committee.

Results

Table 1 shows the percentage rating each strategy as likely to be helpful, while Table 2 shows the percentages rating each as likely to be harmful.

Differences Across Professions and Vignettes

Additional file 1 shows the results when multiple logistic regression was used in the combined professional sample to examine predictors of rating each strategy as likely to be helpful. The additional file also shows the results when examining predictors of rating each strategy as likely to be harmful.

A number of significant differences were found for helpful ratings. *Listen to problems in an understanding way* was recommended less for psychosis than for depression and less for 21-year-olds than 15-year-olds. *Suggest seek professional help* was recommended less by mental health nurses than GPs and more for 21-year-olds than 15-year-olds. *Make an appointment for person to see GP* was recommended more for psychosis than depression, less for social phobia than depression, and less by either psychologists or mental health nurses than GPs. *Ask whether feeling suicidal* was recommended less for social phobia than for depression and less by psychologists than GPs. *Rally friends to cheer up* was generally not seen as a helpful strategy, but was seen as less helpful for psychosis or social phobia than depression, and was recommended less by psychologists and mental health nurses than by GPs. *Keep busy to keep mind off problems* was not generally seen as a helpful strategy, but was recommended less for psychosis than for depression. *Encourage to become more physically active* was recommended less for psychosis than for depression and less by psychiatrists or nurses than GPs.

There were also a number of significant differences for harmful ratings. *Talk to firmly about getting act together* was rated as harmful more by psychologists than GPs, less for depression with alcohol misuse than for depression alone, and for less for 21-year-olds than 15-year olds. *Make an appointment for person to see GP* and *ask whether feeling suicidal* were rated as harmful more for social phobia than for depression. *Suggest have a few drinks to forget troubles* was rated as harmful less for social phobia than depression and less for 21-year-olds than 15-year-olds. *Rally friends to cheer up* was more often rated as harmful by nurses than GPs and more often for psychosis and social phobia than for depression. *Ignore until gets over it* was more often rated as harmful by nurses than by GPs and less often for social phobia than depression. *Keep busy to keep mind off problems* was more often rated as harmful for psychosis than for depression.

The major interest is in how youth and parents rate those first aid strategies about which there is professional consensus on helpfulness or harmfulness.

Agreement Across Professions

While there are many statistically significant differences, it can be seen from the percentages in Table 1 and Table 2 that the differences are comparatively small in magnitude and that there is considerable agreement across professions about what are helpful strategies. There were also few differences between what was recommended for adolescents and young adults. Table 3 lists the strategies for which there is substantial agreement that the strategy is likely to be helpful or likely to be harmful. Looking across the disorders in Table 3 , it can be seen that there is a lot of overlap in recommendations. The main difference is that social phobia received fewer firm recommendations for helpful strategies.

Differences of Public Beliefs From Professional Views

The asterisks in Table 1 and Table 2 ndicate where there were medium or large differences between public and professional ratings. However, some of these differences are with strategies for which there is not professional agreement. The main interest is where there is a difference from the professional beliefs about first aid strategies summarized in Table 3. With strategies recommended by professionals, the major discrepancy is for *ask whether feeling suicidal* which was less frequently rated as helpful and more frequently as harmful by both young people and parents. Young people were also less positive about *make an appointment for person to see GP*, whereas parents were positive about this strategy, consistent with professionals.

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There were fewer discrepancies between professional and public views for first aid strategies that were seen as harmful by professionals. However, young people and their parents were less likely to see *talk firmly about getting act together* as harmful.

While there were a number of statistically significant differences between professionals in their beliefs about first aid strategies, these were minor compared to the overall agreement. There were also statistically significant but small differences in beliefs about what strategies would be helpful for different ages and different disorders. More impressive was the degree of agreement about which strategies would be helpful across a range of disorders and for both adolescents and young adults. Based on the professional agreement found here, there are key strategies that members of the public can be advised to carry out that would be helpful across disorders and age groups.

Rallying friends could be seen as a type of social support, but it is probably a less effective form of social support than listening in an understanding way.

When beliefs of young people and their parents were compared to these professional views, there were several areas of agreement, such as the value of listening to the person's problems in an understanding way, suggesting they seek professional help, not ignoring them, and not suggesting they use substances to cope. A major area of disagreement was in asking about suicidal feelings, which young people and parents were less likely to see as helpful and more likely to see as harmful. This difference may reflect the lay person's fear that mentioning suicide "might put the idea into their head". The beliefs of professionals are supported by the findings of a randomized trial of screening for suicidal thoughts which found no ill effect and some evidence of benefit.[30] The professionals' views support the content of existing training programs like Mental Health First Aid[31] and Applied Suicide Intervention Skills Training (ASIST),[32] which advise the public to talk openly about the subject if they suspect someone is suicidal.

Other areas of discrepancy were found with strategies not endorsed by professionals. Young people and parents were positive about rallying friends to cheer the person up and keeping them busy to keep their mind off problems. However, while professionals did not endorse these strategies, they did not see them as harmful either. Rallying friends could be seen as a type of social support, but it is probably a less effective form of social support than listening in an understanding way. Keeping busy might have some benefits as a distraction technique, but keeping the person's mind off problems is unlikely to promote help-seeking and treatment. Of greater concern is the endorsement by some young people and parents of talking to the person firmly about getting their act

together, which was seen as harmful by most professionals. There is evidence from studies of expressed emotion to support the view that criticizing a person with mental illness is not likely to be helpful.[33]

This study has a number of limitations. The first aid strategies investigated here are only a small subset of the possibilities and should not be seen as exhaustive. There may be important areas that were not covered by the survey questions. Another limitation is that only health professionals were used as a source of expertise, whereas consumers and carers may have much expertise to offer in the area of first aid strategies. An alternative approach which overcomes these limitations is to carry out consensus studies of what are appropriate first aid strategies using panels of consumers and carers, as well as clinicians. A number of such studies have now been carried out,[34-37] looking for first aid strategies that all groups rate as likely to be helpful. The findings of these studies are consistent with the present results, supporting listening to the person, asking about suicidal feelings, encouraging professional help-seeking, and avoiding negative interactions. Finally, there could be unknown sample biases associated with the low response rate for the professional samples. The response rate was lower than in similar surveys a decade ago[20,38] and may reflect the declining response rates of health professionals to postal surveys in Australia and elsewhere,[39] or the focus of the survey on the youth age group which some clinicians may not deal with in their practice. However, the major interest was in finding strategies about which there was high agreement across professional groups, rather than in precisely estimating the beliefs of each profession from a representative sample. Non-response from clinicians with less interest in youth mental health may actually lead to better quality of opinion, even if less representative.

Conclusion

These findings could be used to guide programs to educate the public about what first aid actions are appropriate. Some basic messages could be promoted universally through information campaigns. More detailed messages would require individual training programs like Mental Health First Aid. For some first aid strategies (e.g. asking about suicidal feelings), there is a need to promote greater public knowledge about appropriate actions. However, for strategies where there is already substantial agreement between the public and professionals (e.g. listening in an understanding way), the need may be to train specific skills rather than to increase knowledge. The existing training programs have been aimed at adults who want to provide first aid to others, including youth, rather than at increasing the first aid skills of young people. Given that young people nominate peers as an important source of potential help for mental health problems,[11,18] some consideration needs to be given to how to provide them with some basic first aid skills. Although adolescents may not be mature enough to provide optimal first aid, the reality is that their peers are already turning to them as a source of help, so some guidance is necessary. If the present

The existing training programs have been aimed at adults who want to provide first aid to others, including youth, rather than at increasing the first aid skills of young people.

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findings were used to guide the content of interventions, it is important that those interventions be evaluated in controlled trials to assess the benefits of the first aid strategies taught.

A major area of disagreement was in asking about suicidal feelings, which young people and parents were less likely to see as helpful and more likely to see as harmful.

References

1. Jorm AF: Mental health literacy: public knowledge and beliefs about mental disorders. *Br J Psychiatry* 2000, 177:396-401.
2. Dahlberg KM, Waern M, Runeson B: Mental health literacy and attitudes in a Swedish community sample - investigating the role of personal experience of mental health care. *BMC Public Health* 2008, 8:8.
3. Lauber C, Nordt C, Rössler W: Recommendations of mental health professionals and the general population on how to treat mental disorders. *Soc Psychiatry Psychiatr Epidemiol* 2005, 40:835-843.
4. Lauber C, Nordt C, Falcato L, Rössler W: Do people recognise mental illness? Factors influencing mental health literacy. *Eur Arch Psychiatry Clin Neurosci* 2003, 253:248-251.
5. Schomerus G, Borsche J, Matschinger H, Angermeyer MC: Public knowledge about causes and treatment for schizophrenia: a representative population study. *J Nerv Ment Dis* 2006, 194:622-624.
6. Angermeyer MC, Breier P, Dietrich S, Kenzine D, Matschinger H: Public attitudes toward psychiatric treatment. An international comparison. *Soc Psychiatry Psychiatr Epidemiol* 2005, 40:855-864.
7. Riedel-Heller SG, Matschinger H, Angermeyer MC: Mental disorders - who and what might help? Help-seeking and treatment preferences of the lay public. *Soc Psychiatry Psychiatr Epidemiol* 2005, 40:167-174.
8. Angermeyer MC, Matschinger H, Riedel-Heller SG: What to do about mental disorder - help-seeking recommendations of the lay public. *Acta Psychiatr Scand* 2001, 103:220-225.
9. Kohn R, Saxema A, Levav I, Saraceno B: The treatment gap in mental health care. *Bull World Health Organ* 2004, 82:858-866.
10. Jorm AF, Nakane Y, Christensen H, Yoshioka K, Griffiths KM, Wata Y: Public beliefs about treatment and outcome of mental disorders. *BMC Medicine* 2005, 3:12.
11. Wright A, Harris MG, Wiggers JH, Jorm AF, Cotton SM, Harrigan SM, Hurworth RE, McGorry PD: Recognition of depression and psychosis by young Australians and their beliefs about treatment. *Med J Aust* 2005, 183:18-23.
12. Angermeyer MC, Matschinger H, Riedel-Heller SG: Whom to ask for help in case of a mental disorder? Preferences of the lay public. *Soc Psychiatry Psychiatr Epidemiol* 1999, 34:202-210.
13. Jorm AF, Blewitt KA, Griffiths KM, Kitchener BA, Parslow RA: Mental health first aid responses of the public: results from an Australian national survey. *BMC Psychiatry* 2005, 5:9.
14. Jorm AF, Wright A, Morgan AJ: Beliefs about appropriate first aid for young people with mental disorders: findings from an Australian national survey of youth and parents. *Early Intervention in Psychiatry* 2007, 1:61-70.
15. Kelly CM, Jorm AF, Rodgers B: Adolescents' responses to peers with depression or conduct disorder. *Aust N Z J Psychiatry* 2006, 40:63-66.
16. Dunham K: Young adults' support strategies when peers disclose suicidal intent. *Suicide Life Threat Behav* 2004, 34:56-65.
17. Oakley Browne MA, Wells JE, Scott KM, McGee MA: Lifetime prevalence and projected lifetime risk of DSM-IV disorders in Te Rau Hinengaro: the New Zealand Mental Health Survey. *Aust N Z J Psychiatry* 2006, 40:865-74.
18. Jorm AF, Wright A: Beliefs of young people and their parents about the effectiveness of interventions for mental disorders. *Aust N Z J Psychiatry* 2007, 41:656-666.
19. Lubman DI, Hides L, Jorm AF, Morgan AJ: Health professionals' recognition of co-occurring alcohol and depressive disorders in youth: a survey of Australian general practitioners, psychiatrists, psychologists and mental health nurses using case vignettes. *Aust N Z J Psychiatry* 2007, 41:830-835.
20. Caldwell TM, Jorm AF: Mental health nurses' beliefs about interventions for schizophrenia and depression: a comparison with psychiatrists and the public. *Aust N Z J Psychiatry* 2000, 34:602-611.
21. Kitchener BA, Jorm AF: *Mental Health First Aid Manual.* Canberra, Centre for Mental Health Research; 2002.
22. Jorm AF, Wright A, Morgan AJ: Where to seek help for a mental disorder? National survey of the beliefs of Australian youth and their parents. *Med J Aust* 2007, 187:556-560.
23. Lubman DI, Hides L, Jorm AF: Beliefs of young people and their parents about the harmfulness of alcohol, cannabis and tobacco for mental disorders. *Med J Aust* 2007, 187:266-269.
24. Jorm AF, Wright A: Influences on young people's stigmatising attitudes towards peers with mental disorders: A national survey of young Australians and their parents. *Br J Psychiatry* 2008, 192:144-149.
25. Morgan A, Jorm A: Awareness of *beyondblue: the national depression initiative* in Australian young people. *Australas Psychiatry* 2007, 15:329-333.
26. Jorm AF, Morgan AJ, Wright A: Interventions that are helpful for depression and anxiety in young people: a comparison of clinicians' beliefs with those of youth and their parents. *J Affective Disord*, in press.
27. Jorm AF, Morgan AJ, Wright A: Helpfulness of interventions for early psychosis: a comparison of clinicians' beliefs with those of a community sample of young people and parents. *Psychiatr Serv*, in press.
28. Lubman DI, Jorm AF, Morgan AJ: Psychiatrists' views of the helpfulness of reducing cigarette use for young people with mental disorders. *Aust N Z J Psychiatry* 2007, 41:705.
29. Rosenthal JA: Qualitative descriptors of strength of association and effect size. *J Soc Serv Res* 1996, 21:37-59.
30. Gould MS, Marrocco FA, Kleinman M, Thomas JG, Mostkoff K, Cote J, Davies M: Evaluating iatrogenic risk of youth suicide screening programs: a randomized controlled trial. *JAMA* 2005, 293:1635-1643.
31. Kitchener BA, Jorm AF: Mental health first aid training: review of evaluation studies. *Aust N Z J Psychiatry* 2006, 40:6-8.
32. Ramsay R, Tanney B, Tierney R, Lang W: *ASIST (Applied Suicide Intervention Skills Training) Trainers' Manual.* Calgary, LivingWorks Education; 1999.
33. Marom S, Munitz H, Jones PB, Weizman A, Hermesh H: Familial expressed emotion: outcome and course of Israeli patients with schizophrenia. *Schizophr Bull* 2002, 28:731-743.
34. Langlands RL, Jorm AF, Kelly CM, Kitchener BA: First aid for depression: a Delphi consensus study with consumers, carers and clinicians. *J Affect Disord* 2008, 105:157-165.
35. Langlands RL, Jorm AF, Kelly CM, Kitchener BA: First aid recommendations for psychosis: using the Delphi method to gain consensus between mental health consumers, carers, and clinicians. *Schizophr Bull* 2008, 34:435-443.
36. Kelly CM, Jorm AF, Kitchener BA, Langlands RL: Development of mental health first aid guidelines for suicidal ideation and behaviour: a Delphi study. *BMC Psychiatry* 2008, 8:17.
37. Jorm AF, Minas H, Langlands RL, Kelly CM: First aid guidelines for psychosis in Asian countries: a Delphi consensus study. *Int J Ment Health Syst* 2008, 2:2.
38. Jorm AF, Korten AE, Jacomb PA, Rodgers B, Pollitt P, Christensen H, Henderson S: Helpfulness of interventions for mental disorders: beliefs of health professionals compared to the general public. *Br J Psychiatry* 1997, 171:233-237.
39. McAvoy BR: General practice postal surveys: a questionnaire too far? *BMJ* 1996, 313:732-733.

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"Coming Together of Neighbours"
Inaugural International Conference on Counselling
10 -11 July 2008

The Coming Together of Neighbours conference held in Hong Kong on 10th and 11th of July was a resounding success. There were delegates from China, Hong Kong, Macau, Australia, New Zealand, India, South Korea, France, Japan, Malaysia, Singapore, UK, Netherlands, USA and Canada; a truly international event.

The conference started on the Wednesday evening with a pre-conference cocktail party held in the Staff Room of Polytechnic University. Most of the presenters were bussed to the cocktail party from Shue Yan University where they were being accommodated. At the cocktail party all the presenters and organisers were able to meet over a glass of wine or soft drink with some very delicious treats put on by the Polytechnic catering staff. The atmosphere was very relaxed and many new friendships were struck. For many of us it was a great opportunity to put a face to what had only been an email address after over 12 months of conversing and organising via email. We all spent several hours getting to know one another and for some, used the opportunity to catch up with old aquaintances. Although the temptation to take advantage of the good food and company was great an early night was had by all as we prepared for the next days' formal opening.

Thursday morning saw a great crowd of people from all walks of life heading into Polytechnic University towards the majestic Jockey Club Auditorium. The auditorium itself is a very impressive and modern building three storey building. The auditorium would be the envy of most Australian theatre owners, let alone Universities, with the polished marble floors of the vestibule to the large circular

staircase leading down to the theatre with its marble rest rooms, plush carpet and seating for over 700 people.

The opening started with the traditional Chinese Lion Dance which is used to exorcise bad spirits and summon good luck and fortune. The performers of this dance are obviously very fit and perform some very difficult and energetic stunts. The Lion Dance was followed by a welcome speech by Professor Thomas Wong, Dean of the faculty of Health and Social Sciences at Polytechnic University.

Professor Wong was followed by the first key note speaker Mr Matthew Cheung the Secretary for Labour and Welfare. Mr Cheung, spoke about professional counsellors and para-counsellors in Hong Kong. His speech would have been very challenging for many Australians as he discussed the need for more para-counsellors to be trained in Hong Kong to complement professional counsellors. Mr Cheung's address and ideas made me very much aware of why it is so important to expose ones self to ideas outside of your own environment. It can be easy to become insular and narrow in your professional views if you limit your exposure to similar environments.

Professor Alvin Seung-Ming Leung, Professor in the Department of Educational Psychology, The Chinese University of Hong Kong followed Mr Cheung with an equally challenging address. Professor Cheung's address was titled "Indigenization and Internationalisation in counselling: Contradictions or Complementation?" Professor Leung spoke about the importance of not trying to implement western ideas and training into the Asian community. Counselling in Asia needed to be specific to the Asian culture and psyche, therefore training needs to reflect this. It is not only disrespectful to suppose western techniques and modalities will work in Asia but it is also arrogant. I found his address to be very uplifting as I reflected on the multicultural make up of Australia yet there is school of thought here that modalities such as CBT fit all.

Morning tea followed the keynotes as we all made our way to Lee Shau Kee building to attend the many and varied workshops and seminars. There were 42 workshops and seminars to choose from over the next day and a half. This did not include the 10 plenary sessions in the Thematic Strand on Marriage and Family Counselling. Presenters came from 11 different countries to share their knowledge and experience with the delegates. The majority of the presenters stayed at the accommodation offered in the student wing of Shue Yan University and were bussed to and from Polytechnic each morning and evening. I was told by several presenters that a feeling of family and camaraderie was quickly developed between the presenters as they shared their accommodation, meals and transport together. Constant contact between presenters from so many countries is uncommon and many believed the experience was well worth it as friendships developed. The accommodation at Shue Yan was very modern with air conditioning, TV's and fridges in each room, with some also having their own bathrooms. The view from many of the rooms was also stunning with the accommodation block situated on the side of a large hill on Hong Kong Island. To have been able to appreciate the same view from a hotel would have been very expensive. Not quite my experience as a student at an Australian university!

The conference came to a close on Friday afternoon which came around all too quickly and was saddened with the realisation that 2 years of planning was now coming to a conclusion. Dr Fai-Chung Hu the Vice President (Administration) of Shue Yan University gave the first closing speech followed by myself. I found it difficult to keep my emotions in check as I looked over the audience and identified the many new friends I had made in the 2 year lead up. Some very special people were Catherine Sun, my partner in crime, who was responsible for getting the majority of our funding through sponsors and had worked tirelessly to keep the project on time by co-ordinating the administrative team led by Jennie Lam. Catherine was able to negotiate the free accommodation for the presenters at Shue Yan and had been in constant touch with me almost on a daily basis through out the planning stage. Alan Jamieson, my Scottish compatriot from the BACP, who had been with me in 2006 when I first conceived of the idea of having an Asia Pacific Rim Conference. Alan had been one of only a few who believed that such a conference was possible and encouraged me to follow my dreams. There was also my friend from New Zealand, Anita Bocchino, who had accompanied me on our site tours.

The closing ceremony saw us all then head off to the post conference dinner which gave one and all an informal and pleasant venue to say our last good byes. The dinner was held at the Kook Yuen Hot Pot Seafood Restaurant in Kowloon. We spent several hours enjoying a splendid Chinese meal with several Certificates of Appreciation being awarded to individuals and organisations who had made significant contributions to the conference. The atmosphere at the dinner was very enjoyable and relaxing with many a glass of wine and soft drink being consumed. One last bus trip was had by all as we headed back to our accommodation with one last opportunity to say good bye to our new found friends. The conference was themed "Coming Together of Neighbours", a theme which was very apt. I can honestly say that at the conclusion of the conference we all parted more as friends than neighbours. I am sure I can say on behalf of all who attended that we all look forward to the next conference in 2010.

Philip Armstrong

2008 Conference Chair

ACA

Inaugural International Conference on Counselling 10-11 July 2008

OPENING CEREMONY



















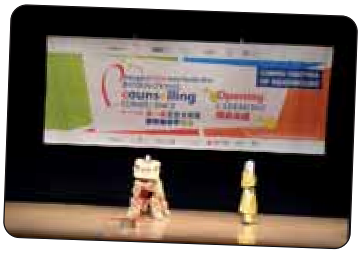








WORKSHOP DAYS





Inaugural International Conference on Counselling 10-11 July 2008
WORKSHOP DAYS































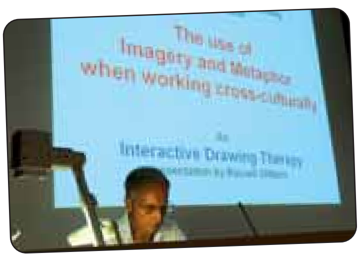

Inaugural International Conference on Counselling 10-11 July 2008

WORKSHOP DAYS








CLOSING CEREMONY
















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Inaugural International Conference on Counselling 10-11 July 2008

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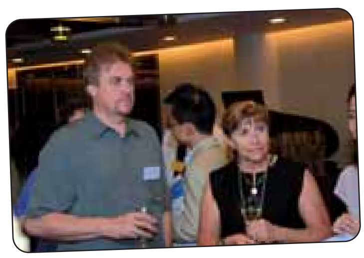
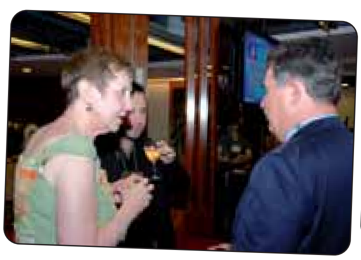
COCKTAIL PARTY




Inaugural International Conference on Counselling 10-11 July 2008

COCKTAIL PARTY

The Paradigm Shift from Counselling to Counselling Supervision

By Veronika Basa

'Supervision has now been recognized as an essential ingredient of counselling training and ongoing counselling support' (Carroll 1996, pg. 4).

In the mental health profession, recognition that supervision is a distinct intervention with its own paradigms is new and has only been evolving in the last decade or so.

For years, supervision has been performed by more experienced members of a profession to teach the less experienced members the craft and tradition of their trade. In the mental health profession, however, recognition that supervision is a distinct intervention with its own paradigms is new and has only been evolving in the last decade or so (Bernard & Goodyear, 1998).

What is a paradigm?

The following dictionaries, define a paradigm as:

1. *'a philosophical and theoretical framework of a scientific school or discipline within which theories, laws, and generalizations and the experiments performed in support of them are formulated; broadly : a philosophical or theoretical framework of any kind'* (The Merriam-Webster Online Dictionary)
2. *'the generally accepted perspective of a particular discipline at a given time; "he framed the problem within the psychoanalytic paradigm'* (http://www.freedictionary.org)
3. *'In linguistics, Ferdinant de Saussure 'a class of elements with similarities.'* (Wikipedia, the free encyclopedia)

Thus, we could define a paradigm as: *'thought patterns or frameworks with its own techniques, concepts, and issues,'* in a particular discipline. To put it into context, we will discuss the paradigm of counselling and counselling supervision and thus the shift in thinking from a counsellor to a counselling supervisor.

What is a paradigm shift?

The term 'paradigm shift' was first used by Thomas Kuhn in his book 'The Structure of Scientific Revolutions' 1962 to describe a *change/shift in basic assumptions within the ruling theory of science.*

To put this term into context, let's have a closer look at the paradigm shift in thought processes from a counsellor to a counselling supervisor; to achieve this we will attempt to consider the components of each discipline in more details and find the similarities and the differences between them. The fundamental

difference may then indicate the shift in the assumptions from one discipline, counselling to the other, counselling supervision, and thus the shift in thought processes from a counsellor to a counselling supervisor.

Definitions

Let us accept the following definitions:

Counselling is *'A principled relationship by the application of one or more psychological theories and a recognized set of communication skills, modified by experience, intuition and other interpersonal factors, problems or aspirations. It predominant ethos is one of facilitation rather than of advice giving or coercion. It may be of very brief or long duration, take place in an organisational or private practice setting and may or may not overlap with practical, medical and other matters of personal welfare'* (Feltham and Dryden, 1993, pg.8).

And

Supervision is *'An intervention provided by a more senior member of a profession to a more junior member or members of that same profession. This relationship is evaluative, extends over time and has the simultaneous purposes of enhancing the professional functioning of the more junior person(s), monitoring the quality of professional services offered to the client(s), she, he, or they see(s), and serving as a gate keeper of those who are to enter the particular profession'* (Bernard & Goodyear, 1998, pg. 6).

Similarities and differences between counselling and counselling supervision

When talking about similarities, both, counselling and counselling supervision require a range of interpersonal and therapeutic skills; some of these skills are fundamental to both roles – for example, both require skills in: listening, hearing, empathizing, reflecting, forming and maintaining a healthy and ethical relationship, supporting, challenging, making connections and intervening at a level which is appropriate to the client/supervisee, all within agreed boundaries of time, regularity, place, confidentiality and payment (Page & Wosket, 2001).

The fundamental differences however, between the two fields are of considerable significance for the practitioner; some of these differences can be described in terms of aims, presentation methods, timing, expectations, responsibilities, and relationship, (Page & Wosket, 2001):

1. **Aims:** The aims in *counselling* is to help the client live a more fulfilling life, whereas in *counselling supervision*, it is to ensure that the supervisee achieves best counselling outcomes by ensuring that the client receives the best and fullest therapeutic use of counselling, and to help the supervisee with skills and resource development, and to be able to reflect upon and to conceptualise the therapeutic process;
2. **Presentation methods:** The presentation methods in *counselling* is up to the client as to how he/she wishes to present his/her dilemmas/issues, usually this is verbal. In *counselling supervision* however, the supervisee's presentation of the client case takes up different forms; this may be notes, verbal, audio/video, or observed/live;
3. **Timing:** The timing and the pace in *counselling* is the choice of the client. In *counselling supervision*, the pace however is determined by the need to resolve the supervisee's issues before the next counselling session;
4. **Expectations:** The expectations in counselling are those of the client, whereas in counselling supervision, are those of the supervisor, who expects the supervisee to attend, prepare for supervision and provide necessary materials.
5. **Responsibilities:** The responsibility to the client in counselling may at times be superseded by moral/legal responsibilities, whereas in counselling supervision it may come before the responsibility to the supervisee.
6. **Relationship** (client/counsellor vs. supervisee/supervisor): The relationships in counselling and counselling supervision have different qualities of containment.

   In the *client/counsellor* relationship the distress and the pain of the client is usually the focus of counselling, as such, the counsellor is subjected to a greater intensity of emotional demand then the supervisor.

Formative evaluation is the ongoing and informal feedback to the supervisee about his/her experiences, and is the bulk of supervision.

The Paradigm Shift from Counselling to Counselling Supervision (Continued)

In the *supervisee/supervisor* relationship the distress and the pain of the supervisee in supervision remains the prime responsibility of the supervisee. The supervisor also provides additional work, such as:

6.1. Holding the counsellor to his/her tasks, and

6.2. Challenging the counsellor in the areas in which he/she is blind, deaf, dumb or numb to client's issues; or assist the counsellor untangle his/her responses to the client by distinguishing those which may come from the counsellor's personal issues from those which may be called up by the client.

The single and the most important paradigmatic difference between counselling and counselling supervision is the evaluative component of supervision to safeguard clients; this is considered to be the nucleus of supervision (Carroll, 1996).

There is a distinction between formative and summative evaluation. Formative evaluation is the ongoing and informal feedback to the supervisee about his/her experiences, and is the bulk of supervision. Summative evaluation is the supervisory report that consists of a more formal assessment of the overall evaluation (Carroll, 1996).

Summative evaluation is the supervisory report that consists of a more formal assessment of the overall evaluation.

The task of evaluation is to (Carroll, 1996):

1. Set up procedures which are used to describe/judge supervisees' performance as competent/effective;
2. Agree on criteria on which judgments will be made;
3. Monitor and evaluate supervisees' work with a view of final decision of the student's/counsellor's future as a counsellor;
4. Implement evaluation procedures via ongoing feedback and formal evaluation (oral/written).

The supervisor has the responsibility to evaluate the trainee and/or supervisee against external set of criteria, criteria that must meet institutional standards but also must reflect national standards of practice; this is assuming that the criteria chosen or derived from professional standards reflects competent counselling practice. The evaluation of trainees is more explicit whereas the evaluation of experienced counsellors is more implicit. Evaluation is also the supervisor's source of interpersonal influence on the supervisee as it provides supervisees with an additional external motivation to change and evolve (Bernard & Goodyear, 1998)

Thus, the evaluative component of supervision makes supervision a distinct intervention, and despite its importance in counselling supervision, it causes discomfort to many supervisees and supervisors (Bernard & Goodyear, 1998):

Supervisees may experience discomfort with evaluation due to:

The evaluative role of the supervisor – this effects the supervisees' perception of the supervisor; they find themselves being thought/mentored and also evaluated by their supervisor against performance criteria which are subjective and ambiguous as a result of evaluating skills being highly complex, personal and difficult to measure (Bernard & Goodyear, 1998);

Power issues - as the evaluation procedures are normally one way, directed towards the supervisee, by its nature, it creates power issues where one person, the supervisor, is the judge and the other, the supervisee, is being judged even in more desirable environments in which the evaluation is a continuous process that is shared and discussed prior to it commencement with the supervisee in a positive relationship with the focus being on the supervisee's work and not on supervisee as a person, and supervisors create space and opportunities for supervisees to evaluate supervisors in this unidirectional evaluation (Carroll, 1996).

Supervisors may experience discomfort and anxiety with evaluation due to:

- *Background training* - the counsellor's role is non-evaluative and none-judgmental – in fact in many cases this non-evaluative component of counselling would have been the reason to their attraction to counselling (Bernard & Goodyear, 1998);
- *The view* - that evaluation interferes with their teaching/mentoring, counselling or consulting roles (Carroll, 1996).
- The *subjective* and the *ambiguous* nature of the performance criteria against which they are expected to evaluate supervisees' performance. .

Evaluation is still at its developmental stage – according to American Psychological Society (APA) there is no research that connects training with competence, i.e. there's no evidence that any counsellor training programs are related to professional competence. Until research determines what is essential for supervisees to learn under supervision, the criteria for evaluation remain a problematic area (Carroll, 1996).

Veronika Basa is a Clinical member of ACA and a member of SCAPE. Veronika holds MA Prelim. (Ling.), BA., Dip. Ed., Dip. Prof. Counselling., Cert. IV in TAA.

For further information on Veronika and the Cert IV on Supervision www.becsonline.com.au

References:

Association of counsellor education and supervision (ACES): *'Ethical guidelines for Counselling Supervisors'* Executive Counsel and Delegate Assembly, March, 1993.

Colin Feltham, 1999 *'Understanding the Counselling Relationship'* Sage Publications P/L (Feltham, 1999)

Collin Feltham, 1995 *What Is Counselling?: The Promise and Problem of the Talking Therapies,* Sage Publications P/L (Feltham, 1995)

C. Feltham and Dryden, 1993 *'Dictionary of Counselling'* Sage Publications P/L (Feltham & Dryden, 1993)

Janine M. Bernard & Rodney K. Goodyear, 'Fundamentals of Clinical Supervision' Second Edition, ALLYN & BACON, 1998

Michael Carroll, Elizabeth Holloway, 1999 *'Counselling Supervision in Context'*, Sage Publications P/L (Carroll & Holloway, 1999)

Michael Carroll (1996) *'Counselling Supervision: Theory, Skills and Practice'* (Carroll, 1996)

Steve Page & Val Wosket (2001) *'Supervising the counsellor: A Cyclical Model'*, Brunner-Routledge; 2 edition (Page & Wosket, 2001)

ACA

Money Masochism and Financial $adism, A Match Made Online By Angela Lewis PhD

Abstract

The Internet has provided unprecedented opportunities for people to start new businesses and make lifestyle choices which may have been unheard of in years gone by. This article describes a relatively new and little known phenomenon which only exists online: financial domination for erotic pleasure.

Introduction

> *Hey little piggie…I WILL take your wallet, I WILL drain you dry…, you will spoil ME and you will get trained to be My perfect human ATM (from the website of a German Money Mistress).*

Money Masochism, (also known as 'money slavery') describes the practice of men giving money or gifts to a woman (or a succession of women) and deriving erotic pleasure from doing so. This practice is completely intentional; either performed under 'voluntary duress', whereby the man role plays being coerced to 'gift' or 'tribute' the mistress, or does it simply as an act of worship and devotion.

A variety of terms can be used to describe the practice of money slavery, including financial servitude, cash fetish, financial domination, financial rape, wallet raping or extreme spoiling. The women who offer these services refer to themselves variously as a Money Domme, (using the female form of dominant in the BDSM sense), Financial Dominant, FinDom or Money Collector. The women also frequently incorporate the title 'Mistress' or 'Goddess' into their titles, (e.g. Mistress Helga or Goddess Petra), as this fits nicely with a profile that relies heavily on subjugation, worship and adoration. They are many online advertisements for these types of services, including videos on the YouTube website.

Some of the pejorative terms used to describe the money masochist (who is almost universally a man), include money slave, human ATM, pay pig, paybot, pay piggie, servant, cashpet, sissie, cash cow and Loser (generally with a capital L, the only capital letter ever used in relation to a money slave).

The practice of money masochism has its roots in a dominance and submission dynamic, with the Money Mistress taking the role of dominant and the money masochist taking the role of subordinate. Dominance and submission in an erotic sense is characterised by a consensual *exchange* of power so that one partner dominates the other either physically or mentally, however while physical domination may not always be present, for practitioners of domination and

Money Masochism is completely intentional; either performed under 'voluntary duress', or 'tribute', and is simply as an act of worship and devotion.

Money Masochism and Financial $adism, A Match Made Online (Continued)

submission (D/s), mental or psychological domination will always be present. Contemplation of these practices may appear alarming to those who do not find them attractive, given that they may mimic situations such as slavery, abusive parenting or misogyny (Easton and Liszt 2000), however the accounts of those that enjoy voluntary dominance and submission are highly complimentary and for some can more important to their sexuality than physical stimulation (Alison, Santtiilla, Sandnabba and Nordling 2001).

Show Me the Money: How It Works

As is the case with the two Money Mistresses I interviewed (see below), many of the Mistresses began their careers as phone sex workers or continue to use this avenue to attract new customers. All the women advertising themselves as Money Mistresses are very clear about what they require and their terms of operation, as this sample from the website of Mistress Annika attests:

> *I am a spoiled bitch who loves the sound of My [sic] slaves spending all they have in the mere hope of being allowed to express their worthless selves to Me. I expect total obedience from My whores, and I expect to be Spoiled and Treated Lavishly. I am not interested in seeing you grovel in person, you will be lucky to speak with Me on the phone, and to view images of My glorious Big Beautiful Body.*

Once she takes him on as her slave she will require various forms of remuneration ranging from regular tributes, to requiring the money slave to make regular monthly payments for her manicures, pedicures, hairstylist or gym membership, or contributing towards to her holiday expenses.

The terms of engagement generally involve a first step of sending the Money Mistress an initiation fee (the amount varies), so she may consider whether she wishes to begin a relationship with the man. Once she takes him on as her slave she will require various forms of remuneration ranging from regular tributes, (which are preset amounts ranging anywhere from $25 to $100), to requiring the money slave to make regular monthly payments for her manicures, pedicures, hairstylist or gym membership, or contributing towards to her holiday expenses. Some Money Mistresses maintain gift lists at various department stores similar to a wedding registry and the money slave can use this to order online and have the articles delivered to her. Transactions and money tributes are done online through a third party such as PayPal or credit card debit, or the mistresses get cash sent to a post office box or via a money order. It is very rare for a money slave and money mistress to ever meet and the relationship is limited to emails, MSN messenger, web-cam and the mistress sending photos or allowing telephone calls – all dependant on whether the man has gifted or paid amounts that have pleased the mistress.

As one mistress so succinctly writes on her website:

> *You know you are just salivating to spend some of that f***ing money on Me, and here is your chance. Here is how this works, you want to buy something for Me, you send the f***ing money to ME, and I buy it. If it is something I will wear on cam (I will not wear anything exceptionally revealing on cam) you will be able to request that I wear it during a cam session you have scheduled separately. If it is not something I will wear on cam, you can get your jollies knowing I am f***ing other men wearing something you bought for Me.*

Some Money Mistresses also provide a blackmail domination service. How this works is that the man voluntarily fills out an application form with his name, address, employer details, the phone number of his wife or girlfriend and discrediting information of his choosing, which he then submits it to the Mistress. The money slave is then required to pay the mistress to avoid having this information revealed publicly. Disturbing as this sounds, the blackmail is generally always negotiated to run for a specific time, with a buy out clause at the end.

THE AUSTRALIAN SOCIETY OF CLINICAL HYPNOTHERAPISTS

RELATIONSHIPS

ONE DAY WORKSHOP

18th October, 2008

COLLEEN HIRST – *"You Said What!?"*

Exploring The Communication Variable In Intimate Relationships

Colleen Hirst is a registered psychologist, with a Masters degree in Family Therapy. She has been a practicing counsellor for over 28 years and is currently in private practice based in Merrylands, NSW. This presentation will be interactive and fun!

JO-ANNE BAKER – *"Key Ingredients To Making A Relationship Work"*

Jo-Anne will discuss the key ingredients that make a relationship work. Her focus will be on imparting techniques and tools that she has found successful in her own practice. Jo-Anne will discuss how couples can priorities their relationship, develop better skills in understanding one another and how conflict can work successfully with good communication. Using case studies she will also look at how a couple can spice up their sex life, what are the key factors essential to have an on-going loving relationship and also how relationships change as we age.

LIDY SEYSENER – *"T.A. In Relationships and Game Therapy"*

Lidy has twenty years experience as a Counsellor/Psychotherapist. She is also a Transactional Analyst, Hypnotherapist, NLP Master Practitioner and Family Law Mediator.

This presentation will focus on the way Lidy works with couples from a T.A. perspective, focusing on the 'Five Phases of Relationship' and on 'The Games People in Relationships Play'. Lidy will also share with you her most recent book – 'Relationships – A Couple's Journey'

MARY MCGUINESS *"16 Different Personality Types - 16 Different Ways of Relating"*

Mary McGuiness has 21 years of experience teaching about personality theory and training professionals to use Myers-Briggs Type Indicator. She is the founding Director of the Institute for Type Development, a national training organisation that provides Accreditation in the use of the Myers-Briggs Type Indicator. Mary is an international keynote speaker and has published three books. In this session we will explore the personality types described by Carl Jung and Isabel Myers, focusing on how each type communicates and how each deals with conflict. There will be some interactive exercises designed to provide insights into how to enhance the quality of relationships.

Time	9am registration for 9.30am start	
Date	18th October, 2008	
R.S.V.P.	**8th October, 2008**	
Venue	Ryde Eastwood Leagues Club 117 Rydale Road, West Ryde	
Cost	Member Early Bird – for cheques arriving **before 8th Oct**	$65.00
	Member	$85.00
	Non Member Early Bird – cheques arriving **before 8th Oct**	$85.00
	Non Member	$105.00

NB. Membership rates apply to ASCH members only.

Please make all cheques payable to the ASCH and post to

Wendy Bunning
51 Nalya Road Berowra Heights
NSW 2082

Money Masochism and Financial $adism, A Match Made Online (Continued)

These exchanges of money or goods involve no sex or physical interaction; instead the men willingly exchange cash and gifts for the opportunity to be psychologically humiliated, in ways that are mandated by what their own erotic requirements. While the humiliation is generally governed for the size of the tribute or gift, that communication is mostly limited and will vary according to the Mistresses. If the mistress gives the slave any attention in terms of personal contact, it may be to talk with him about how what he is doing is benefiting her life (e.g. 'I just had a wonderful holiday, thanks Loser'). If the slave wants to climax he will need to get the Mistress's permission, which involves paying for the priviledge of her permission to do so. While the relationships always operate in a strictly one way dynamic, with a money slave unable to ask anything in return from the Money Mistress, the professional Mistresses ensure they tailor 'a program' around the needs of the slave, to ensure they are getting their needs met and remain a worthwhile and paying client. For example, a man may want to wear a nappy in his private time, however he needs to be dominated or forced into doing this. He would let the Mistress know of his requirements and then when he pays her a financial tribute she tells him he has to wear a nappy, take a photo of himself and then send it to her. While attention from the Mistress can consist of email or telephone calls, it always involves humiliation. This humiliation takes various forms depending on the people involved, but may include having the money slaves being told to perform degrading tasks, being verbally castigated, having derogatory posts made about them on her website, being constantly harangued for more money, being told to wear women's panties or clothing, or not being allowed to climax; or some other humiliating task or activity that the Mistress knows the slave craves.

She maintains that the pictures of her on the website (despite not actually being of her), are very close to her own physical representation.

Over the course of a number of interviews, two Mistresses were kind enough to share some insights in their careers. I begin with Mistress Malika (not her real name), a 32 year old woman from Canberra Australia, who shared some of her philosophies on dealing with her money slaves.

> *Firstly I need to think about how much I can actually get from this guy, because after all this is my business and my time is my investment. I need to sort out if this is a man with deep pockets, or just full of big talk, or one I might have on a long term cash drip. He may be the sort I will only benefit from in terms of one big hit as he may not have the attention span or interest to make a long term commitment and I need to take that onboard.*
>
> *Another aspect I have to consider is how far I can push him in ways that will ensure he pays. It is a known fact that money piggies have different levels of tolerance, so for that to work successfully for both of us, I have to understand him. For example, for some I may need to be quite aggressive and speak harshly in ways that are bossy or intimidating, while with others it is more a process of seducing them into giving up the money while still letting him know who is the boss – me of course. All this takes my time and consideration, so I feel I do earn the money.*
>
> *Keeping a man around for an extended period of time is probably the most important to me and ideally I am looking to lock him into a long term payment schedule as this takes less work then starting up new guys all the time. But I have so many clients at the moment that I don't stress myself too hard over this aspect.*

Mistress Malika occasionally works as a phone sex operator to supplement her financial domination business as she finds the business peaks and troughs, given that her pay pigs also have personal financial obligations as well as supporting her lifestyle. She will not conduct web-cam sessions and only provides her money slaves with emails and some MSN messenger chat as she has young children and as such is extremely careful about guarding her identity. She maintains that the pictures of her on the website (despite not actually being of her), are very close to her own physical representation.

This is in sharp contrast to Mistress Michelle (her real name), who shares her activities with friends and family (aside from her parents) and uses her real Christian name.

My friends love it and a lot of the time I'm with them and they get to witness everything that goes on. They love to laugh at all my Losers and all the different fetishes. I think I have shown them a whole new world that they never new existed. I also use a couple of my girlfriends on occasion too if the piggy wants to be used by two.

Mistress Michelle was very generous with her time in having a number of email conversations with me around her career as a Mistress. Michelle differs from many of the other Mistresses online in that she visually presents herself honestly as herself, and provides quite a lot of free material in the form of YouTube videos. This is in stark contrast to many of the Mistress websites online, most of whom try to present more in terms of what one would expect from a model, i.e. someone glamorous, young, nubile, sexy and thin. There is of course no guarantee that the images of the model like creatures the men are looking at are the real photos of the Mistresses and it has been known to happen that the 'Mistresses' are in fact men themselves, taking advantage of a lucrative market (Durkin 2007) . Michelle on the other hand is a 45 year old mother from the Southern states of USA. She does not use fake model shots and is in an age bracket that many might consider a detriment to her success in this field; however this has not been the case. Michelle began her career as a phone sex worker and when she stumbled on men who enjoyed financial domination she started her own website.

Initially she felt she had to hide her own identity and put up modelling shots of other women, however this proved problematic when men required personal photos and some web-cam time, so she made the move to being herself and has not looked back. She calls the exchange of cash and gifts 'spoiling' and refers to her men as 'losers' showing their photos and tributes on her website, 'drainyourwallet.com'. She is particularly proud of the relationship she has had with one loser for the past 5 years:

I have one REALLY good Loser….I call him my "Number One Loser." I've owned him for 5 years and I've taken $87,000 from him. The first night I took $5,000 and I couldn't believe it! I figured that would be the last time I would hear from him and in a couple days he was making contact and wanting me to take more. Long story short….the first week I took $25,000! It is getting harder and harder for him to do any these days but he still makes the effort!

Mistress Michelle's clientele vary across a wide spectrum and include professionals such as lawyers and doctors as well as some men who 'do the best they can' to spoil her while only making minimum wage. Despite spending a long time in this industry, Michelle freely admits she still doesn't know what really attracts them, but relies on the fact that what she terms 'the little head' does the thinking for them and its how she is able to control them. I found Mistress Michelle to be different to others in this

There is of course no guarantee that the images of the model like creatures the men are looking at are the real photos of the Mistresses and it has been known to happen that the 'Mistresses' are in fact men themselves

Money Masochism and Financial $adism, A Match Made Online (Continued)

market in that she displays a type of respect and humanity in her videos and taped chats that is at odds with what she does and is completely different with how the other Mistresses present themselves and this was actually what motivated me to contact her at the outset. So while she does practice financial domination, she presents herself honestly and genuinely tries to cater to the needs of 'her losers'. She also believes in positive reinforcement and for her that comes in the form of supplying a special picture, personalised audio message or gift of a personal item. If they have been particularly 'good' in terms of spoiling her, she also spends time having one to one chat time with them.

Getting What You Pay For

While the world of financial domination seems to be full of behaviours and practices that appear to be totally one way, the money masochist does it voluntarily because it fulfils his own particular needs, which while they vary according to the individual are predicated on experiencing some type of psychological pain or humiliation that comes from experiencing force (Llewellen 2001). As described previously, this practice falls into the world of BDSM, with the Internet providing a postmodern opportunity that allows for another manifestation of masochism that was not really possible before the World Wide Web. Research actually shows that most self-identified masochists are well educated, well adjusted and sexually creative individuals (Sandnabba, Adademi, Santilla and Nordling 1999), who generally enjoy a level of wealth and status (Baumeister and Butler, 1997). Given that this segment of society are generally the forerunners in both adopting new technology and using it in innovative ways (Cooper 2004), it is perhaps not surprising that some masochists have found another way to experience their particular form of erotic fulfilment that is facilitated by technology.

The few blogs that are maintained by money slaves almost universally focus on the worship aspect and many connect it to a personal religious experience.

For some men the mere process of making payments to a strange woman is reported as completely arousing; as one money slave framed it:

> *The act of paying is just so mindblowing. When I see how much I have paid her I always masturbate with the credit card statement wrapped around the hand that is holding my dick.*

The Money Mistresses are also well aware of the level of excitement related to paying them and many make references to 'wallet raping' on their websites as an enticement, as well as making frequent associations between the giving of money and sexual fulfilment.

For other men practicing money slavery may be intertwined with a need to pay a type of penance in a Catholic sense, because on some level the man feels he is unworthy of being in contact with a powerful 'goddess figure' unless he sacrifices something valuable, which in this case is money. The Money Mistresses appear to understand this motivation all too well, as they all rely heavily on promoting their goddess stature, as this Mistress describing her services below:

> *I am a Goddess of exquisite tastes. I will rape your wallet and leave you begging to send Me more tributes and gifts. I have zero compassion for nasty little cumsquirters like you, you are completely worthless except to be My little cash piggy and My complete and total slave.*

The few blogs that are maintained by money slaves almost universally focus on the worship aspect and many connect it to a personal religious experience, characterising themselves as worshiping at the 'church of their goddess', or describing their devotion in terms of their 'religion' as this sample shows:

> *…by buying You gifts, giving You money and being Your slave I have my sole purpose in life now. It has become clear to me that this worshiping you is the real reason for me being. The meaning of life is all about trying to please You, even though I* [sic] *will never come close to pleasing You it will be my eternal pleasure, trying by giving all I can give, knowing it will never be enough in the face of your eternal greatness and goodness, a power so much greater than anything on this earth* (anonymous money slave).

It is an accepted fact that in most cases the gifts or money paid by the money slave garner very little attention from the money mistress (or $adist as some call them). This means that when they do receive a mention on her website (a common practice is to list which money slave tributed or gifted what, in a type of honour role scenario), they are motivated to spend more in order to receive continued attention in the form of an online mention, or even to receive a personal email. In this way the process continually feeds into the money slave's masochistic tendencies.

The now defunct 'Money Masochism' group on Yahoo ran a poll among members and in response to the question "How much attention does an MM REALLY need from his $adist?" 50% of the money masochists who responded said they only needed attention once a week or less and almost 25% stating once every other week or less would sustain their obsession and the relationship. An overwhelming 85% of those surveyed said that phone, email and chat were sufficient, with no 'in person' contact with the mistress deemed necessary.

And finally, when asked what type of communication a money slave needed from his Money Mistress, 47% agreed with the statement that 'simple reminders or threats about making their payments on time' or 'acknowledgement of receipt of their payment or completed assignment', would be acceptable to them.

Based on this poll, it would seem that many money slaves can exist on very little attention or contact and therefore do 'get what they pay for'. As one devotee explained it:

> *Because I am absolute worthless pile of shit, I will devote my entire being to worshipping & serving my Goddess, whether she acknowledges my worthless life or not.*

Most of the women who act in the role of Money Mistress understand the requirements of the role, as they uniformly present themselves online in the character of a powerful, sometimes shrewish, always demanding 'uber-woman' who is entitled to money, worship and adoration. So in this respect they fill a market niche, as they provide an ideal that some men are both seeking and willing to pay for.

However regularly buying gifts and sending money must have some negative consequences for the men concerned and it is entirely possible that some are forsaking their own financial obligations or creating a situation of debt for themselves because they are addicted to worshipping their mistress. As Goddess Krystal reminds us….

> *All that you are you will give up once I own you. Your whole life will be devoted to acquiring for me all of my desires, whims, even things I know not yet that I want….*

Lingo

Cumtax – paying money in return for being allowed to climax (alone).
CPA certified paypig abusers
FinDom – financial domination
Pay pig – Money masochist
Human ATM – Money masochist
Money Mistress – a woman who is given money, gifts or tributes voluntarily by men who she may never have met in real life.
Whore – a money slave in a relationship with a Money Mistress

Acknowledgements:

Thank you to Mistresses Michelle and Malika for their time in sharing their insights with me. Mistress Michelle's website can be viewed at www.drainyourwallet.com and her daughter's website at www.princessamanda.com.

References

Alison, L, Santila, P, Sandnabba, N.K. and Nordling, N. (2001). Sadomasochistically-oriented behavior: Diversity in practice and meaning.' *Archives of Sexual Behavior*'. Vol 24, pp.631-654.

Baumeister, R. and Butler, J. (1997). *Sexual Masochism: Deviance without Pathology*. Erlbaum, New Jersey.

Cooper, A. (2004). 'Online Sexual Activity in the New Millennium' *Contemporary Sexuality*, Vol 38, No. 3, pp i-vii.

Durkin, K. (2007). 'Show Me the Money', Journal of Deviant Behavior, Vol 28, No. 4, pp. 355-378.

Easton, D and Liszt, C. (2000). *When Someone you Love is Kinky*. Greenery Press, Oakland.

Llewellen, R.E. (2001). *Origins and Definistions, Sexual Sadism and Masochism*. Irvington Publishers, New York.

Sandnabba, N.K. Adademi, A., Santilla, P. and Nordling, N. (1999). 'Sexual behavior and social adaptation among sadomasochistically-oriented males'. *Journal of Sex Research*, Vol 30, pp. 1-13.

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Regularly buying gifts and sending money must have some negative consequences for the men concerned and it is entirely possible that some are forsaking their own financial obligations or creating a situation of debt for themselves because they are addicted to worshipping their mistress.

Deregistration Notice

The ACA would like to clarify a deregistration notice that appeared in the Winter 2008 edition of the Counselling Australia Journal. The journal outlines the deregistration of a Mrs L. Cross. Since the ACA has more than one member that could fit this description, it is important that we further elaborate on this deregistration.

The ACA member who has been deregistered from the ACA is:

Mrs Linda Cross
ACA member number 2844

We apologise for any ACA member who was negatively affected by this printing error.

If you have any further questions or queries please don't hesitate to contact ACA.

Kind regards
Marissa Price, ACA Administrator

Ms Sherring is to undergo a 1 year educative probationary period.

Book Reviews

Happy Parents Happy Kids
By Terrence McClendon

Human Values & Ethics in the Workplace
By Glen Martin

Overcoming Depression and Low Mood
By Chris Williams

Happy Parents Happy Kids

By Terrence McClendon MA

Every now and then, an inspirational gem appears to guide parents in nurturing the development of their children. *Happy Parents Happy Kids—Words and Actions for Parents and Kids*, written by Terrence McClendon, MA, presents parenting issues from a unique perspective that offers guidance and encouragement to parents in their special work of forming children into responsible, balanced and mature individuals.

McClendon's work is far from the "shoulds" and "should nots" that underpin the usual ten commandments of good or successful parenting. Rather, this author invites a reflective and thoughtful approach that evokes positive responses from children as they begin learning basic life skills and engage in balanced meaning-making around the complexities they will encounter in their young lives. Through studying this easy-to-read book, parents are encouraged to reflect upon, and develop, new ways of communicating with their children, tapping into language that evokes positive responses from them.

Special emphasis is placed on useful techniques and strategies embedded in the way parents use this language of communication. This is known as the Neuro-Linguistic Programming approach that has a profound influence on stimulating an individual's awareness of what is heard, seen or felt, and then orienting one's responses according to each particular person's sensory orientations. Parents will learn new ways of intentionally 'knowing' their children, communicating with them as unique individuals, and discovering what works with each one. Practical application of McClendon's pointers will transform parenting, through the creation of a particular rapport and congruence with each child.

Above all, McClendon's book highlights the fact that being a parent involves far more than biological reproduction, the provision of nourishment and shelter, and general care of children. Parents (teachers, carers, and counsellors) will be stimulated to find new strategies that foster cooperation and maturity with those who are given into their care.

Reviewed by Teree Spencer

Human Values & Ethics in the Workplace

By Glen Martin

Published by G. Martin, Sydney 2007 ISBN 9780980404500 (pbk.).

This book asks a very important question: ***"Is it possible in the current business environment to work and lead with integrity and values?"*** As Permanent Chair of the Australian Counselling Association's Complaint's Tribunal I was particularly interested in this question posed by Mr Martin.

In his introduction Mr Martin acknowledges that, "…many people do not believe it is possible to work ethically or with integrity." One would hope that the "many people" does not include many counsellors! However, I do know some who think they can walk a very delicate, and invisible, tightrope by treating their clients in session in a different manner from the way they treat them and others in the course of the business aspects of their practice. I do not personally believe this is really possible and therefore am glad that Mr Martin shows such people an ethical and integrity laden way forward that involves no such mental gymnastics!

As all such texts must, Mr Martin begins with an analysis of core human values. I say must because it is here, if anywhere, that we must go if we seek to develop what he calls "a framework for conduct". Mr Martin starts by determining five basic core values and then relates them to seven differing world views – examining the place of each value within each specific world view. Of course, no list of world views could hope to be exhaustive, nor could any one view encompass the entirety of any one person's outlook on life, however one can't help but feel that Mr Martin has done a good job here and much of what he says makes good sense.

Having established these core values and system of world views (which he sees as being evolutionary - much in the same way as occurs in Kohlberg's stages of moral development) he goes on to show how *understanding* these systems enables us to foster positive ethical behaviour in the workplace among both workers and employers.

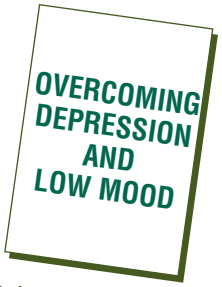
All in all Mr Martin presents a very positive picture of what is not only possible but also practical and rewarding for those workplaces that take such an action plan on.

I do recommend this book for its valuable insights.

Reviewed by Adrian Hellwig

Overcoming Depression and Low Mood

A five areas approach by Chris Williams



This book is full of key skills that teach you how to discover why you feel as you do, Key Skills that you can use to improve things. Self-help approaches are being used to help you overcome problems of Low Mood and Depression. This book has many self-help materials to show in many different ways. The resources in this book could be used for yourself, a family member needing to know more about Depression and Low Mood, or perhaps close friends.

Some things you can get out of reading these work books:

- Discover how you feel as you do
- Develop better problem solving skills
- Re-balance relationships by becoming more assertive

- Become more active and rediscover the fun in life
- Build helpful responses to life stresses
- Discover how to sleep better
- Learn how to change negative and undermining thinking
- Stop reacting in ways that backfire
- Make choices that boost a healthy lifestyle
- Plan for the future in order to stay well

Depression and Low Mood are common and can affect many lives, as no one is immune from depression. The content of these workbooks are based upon the Cognitive Behavior Therapy (CBT) approach, to help change certain thoughts and behavior patterns that can have a significant impact on improving how we feel. Each of these work books inform you and teach you important in formation about how Depression and Low Mood can affect us.

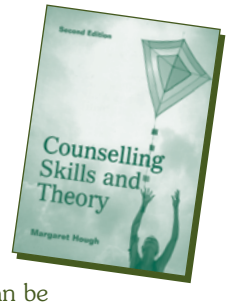
This workbook covers:

- An introduction to the course
- A brief introduction to Low Mood and Depression
- An overview of the five are as approach to understanding Low Mood
- Optional information on how to overcome common blocks/problems in making changes
- How to get the most out of the course workbooks
- A summary and practice plan
- An appendix with a learning achievement record sheet

The CBT approach used in these workbooks are attractive to many people becuase it is practical and focuses on problems they face now. CBT is a very affective way of improving Low Mood. These workbooks are easy to follow and I would certainly recommend to anyone dealing with such people or themselves to read, as this book offers much help when experiencing Low Mood and Depression.

Reviewed by Robyn Johnston

Counselling Skills and Theory: Margaret Hough. 2 edition



Written by Margaret Hough

(Hodder Arnold-UK)

It was with a little dread that I approached the task of reviewing a book titled "Counselling Skills and Theory" for as we are all aware, theory can be dry and tedious! However it was not so with this book! My background in training and teaching counselling students with AIFC has had me wading through many a training book. This one was quite engaging! It aims at teaching the foundational basics of counselling up to the diploma level. It skillfully covers all the main counselling approaches with great clarity whilst interspersing frequent "case studies" (real life scenarios) to bring to life the theory. There are excellent exercises interspersed for students to do in groups, ideally with a trainer.

Margaret Hough draws out similarities, core skills, strengths, and limitations for all the main counselling approaches. I was pleased to see that she also draws the student counsellor towards a wholistic approach to counselling where the care of the body (nutrition, exercise etc) is not neglected. The final chapter emphasized thoroughly the ethics vital for the basis of all good counselling.

There is an excellent chapter on group work which is becoming more widely accepted as a context in which great teaching, healing and growth can occur. I have personally seen the great healing that takes place in small groups with my involvement in various care/recovery groups within a church/community context and so was pleased to see the inclusion of this modality.

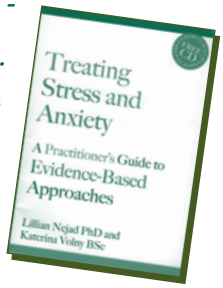
At the end of each chapter there are a wide variety of helpful references, further reading and resources including web sites. However this being a British publication, many of the resources quoted are from the UK as are the quotes regarding ethical standards which are taken from the BACP (British Association for Counselling and Psychotherapy). I did not see any references, further reading or resources of Australian origin.

Overall, as an introductory text for students of counselling Margaret Hough's contribution is relevant and well presented. It was quite a delightful task to review this book.

Reviewed by Dr Paula Tan

Counselling Skills and Theory: Margaret Hough. 2 edition
Written by Margaret Hough

Treating Stress and Anxiety - A Practitioner's Guide to evidence-Based Approaches.



Camarthen, Wales: Crown House Publishing. Nejad, 1. & Volny, K. (2008).

This is by far the most practical and useful book I have come across, filled with innovative evidence-based approaches for dealing with various forms of stress and anxiety and stress related difficulties It is a textbook and guide that can be used by clinicians, therapists and educators across the health professions and has the added bonus of numerous helpful ready to use handouts, as well as a supplementary CD. The authors have skillfully attended to a range of theoretical perspectives, including medical, biological, biopsychosocial and psychological and counselling theories.

Beginning with a clear and succinct explanation and overview of stress and anxiety, the authors then demonstrate forms of assessment, not only for the clinician but also for the clients themselves, enabling those to address the stigma that may be associated with mental illness. Much research evidence has been provided to show the usefulness of Cognitive Behaviour Therapy in the treatment of anxiety disorders and the authors highlight the helpfulness of this alongside appropriate medications. Just as importantly, the authors examine practical and positive approaches to maintaining emotional and mental health; easily taught or learnt by both practitioners and clients. Several chapters deal with the impact of thoughts on stress and anxiety, how to

Treating Stress and Anxiety -A Practitioner's Guide to evidence-Based Approaches.
By Lillian Nejad & Katharina Volny

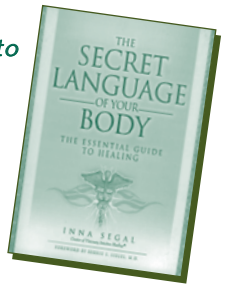
Book Reviews (Contiued)

face one's fears, exercises to assist in the event of relapse and the supportive nature of group work.

Nejad and Volny have compiled a work that is very much in keeping with the recent psychological approach of positive psychology, challenging clinicians and clients alike to consider strengthening self-empowerment in the face of stress and anxiety that are aspects of daily modern living. I will certainly use this book in teaching Health Psychology and encourage all health professionals to obtain their own copy.

Reviewed by Dr Ann Moir-Bussy.

The Secret Language of the Body: The Essential Guide to Healing



The Secret Language of the Body: The Essential Guide to Healing
By Inna Segal

Written by Inna Segal(2007)

In the same genre as the work of Louise Hay and Caroline Myss, The Secret Language of the Body is a guide to the understanding of self healing through the clearing of destructive patterns, beliefs and emotional baggage. It is a practical guide, which focuses on the use of meditation and visualisation to enable people to heal themselves through the use of positive thought and the clearing of negativity.

The style is simple and comprehensive, and the passion of the author , Inna Segal, for intuitive healing is obvious. The introduction is inspiring as Inna relates her own experiences and explains the fundamentals of health as it relates to the mind, body and spirit.

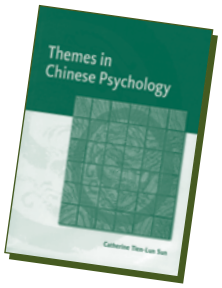
The Secret Language of the Body is useful as a quick reference book because of its well-organised use of sections which focus on different aspects of healing. Different sections include the ten principles of healing, descriptions of different ailments and physical disorders, activities related to these conditions and a section on the power of colour to heal. The majority of the book focuses on the diseases affecting different organs and body parts but the most interesting sections describe various meditations, visualisations and positive thought processes to promote healing.

This book is an excellent resource for clients and counsellors who are interested in alte-rna-tiv e methods of healing and empowering people to seltheal. Those-sceptical of such discourses would easily dismiss this book, but they would miss the opportunity to explore methods which may be useful where all else has failed.

Counsellors would find this comprehensive guide useful for clients who appreciate a more spiritual and emotional approach to healing and who are curious or passionate about the connections between mind, body and spirit and the power of meditation.

Review by Natina Eggleton

Themes in Chinese Psychology



Themes in Chinese Psychology
Author: Catherine Tien-Lun Sun

Author: Catherine Tien-Lun Sun

This is a book that anyone who has any contact with people of Chines origin or are simply interested in the Chinese psyche should read. Dr Catherine Sun has been able to articulate the main themes to Chinese psychology in very readable and entertaining way. The book starts by covering the three main influences on Chinese psychology these being Confucianism, Taoism and Buddhism. Being a history buff a found these chapters very interesting especially how each theme influenced Chinese cultures over time. The book then moves onto Social Psychological Characteristics which focuses on the Self in Chinese culture. Catherine takes you on a journey through the self in various settings from social orientation to the private self. As a westerner many of these concepts can be difficult to relate to. However surprisingly many are simple to relate to especially if you have spent time in group culture such as the military, police service or any of the emergency services.

The book then moves the issues of filial piety which again can be a challenge to understand from a Western perspective if you are from generation x or y. I found the Chapter on Female gender Roles and Gender Egalitarianism in China very enlightening especially the introduction. Here Catherine informs us that a disproportionately high number of young women inn rural villages commit suicide often by ingesting pesticides. This is seen as a form of resistance to the traditional preference of having a son. The stark facts of being a women in an system that supports a patriarchal system that also subjugates women helps the reader to understand the future challenges facing Chinese communities, the government and both genders.

The Chapter on emotions is also very informative as the author educates us beyond the stereotypical image of the emotionless Chinese perception held by many. Interestingly Catherine explains that it is behaviour that affirms social order in China not emotions and therefore emotions take a back seat as being unimportant and concomitant. The book itself is a revelation and both supports and breaks many myths that are held by westerners in relation to the Chinese psyche. This book is a must for anyone who intends to spend any time working with people from a Chinese back ground.

Reviewed by editor of CA, Philip Armstrong, fellow of ACA.

ACA

Basa Education & Counselling Services

(69828)

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Course Designer & Developer: **Veronika Basa**

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DELIVERY MODES

The Workshop Learning Model - suited to those who enjoy learning with peers in an interactive learning environment with adult learning principles and accelerated learning techniques.

The Workplace Learning Model - suited to those who are working as counselling supervisors and want to gain formal qualifications within their workplace.

The Distance Learning Model (DL) - suited to those who are unable to attend the Workshop and/or Workplace Learning Programs due employment, distance or time.

The Recognition of Prior Learning (RPL) - suited to those who have extensive experience in counselling supervision and are able to demonstrate competency via their workplace experience.

COURSE CONTENT

1. Working within a counselling supervision framework
2. Issues in Supervision
3. Supervision Interventions
4. Self Evaluation
5. Supervision Tools/Instruments

STUDY MATERIALS

We provide the required learning materials to complete your studies. The course recourses are designed to assist your comprehension, research skills and other skills relating to counselling supervision and counselling supervision models, to enable you to confidently and competently perform counselling supervision.

ASSESSMENT

Assessments of your competency against the required Units of Competency include:

1. Demonstration
2. Observation
3. Questioning (oral/written)
4. Authenticated evidence of relevant work experience and/or formal/informal learning.
5. Written assignments/projects

RESULTS TRAINING AUSTRALIA (RTO # 60098)

Basa Education and Counselling Services (BECS), is working in partnership with Results Training Australia a Registered Training Organisation (RTO # 60098) who will issue the Certificate IV in Counselling Supervision to those who demonstrate competency in this course."

AUSTRALIAN COUNSELLING ASSOCIATION (ACA)

The Australian Counselling Association (ACA), has approved and accepted this course as an appropriate accredited level of training for their counselling supervisors.

Essential entry criteria set by ACA - Extensive experience as a counsellor – clinical level practitioner with a minimum of 6 yrs experience and having a minimum of 100 of counselling supervision.

BOOKINGS AND ENQUIRIES

Basa Education & Counselling Services
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Postal Address: - GPO Box 359 Chelsea Vic 3196
Telephone: 03 9772 1940
Mobile: 0418 387 982
Email: info@becsonline.com.au
Web: www.becsonline.com.au

ACA

The (69828) Certificate IV in Counselling Supervision is a self-directed learning program for experienced counselors interested in supervising other counselors.

Register of ACA Approved Supervisors

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
NEW SOUTH WALES					
Cate Clark	Albury	02 6041 1913 or 0428 411 906	Grad Dip. Mental Health, Supervisor	$75	Face to Face, Phone, Group
Martin Hunter-Jones	Avalon Beach	02 9973 4997	MA, A d. Ed Ba Psych, Philos	$100	Face to Face, Phone, Group
Jennifer Cieslak	Bathurst	02 6332 4767	Mast. Couns., Grad Dip Couns, Supervisor Trng	$77	Face to Face, Phone, Group
Patricia Newton	Dee Why / Mona Vale	02 9982 9988			
		or 0411 659 982	RN, Rmid, Grad Dip Couns, Cert CISMFA Trainer, Cert Supervision	$100	Face to Face & Group
Carol Stuart	Bondi Junction	02 9387 7355	Dip. Prof. Counselling, Supervisor Trng, Workplace Trainer	$88, $70 (conc.)	Face to Face, Phone
Heidi McConkey	Bondi Junction	02 9386 5656	Dip Prof. Couns. Prof. Sup (ACCS)	$99 Ind, $33 Grp	Face to Face, Phone, Group
Gary Green	Brighton Le-Sands	02 9597 7779	MA Couns. (Psych. UWS), Grad Dip Couns. (Spo. Perf. Psych. ACAP), Dip E.S.T. (Mac.), Cert. NLP Prac. (QCS), Cert. Hypno. (NSWSHS), Level 1 Coach Cert. (ASC), CMACA, CMCAPA	$150	Group and Phone by Negotiation
Thomas Kempley	Green Point	0402 265 535	MA Counselling, Supervisor Training	$55	Face to Face, Phone, Group
Lyndall Briggs	Kingsgrove	02 9024 5182	Dip. Couns., Dip. Clin. Hypno., Clin Supervisor	$66	Face to Face, Phone, Group
Erica Pitman	Bathurst	02 6332 9498	Supervisor Training (ACAP) Adv Dip App Soc Sci (Counselling)		
			Reg. Mem. PACFA, Clinical Mem. CAPA, Cert IV Workplace Training	$85	Face to Face & Phone
Robert Scherf	Tamworth	(02) 6762 1783 0403 602 094	Registered Psychologist	$120	Face to Face, Group
Samantha Jones	Lindfield	02 9416 6277	Clinical Hypnotherapist, Supervisor Trng	$90 Ind, $40 Grp	Face to Face, Group (2 hrs)
Lidy Seysener	Mona Vale	02 9997 8518	Cet Couns & Psychotherapy Prof Sup (ACCS), Masters NLP	$150	Face to Face, Phone, Group
Sarah McMahon	West Penant Hills	0414 768 575	BA (Psych); PG Dip Psych) COA of Supervision (CCC)	$100	Face to Face, Phone, Group
Gordon Young	Manly	02 9977 0779	Dip Hypnotherapy, Dip Couns, NLP Trainer, BA (Hons). Supervisor training	$77	Face to Face, Phone, Group
Brigitte Madeiski	Penrith	02 4727 7499	Dip Prof. Couns. Dip Womens Dev, Dip PSC, Superv. Trg (AIPC)	Neg.	Face to Face, Phone, Group
Sue Edwards	Alexandria	0413 668 759	Dip Prof Couns, Supervisor Trg (ACCS), CMCCA, CPC, Dip Bus Admin, Cert Train & Asses.	$88	Face to Face, Phone, Group
Patriciah Catley	NSW	02 9606 4390	Dip Couns., Dip . Cl. Hypno, Supervisor, Mentor, EN NLP	$90	Face to Face
Elizabeth Lodge	Silverdale	02 4774 2958	Dip. Coun, Dip. Psych, Dip. Hyp	$70	Face to Face, Phone, Group
Grahame Smith	Singleton Heights	0428 218 808	Dip Prof Couns, Supervisor Trg (AIPC)	$66	Face to Face, Phone, Group
Donald Marmara	Sydney	02 9413 9794	Somatic Psych. Cert. Dev. Psych	$120	Face to Face, Phone, Group
Dr Randolph Bowers	West Armidale	02 6771 2152	PhD., Med Couns. CPNLP,GCHE, BA,CPC, CMACA, RSACA	$80	Face to Face, Phone, Group
Jacqueline Segal	Wisemans Ferry	02 4566 4614	MA Applied Science, Supervisor Trg (AIPC)	$120	Face to Face, Phone, Group
Leon Cowen	Lindfield	02 9415 6500	M.Adult Ed; Cert IV (train), Cert Supervisor; Cert Counselling	$150	Face to Face, Phone, Group
Karen Daniel	Turramurra	02 9449 7121	Expressive Therapies & Sandplay Therapy, Supervisor. Traing., (ACCS)	$120 / 2hr Session	Face to Face
Sandra Kutledge	Nowra	02 4446 0452	CCC Supervisor Training	$77	Phone
Brian Edwards	Forresters Beach	0412 912 288	B. Couns UNE, Dip Counselling	$65	Face to Face, Phone, Group
Brian Lamb	Hamilton	02 4940 2000	B Couns, Supervisor Training	$88	Face to Face, Phone, Group
Roy Dorahy	Hamilton	02 4933 4209	Supervisor Training	$88	Face to Face, Group
Lorraine Dailey	Maroota	02 9568 0265	Masters Applied Science Supervisor Clinical	$90	Face to Face, Phone, Group
Heidi Heron	Sydney	02 9364 5418 or 0414 366 003	AIPC Sup Training, CMACA	$120 ind/ $75 grp/2 hrs	Face to Face, Phone, Group
Michael Cohn	NSW	02 9130 5611 or			
		0413 947 582	B.Com, LL.B, Grad Dip Couns (ACAP), Master Couns (UWS)	$100	Face to Face, Phone, Group
QUEENSLAND					
Christine Perry	Albany Hills & Beerwah	0412 604 701	Dip. T., B. Ed. MA Couns, Cert IV Ass & Work Trng	$66	Face to Face
Carol Farnell	North Maclean	0410 410 456	B Psych (H), B Bch Sc	$100	Face to Face, Phone, Group
Rev. Bruce Lauder	Fitzgibbon	(07) 4946 2992 0437 007 950	Bach Theology	$75	Face to Face, Phone
Myra Cummings	Durack/Inala	0412 537 647	Dip Prof. Couns. Prof. Supervisor Training (AIPC)	$66	Face to Face, Phone
Cameron Covey	Eumundi	07 5442 7107 or 0418 749 849	Grad Dip. (Couns.), BA (Beh.Sci), Prof. Sup (AIPC)	$88 Org $66 Ind	Face to Face, Phone, Group
Judy Boyland	Springwood	0413 358 234	Dip Prof Couns., Supervisor Trg (ACCS) Cert. Reality Therapist, M Ed	$75	Face to Face, Phone
Philip Armstrong	Grange	07 3356 4937	B. Couns., Dip Psych, SOA Supervision (Rel Aust)	$88	Face to Face, Phone
Dr. Jason Dixon	Mitchelton	0416 628 000	Coun Super Training, Coun Ed	$75	Face to Face
Gwenda Logan	Kallangur	0438 448 949	MA Couns., B. Soc Sc., IV Cert Workpl Ass & Trng, JP (C/Dec)	$100	Face to Face, Phone, Group
Boyo Barter	Wynnum & Coorparoo	0421 575 446	MA Mental Health, Post Grad Soc Wk, BA Wk, Gestalt	$80	Face to Face, Phone, Group
Beverely Howarth	Mitchelton	07 3876 2100	Dip Prof. Healing Science, CIL Practitioner	$120	Face to Face, Phone, Group
Kaye Laemmle	Southport, Gold Coast	07 5591 1299	Dip Prof. Couns., SOA Supervision (Re. Aust)	$80	Face to Face, Phone, Group
Dr. David Kliese	Sunshine Coast	07 5476 8122	Dip. Prof. Couns. Prof. Sup (AIPC), Dip Clin Hyp.	$75	Face to Face, Phone
Dr John Barletta	Grange	0413 831 946			
		07 3356 4937	PhD, Psych Board Accreditation, Grad Dip Couns, Registered Psychologist	$121	Face to Face, Phone
Stacey Lloyd	Brisbane South	07 3420 4127 or 0414 644 650	MA (Couns), BA (Psych), Dip.Bus (Mgnt), Cert IV Trng & Asst	$90	Face to Face, Phone, Group
Yildiz Sethi	Hamilton	07 3862 2093	B.Ed. Grad Dip Couns, Dip Hypnotherapy, NLP Pract. Prof. Sup.,		
			Family Constellation, Brief Therapist, Educator ACAP, LP Pract.	$80 Ind, $40 pp Grp	Face to Face, Phone, Group
Dawn Spinks	Birkdale	0417 633 977	BA Hons (Psych & Education), MPH, MACA (Clinical)	$110	Face to Face, Phone

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
QUEENSLAND					
Catherine Dodemont	Grange	07 3356 4937	B SocSci (ACU), MCouns, ACA accredited Supervision Workshop, TAA40104, Pre-Marriage Educator (Foccus), CMACA	$95, $30 Group	Face to Face, Phone, Small Group, Long Dist. Phone
Edward Riley	Hope Island	07 5530 8953	B.Ed. MPA, Grad Dip SocSci (Counselling), MA, Clinical Membership, QAFT	$88	Face to Face, Phone, Group
Roni Harvey	Springwood	07 3299 2284	Master Counselling, Dipl Appl Sci Comm & Human Serv,		
		or 0432 862 105	Cert IV Workpl Ass & Tray, JP skype	$70	Face to Face, Phone, Group
Alison Lee	Maroochydore	0410 457 208	Masters Gestalt Therapy	$100	Face to Face, Phone, Group
Lyn Baird	Maroochydore	07 5451 0555 or 0422 223 072	GD Counsell, Dip Psych, SOP Supervision	$77.00	Face to Face, Group
Sharron Mackison	Caboolture	07 5497 4610	Dip Couns, Dip Clinical Hypnotherapy, NLP Pract, Cert IV WPA&ST	$80 Ind, $25 pp Gr	Face to Face, Phone, Group
Frances Taylor	Tanah Merah	07 3388 1054 or			
		0415 959 267	Dip. Prof. Couns., Dip Clin Hypnosis, Dip Multi Addiction	$70	Face to Face & Phone
VICTORIA					
Deborah Cameron	Albert Park	(03) 9893 9422 0438 831 690	M.Couns (Monash), SOA Supervisor Training, M Spec Ed (Spnds) (Deakin) B.A/ (S.Sc) (Deakin)	$99	Face to Face, Phone, Group
Claire Sargent	Canterbury	0409 438 514	BA Hons Psychologist	$110	Face to Face, Phone, Group
Veronika Basa	Chelsea	03 9772 1940	BA Dip Ed., MA Prel Ling., Dip Prof Coun., Supervisor Trng	$80 Ind, $25 Grp	Face to Face, Phone, Group
Miguel Barreiro	Croydon	03 9723 1441	BBSc (Hon) Psychologist	$90	Face to Face, Phone, Group
Sandra Brown	Frankston	03 9783 3222 or 0413 332 675	B. Ed Stud (Mon), Dip Prof. Couns., Dip Clin. Hyp, Prof. Sup (NALAG & ACCS)	$77	Face to Face, Phone, Group
Carol Hardy	Highett	03 9558 3980	Dip App Science (Couns) Grad Cert Bereavement Cert IV Asst &		
			W/place Training & Adv Dip SO Therapy, Prof supervisor	$75	Face to Face, Phone
Michael Woolsey	Seaford	03 9786 8006)	Registered ACA supervisor	$80	Face to Face, Phone
Geoffrey Groube	Heathmont	03 8717 6953	Dip. Prof. Couns., Prof. Supervisor Trg (AIPC)	$75	Face to Face, Phone, Group
Elena Zolkover	Hampton	03 9502 0608	ACA Supervisor, Loss & Grief Counsellor, Adv dip Couns Swinburns, BSW Monash	$80 ind / $20 grp	Face to Face, Phone, Group
Molly Carlile	Inverloch	0419 579 960	RN, B.Ed. Stud., Dip Prof Couns, Supervisor AICD Dip	$100	Phone
Gerard Koe	Keysborough	0403 214 465	Teach Cert., BA Psych, MA Past Couns.	$70	Face to Face
Hans Schmid	Knoxfield	03 9763 8561	Dip. Prof. Couns. Prof. Superv. Trg. (HAD)	$70	Face to Face, Phone
Sharon Anderson	Nunawading	03 9877 3351	Registered Psychologist	$90	Face to Face, Phone, Group
Sandra Bowden	Rowville	0438 291 874	Dip. Prof. Couns., Prof. Supervisor Trg (ACCS)	$60	Face to Face & Phone
Judith Ayre	St Kilda East	03 9526 6958	Dr Coun & Psych, Dip Clin Hyp., Gr.Dip Coun., Gr. Dip Conf. Res., B.A.	$70	Face to Face
Barbara Matheson	Hallam	03 9703 2920	Dip. Appl Sc (Couns.) AAI, Prof. Sup (ACCS)	$66 Ind, $25 Grp	Face to Face, Phone, Group
Rosemary Caracedo-Santos	Ocean Grove,	03 5255 2127	Dip Prof Couns, Cert IV Health Clinical Hypnosis	$66 ind, $35 group	Face to Face & Phone
Joanne Ablett	Phillip Island	03 5956 8306	B.Ed, AdvPract, Cert in Expressive Therapies	$60	Face to Face, Phone, Group
Zoe Krupka	Seddon	0408 880 852	Cert Prof Supervision, MA Counselling and Human Services	$100	Face to Face, Phone, Group
John Hunter	Kew East	03 9721 3626	Bach Counselling, supervisor Training	$100	Face to Face, Phone
Christopher Caldwell	Sassafras	03 9755 1965	Reg Psych	$90 ind / $30 grp	Face to Face, Group
Donna Loiacono	Nunawading	03 9877 3351	Reg Psych	$90	Face to Face, Phone, Group
SOUTH AUSTRALIA					
Dr Odette Reader	Norwood	0411 289 869	Cert IV Training & Assesment, Adv Dip TA,	$110	Face to Face, Phone, Group
Adrienne Jeffries	Erindale	0414 390 163	BA Social Work, Dip Psychosynthesis	$100	Face to Face, Phone, Group
Moira Joyce	Frewville	1300 556 892	B. App Sc (Soc Wrk), Cert Mediation, Cert Fam Ther, Cert Couple Ther, Supervisor Trng	$100	Face to Face, Phone, Group
Anne Hamilton	Gladstone	08 8662 2386	RN, RPN, MHN, Grad Dip H Counselling, Supervisor (ACA),		
		0416 060 835	Master NLP, Coaching and Timeline Therapy	$99	Face to Face, Phone, Group
Dr Nadine Pelling	Adelaide	0402 598 580	M.A. Ph.D Psychologist & Counsellor	$100	Face to Face, Phone, Group
Maurice Benfredi	Glenelg South	08 8110 1222	Grad Dip Hlth Couns, Dip Counselling and Comm, Advanced Dip Appl Soc Sc	$90	Face to Face, Phone, Group
Carol Moore	Old Reynella	08 8232 7511	Dip. Prof. Couns. B. Bus HRD, Prof Supervisor	$99 Ind, $35 Grp	Face to Face, Phone, Group
WESTERN AUSTRALIA					
Christine Ockenfels	Lemming	0438 312 173	MA. Couns., Grad Dip Couns. Dip. C. Couns. Sup Trng (Wasley)	$66	Face to Face, Phone
Dr Kevin Franklin	Mt Lawley	08 9328 6684	PhD (Clin Psych), Trainer, Educator, Practitioner	$100	Face to Face
Carolyn Midwood	Sorrento/Victoria Park	08 9448 3210	MA. Couns. NLP, Sup Trg, Dip Prof. Couns. Cert IV Sm Bus Mgt	$110	Face to Face, Phone, Group
Eva Lenz	Fremantle	08 9336 3330	Adv. Dip. Edu. Couns., M.A., Religion, Dip Teach	$75	Face to Face, Phone, Group
Lillian Wolfinger	Yokine	08 9345 0387	Professional Supervison	$60	Face to Face, Phone
Beverley Abel	Scarborough	08 9341 7981			
		0402 902 264	Registered Psychologist	$110	Face to Face
Deidre Nye	Gosnells	08 9490 2278 0409 901 351	Supervisor Training	$80	Face to Face, Phone, Group
John Dallimore	Fremantle	0437 087 119	COA of Supervision (CCC) B. Couns B. Appl. Psych	$90	Face to Face, Phone, Group
TASMANIA					
David Hayden	Howrah	0417 581 699	Dip. Prof. Couns. Prof. Sup (AIPC)	$80	Face to Face, Phone, Group
Hazel Jones	Currambine	08 9304 0960	Sup. Training	Neg	Face to Face, Phone, Group
NORTHERN TERRITORY					
Rian Rombouts	Parap	08 8981 8030	Dip Mental Health, Dip Clin Hypno, Supervisor Trg	$88	Face to Face, Phone
Margaret Lambert	Brinkin	08 8945 9588		$80 ind	
		0414 459 585	Dip.T, B.Ed, Grad.Dip.Arts, Grad.Dip.Psych., B.Beh.Sc.(Hons).	$120 group	Face to Face, Phone, Group
SINGAPORE					
Hoong Wee Min	Singapore	65 9624 5885	MA Social Science, Supervisor Trng	$100	Face to Face & Group
Laurence Ho Swee Min	Singapore	65 6440 5061	Cert. Clin. Super., Sert. Super. Train.	$70 -$90	Face to Face, Phone, Group

Registration Form

Title: _____ Name: _____

Position: _____

Organisation: _____

Address: _____

_____ Post Code: _____

Daytime Phone: _____

Mobile: _____

Email: _____

Membership Organisation: _____

Membership Number: _____

Preferred Name on Name Badge: _____

I would like to attend the following (Please Tick)

Workshops (Please list preference in order: 1, 2, and 3)

Saturday 8th November

Session One – 11.00am

___ Workshop 1 Counselling Without Self Injury

___ Workshop 2 Self Harm & Self Care

___ Workshop 3 Living with Aspergers

Session Two – 1.30pm

___ Workshop 4 Schema-Focused Therapy

___ Workshop 5 Brief Therapy No Longer Shallow Therapy

___ Workshop 6 Resilience Coaching

Session Three – 3.30pm

___ Workshop 7 Visual Art Therapy for Young People

___ Workshop 8 Cutting In, Cutting Through - Understanding

___ Workshop 9 Physical Pain Relief Through Self Mutilation

Saturday 8th November - Dinner

___ **FPCQ and ACA Gala Dinner for Delegates, Members and Partners - $80 per person**

Sunday 9th November

Session Four – 9.00am

___ Workshop 10 Triple S Methodology of Suicide Minimisation

___ Workshop 11 Shared Parenting and the Family Law Act

___ Workshop 12 Working with People Affected By Eating Issues

___ **Forum 10.45am All are encouraged to attend**

Session Five – 1.00pm

___ Workshop 13 Recovery Oriented Strategies

___ Workshop 14 Knowing the Insides

___ Workshop 15 Self Harmed – Ask the Survivors

Costs - Conference (excludes dinner)

	Early Bird	Both Days	One Day
FPCQ Members	$400.00	$450.00	$300.00
ACA Members	$425.00	$475.00	$300.00
Non Members	$450.00	$525.00	$300.00

Early Bird rate applies to 5pm 30 September 2008
Coffee on arrival, morning tea, lunch and afternoon tea incl.

Accommodation- Rydges of South Bank	Cost per night
Standard Room	$199.00
Superior Room	$239.00
One Bedroom Suite	$289.00

Add $25 per person for breakfast (maximum 2 to a room)
Please contact 'Rydges Reservations' on 07 3364 0800 quoting "FPCQ Conference"

Interstate Air Flights
A number of tickets for direct return flights have been set aside at June 08 prices with Virgin Blue. **These must be booked through FPCQ and not Virgin Blue direct. These must be taken up by September 1 2008 on first come first served basis.**

Perth	return ticket $668.00
Adelaide	return ticket $308.00
Canberra	return ticket $438.00
Melbourne	return ticket $360.00
Sydney	return ticket $240.00

Payment Details

I am attending the FPCQ Conference 2008
both / one day(s) $_____

I am attending the Dinner with ____ Guests $_____

I am booking return flights from:

☐ Perth ☐ Adelaide ☐ Canberra
☐ Melbourne ☐ Sydney, for ____ persons $_____

Total **$**_____

I enclose a cheque made out to FPCQ OR

Internet Banking
If you wish to pay via Internet Banking, please ensure your name is listed on the transfer and also post or email registration including printout of the internet payment.

Payment details for Internet Banking

Financial Institution	Commonwealth Bank
BSB Number	064 127
Account Number	10143410
Account Name	Federation of Psychotherapists and Counsellors of Queensland Inc
Amount	Total cost of registration
Description	Self Harm Conference
Remitter Name	Delegate or Company Name

Credit Card Payment

Please charge my credit card:

☐ Bankcard ☐ Mastercard ☐ Visa

Card Number _____ / _____ / _____ / _____

Expiry Date: ____ / ____

Card Name: _____

Signature: _____

To Register

Fax to 07 3356 4355
Or
post to FPCQ, PO Box 160, Grange QLD 4051

Enquiries

Phone: 07 3356 4937
Or
Email: secretary@fpcq.asn.au

Please photocopy this form if you wish to use it.

FPCQ

Federation of Psychotherapists & Counsellors of Queensland Inc

invites you to the second

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in partnership with

ACA AUSTRALIAN COUNSELLING ASSOCIATION

Self Harm: FEAR OR KNOWLEDGE?

Saturday 8th & Sunday 9th November 2008

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The conference is open to all, whether or not members of professional associations

For on line membership information and details about . . .

***the* Association for Counsellors in Australia**

please visit the

ACA Website

at

http://www.theaca.net.au

ACA AUSTRALIAN COUNSELLING ASSOCIATION

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