Volume 10 Number 1 **Autumn 2010**

COUNSELLING AUSTRALIA

Australian Counselling Association Journal
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'Best practice' guidelines for working with adult survivors of childhood abuse

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Counselling Australia

Published by
Australian Counselling Association Pty Ltd
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Grange QLD 4051
Telephone: 1300 784 333
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Printed by
Cross & Hamilton Printers

Front Cover by
Bodal Graphic Design Pty. Ltd.

ISSN 1445-5285

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Editorial By Philip Armstrong

I hope all our readers had an exciting and/or restful break from the stresses of their working life. We seem to have moved through the last three months without any terrible loss of life to disasters in our region such as devastating bush fires such as Ash Saturday last year or the Tsunami several years before. I am sure this is a relief for all however our thoughts go out to the people of Haiti.

I am always reticent about entering into the discussion of climate change as that is a personal issue in relation to what you believe and what if anything should be done however one thing I can say is that the weather is certainly unpredictable at the moment. Although we have had no great loss of life there have been deaths around Australia due to extreme weather conditions particularly in areas where there has been flooding. I understand new records in rain fall have occurred in many places as well as new records in high temperatures. Melbourne and Adelaide experienced temperatures in the 40's (Celsius). So I am not sure where that leaves us with climate change but we are certainly experiencing extremes that seem to becoming more regular. One thing that does come around regularly is the Federal election.

This year is an election year which always brings hopes of change and possibilities. ACA will be putting together significant resources to speak to both political parties and present them with potential solutions to bring into check the major Medicare blow out due to the Better Access Initiative. It is obvious that the current policy of prioritising treatment at the expense of prevention and early intervention in mental health has not worked. The most viable option to turn this around is to introduce prevention and early intervention services delivered by registered counsellors. An analogy I use quite often is that counselling can be seen as a vaccine to maximise prevention and minimise the need for treatment of mental illness.

ACA will be putting together significant resources to speak to both political parties and present them with potential solutions to bring into check the major Medicare blow out due to the Better Access Initiative.

Vaccines are when compared to treatment inexpensive, far more accessible, can be delivered regardless of demographic, socioeconomic or geographical barriers and do not rely on expensive and highly trained specialists to apply. The most important benefit of a vaccine is that consumers do not need to suffer from an illness that can be prevented in many cases before being able to access help. It seems ridiculous that in a country such as Australia we have a mental health system that only supports you once you require treatment but spends millions on vaccinating its population against most communicable diseases. Mental health issues may not be contagious but the 1.5 billion dollar blow out expected by 2011 in the Better Access Initiative would indicate the cost of treatment in mental health is one of the highest of all Medicare items and need to be checked.

This blow out alone would demonstrate that a lack of early intervention and prevention services has generated a financial burden for Medicare that cannot be sustained. It would seem that a viable policy in relation to medical services is not considered viable in Mental Health yet the facts speak for themselves. No vaccine offers 100% protection however it is common economical sense that prevention is far more cost effective than treatment. It is imperative that treatment services are well resourced with appropriately trained staff but it would make sense if early intervention and prevention services were given priority at this time. ACA is in the process of developing a policy paper that will outline our policy in these areas. The intention of developing such a paper is to give the government a workable and cost effective option, there is no point in being critical if you do not have a solution. According to

the "Light on the Hill: History Repeating" speech the current Health Minister made on 20th of September 2008 prevention is her passion. If she is true to her word there should be significant interest in the ACA Policy paper. The following is an excerpt from the Light on the Hill speech:

"To intervene at a point that might actually make a difference, we must focus our efforts on prevention – teaching kids, no matter where they come from, healthy habits; educating young adults, as their bodies begin to slow, about what they can do to avoid diabetes; giving older adults the tools to prevent heart disease.

I'm passionate about this – because it will help turn around disadvantage and give people a real go at a fulfilling and productive life.

At the moment, though, Medicare and the PBS can't help us make that leap to prevention in our health system. Our workforce, the way we fund health, and much, much more will also need to be reshaped if we are to prevent, not just cure, the illness and accidents that can afflict us all.

This must be part of the next generation of health reforms, and it is the key to achieving Chifley's vision of bringing something better to the people."

ACA

'Best practice' guidelines for working with adult survivors of childhood abuse

By Dominiek Coates

Abstract

This work reviews a range of therapeutic models for working with adult survivors of childhood abuse and identifies a set of ASCA (Adults Surviving Child Abuse) 'best practice' guidelines. Health professionals use a variety of therapeutic approaches and techniques in their work with survivors of child abuse. These approaches are integrative or eclectic and demonstrate responses to individual client needs during the recovery process. In developing its guidelines, ASCA has conducted a review of the literature and considered both empirical studies and clinical work. ASCA's 'best practice' guidelines will be outlined and explored in depth.

In Australia, during 2007-08 there were 317,526 reports of suspected child abuse and neglect made to state and territory authorities. The total number of substantiations in that year across Australia was 55,120 (Australian Institute of Health and Welfare, 2009). It is well known that children subjected to abuse and neglect are more likely to develop mental and physical health problems as adults. Many empirical studies have documented the propensity of childhood abuse to manifest in adulthood as symptoms of distress (Draper et al., 2007; Spila, Makara, Kozak, & Urbanska, 2008). Commonly, these symptoms fit the diagnostic criteria for post traumatic stress disorder or borderline personality disorder (Briere & Scott, 2006; Herman, 1992).

A number of recent studies have highlighted the difficulties many adult survivors of child abuse have accessing services and suitably qualified health professionals (Harper, Stalker, Palmer, & Gadbois, 2007; Henderson, 2006; O'Brien, Henderson, & Bateman, 2007). A number of studies, including an ASCA audit, identified a lack of services in Australia working with survivors of childhood abuse, with few health professionals holding specialised training in the area. In addition, research indicates that services are often reluctant to work with this client group because of the group's perceived resistance to change, ways of relating to health professionals, and the nature of the work (Saakvitne, Gamble, Pearlman, & Tabor, 2000).

A skilled, experienced and knowledgeable professional workforce is needed to meet the complex needs of this client group. Many training and treatment programs have not yet integrated the wealth of new knowledge about the biological and interpersonal consequences of childhood trauma from the past two decades (Saakvitne et al., 2000). Studies suggest that mental health training in psychiatry, psychology, social work, counselling, medicine, nursing and other human services disciplines often do not prepare health care professionals to work effectively with adult survivors of childhood abuse.

ASCA recommends the following 'best practice' guidelines for those working with adult survivors of child abuse:

1. *Do not assume an invariably causal relationship between child abuse and later psychopathology*

It is important not to assume a history of childhood abuse in clients who demonstrate significant psychopathology, nor assume that clients with histories of childhood abuse experience significant long term impacts.

Psychopathology sometimes associated with childhood abuse does not indicate a history of childhood abuse. It is hazardous to assume a history of childhood abuse in light of symptoms, in particular when clients have not presented as survivors of child abuse. Even though there is evidence to suggest the existence of traumatic amnesia in some adult survivors of child abuse, with some survivors not recalling childhood abusive experiences for years (Dallam, 2001; William, 1994) it is harmful to make sense of symptoms by concluding a history of childhood abuse. Vulnerable clients can be suggestible when "unwittingly coached by a respected authority figure" such as a therapist and 'recall' memories that never occurred (Lego, 1996, p. 110). The existence of 'false memory syndrome' and the degree to which a therapist can influence a client is controversial and highly debated; however, a number of studies have shown that memories can be created in laboratory settings (Gallop, Austin, McCay, Bayer, & Peternelj-Taylor, 1997). As such, it is vital of therapists to be knowledgeable about human memory processes and traumatic memory processes to be able to accurately explain these processes to clients.

In addition, it is important not to assume that clients with histories of childhood abuse experience significant long term impacts. The extent and nature of the impact varies from person to person. A number of reviews have estimated that between a third and half of individuals who have experienced sexual abuse do not exhibit adult psychiatric or psychological problems (Fergusson & Mullen, 1999; McGloin & Widom, 2001). A variety of factors may influence if and how abuse has an impact, including variables such as the gender of the victim and perpetrator, the type and severity of the abuse, the duration of and time since the abuse, family reactions and perceived social support, disposition and bio-psychological factors (Collishaw et al., 2007; Futa, Nash, Hansen, & Garbin, 2003; Lauterbach, Koch, & Porter, 2007; McClure, Chavez, Agars, Peacock, & Matosian, 2007; Pickering, Farmer, & McGuffin, 2004; Ullman, Filipas, Townsend, & Starzynski, 2007).

Many empirical studies have documented the propensity of childhood abuse to manifest in adulthood as symptoms of distress

Research has shown that how trauma survivors perceive the trauma is a more important predictor of psychological well being than the exact nature of the trauma (Giant & Vantanian, 2003). As such, it is hazardous for a therapist to assume, and convey, that the child abusive experiences the client might report are intrinsically traumatic as this may create a traumatic reaction in someone who may not otherwise experience one.

2. *Provide a safe place for the client*

Only a perceived safe environment can allow those who have been exposed to danger to let their guard down and experience the luxury of introspection and connection (Briere & Scott, 2006). At its core, being abused in childhood means being and feeling unsafe. Therefore a framework of physical, emotional and psychological safety is vital for any therapeutic process

'Best practice' guidelines for working with adult survivors of childhood abuse (Continued)

(Briere & Scott, 2006). Building a trusting relationship with a survivor of childhood abuse can be very challenging, as those who have been repeatedly hurt in interpersonal relationships have acquired a range of ways to guard against future harm. Survivors of child abuse are often vigilant, cautious, suspicious and/or angry, and hide certain aspects of themselves (Saakvitne et al., 2000).

Even though many survivors may want to talk to their therapist about their feelings, shame as well as fear of the therapist's response stops them from doing so (Harper et al., 2007). Health professionals need to be patient with survivor clients, and willing to wait until the client feels ready to reveal painful material. Studies highlight that many survivors take time to believe that it is safe to reveal their feelings honestly in therapy and develop a trusting relationship with the therapist (Harper et al., 2007).

Periodically checking with a survivor client about his/her experience of the therapeutic relationship may help the client identify issues of mistrust. It also gives the client permission to discuss what might be interfering with his/her ability to honestly express thoughts and feelings (Harper et al., 2007). Developing good rapport between therapist and client is a prerequisite to addressing traumatic memories or applying any technique, even if it takes months or years (Rothschild, 2003). Working with trauma involves helping the client loosen the defences he/she has used to cope with the trauma. If the therapy situation does not feel safe, a loosening of those defences can lead to decomposition or even increase the client's vulnerability to further harm (Rothschild, 2003).

Offering survivor clients choices and acknowledging the client's insights and ideas about their own recovery are often identified as helpful by survivors.

3. Ensure client empowerment and collaboration

Saakvitne et al. (2000) stress collaboration and empowerment as key to working effectively with survivors of childhood abuse. Survivors benefit most when they participate actively in their treatment and have control over decisions that affect them, with interventions more effective when developed collaboratively (Saakvitne et al., 2000). This can be difficult when working with clients who are at risk of harm, at their own hands or by others, or at risk of harming others. Collaboration requires acknowledging our responsibility to our clients and the power we have in the relationship while deferring to each client's personal expertise and authority.

In certain crisis situations, for example, where restraint is considered, ensuring client empowerment and collaboration can be challenging. If a client must be contained to achieve safety, it is best to elicit his/her cooperation. It is preferable to say what you are going to do before doing it and to ask the client to do it him/herself. The more you include a client in the process, the more the process becomes part of treatment, i.e. a way of helping a client expand his/her repertoire of coping skills and increasing his/her sense of personal control over his/her own actions and environment. As recommended by Saakvitne et al. (2000) the more you name what is happening and invite the client's collaboration towards achieving safety, the more you differentiate the present from the past. After a crisis intervention, a debriefing with the client should always occur to discuss what was helpful and what could have been done differently.

To ensure that adults abused as children feel they have some control over their treatment, it is important to follow the client's lead in therapy (Briere & Scott, 2006; Harper et al., 2007). This is highlighted in a study by Ullman, Filipas, Townsend, & Starzynski (2007) which found that a perception of control over the recovery process was associated with less distress for survivors of childhood abuse. Research shows that therapists who are patient, understanding and respectful of a survivor's need to feel in control when working towards their own solutions are viewed as most helpful (Harper et al., 2007). It is vital for survivor clients to find their own solutions in their own time. Offering survivor clients choices and acknowledging the client's insights and ideas about their own recovery are often identified as helpful by survivors. It is especially important that therapists do not assume that adult survivors are fragile; health professionals need to refrain from doing for survivors what survivors can do for themselves (Harper et al., 2007).

Maintaining a sense of control over which therapeutic issues are addressed, and when, helps the survivor manage overwhelming feelings. At the same time, however, it is important to ensure that important issues are not evaded indefinitely. A balance between following your client's lead while at the same ensuring important issues are explored without overwhelming your client can be achieved by carefully monitoring your client's levels of arousal. Difficult material can be introduced when the client appears not to be overwhelmed or hyper-aroused. A discussion on the importance of not overwhelming your clients and how to recognise if your client is overwhelmed is outlined under 'teach clients adaptive coping strategies'.

4. Communicate and sustain hope and respect

It is vital to communicate and sustain hope and respect when working with survivors of childhood abuse. In regards to respect, a health professional's respect for the client is conveyed in many ways, including forms of address, respect for confidentiality, punctuality, sensitive use of language, admitting when you have made a mistake or feel unsure and assuming that the client as well as the health professional has valid points of view (Saakvitne et al., 2000).

In conveying hope, while it's important to empathise with the survivor's current hurt and despair, it is important to envisage the survivor's potential future self (Saakvitne et al., 2000; Rothschild, 2003). Hope is also conveyed by identifying and building on the client's internal and external resources. Helping the survivor client identify the resources he/she already possesses is an important step in the recovery process (such as: a sense of humour and defence mechanisms, interpersonal resources such as friendships, family, pets, belief system, etc.).

5. Facilitate disclosure without overwhelming the client

Disclosure for survivors of child abuse may bring their abuse story back to the surface, and this can be very

overwhelming. Facing memories and experiencing flashbacks can be painful and/or overwhelming, and can trigger automatic childhood responses such as running away, avoidance or denial (van Loon & Kralik, 2005; Harper et al., 2007). Some professionals feel nothing is to be gained by revisiting past experiences, or delving into them. Others believe that disclosure externalises those past experiences, and disentangles the issues they invoke from who the survivor really is, making it possible to separate the survivor from the abuse experiences (van Loon & Kralik, 2005). In the same way, some studies with survivor participants have found that some survivors find disclosure helpful, while others do not (Harper et al., 2007). If a survivor does not want to disclose, he/she may not be ready, or it may not be a necessary part of the individual's 'recovery journey'.

Self-trauma therapy, a therapeutic model developed by John Briere (2004), stresses the importance of processing traumatic material through disclosure, without overwhelming the client. He explains that many untreated survivors of childhood abuse spend considerable time and energy attempting to counter trauma-related distress with avoidance mechanisms such as dissociation, externalisation or substance abuse. He argues that even though such avoidance may reduce symptoms of distress and help the client feel less overwhelmed, avoidance may prevent adequate processing of traumatic material, leaving post- traumatic symptoms relatively undiminished. Self-trauma therapy also recognises that exposure to traumatic material through disclosure may overwhelm the survivor, especially when if the survivor has difficulties regulating affect. Therefore, a primary goal of self-trauma therapy is to avoid overwhelming the client (either by exposing them to unacceptable levels of post traumatic distress or by inappropriate discouragement of critical avoidance-activities). At the same time the therapist must facilitate exposure to traumatic material so it can be desensitised and integrated (Briere, 2004). Effective therapeutic responses occur on a continuum, between interventions devoted to a greater awareness of potentially threatening, but therapeutically important material (exposure), and those that support and solidify previous progress (consolidation). Consolidation is concerned with safety and involves activities that reduce arousal and ground the client in the here and now (Briere, 2004). For an in-depth discussion on how to balance exposure and consolidation please note the work of Briere and Scott (2007).

Some professionals feel nothing is to be gained by revisiting past experiences, or delving into them.

6. View symptoms as adaptations

It is important to view the client's current behaviour in light of their abuse history. The essence of a trauma model is recognition of the trauma in relation to the

‘Best practice’ guidelines for working with adult survivors of childhood abuse (Continued)

current behaviour, and recognition of trauma symptoms (Bloom, 1997; Briere & Scott, 2006). It is important to focus on encouraging a change in how the client interprets his/her symptoms and maladaptive behaviours (Harper et al., 2007). It is the health professional’s responsibility to reframe the client’s responses to the abuse. While certain coping strategies were functional for the child-victim they may not be helpful in present life situations. Reframing feelings and behaviour as coping strategies adaptive to surviving past abuse can herald positive change. Research shows that survivors find it helpful when professionals help them make the connection between their current symptoms and behaviour, and their abuse history. Survivors find it helpful when therapists assist them to understand their feelings and coping strategies in the context of their specific abuse history (Harper et al., 2007).

Research tells us that the bodies of children who are being abused react and adapt to the unpredictable environments to which they are exposed.

7. Have a broad knowledge of trauma theory and provide the client with psycho-education

Psycho-education is an important aspect of trauma therapy (Briere & Scott, 2006). Health professionals can assist survivors by providing accurate information about the nature of trauma and its effects, and by working with the survivor to integrate this new information and its implications into his/her overall perspective (Briere & Scott, 2006).

Understanding how the brain and body process traumatic events can help the survivor learn how to regulate affect and pain (Rothschild, 2003). Helping clients recognise the relationship between their abuse histories and some of their symptoms/impacts may motivate survivor clients to engage in more adaptive coping strategies in the present. Explaining the impact of child abuse on brain development and hormone secretion can be very helpful to some clients. The link between a history of childhood abuse and neglect, and neuro-endocrine impacts, including alteration in cortisol (i.e. ‘stress hormone’) production, has been well established (Joyce et al., 2007; Linares et al., 2008). Neuro-endocrine dysregulation, in particular an overproduction of cortisol may contribute to the difficulties some survivors of childhood abuse experience in tolerating distress. Research tells us that the bodies of children who are being abused react and adapt to the unpredictable environments to which they are exposed. Their nervous systems run constantly on high as they anticipate further danger; this floods the body with fight-or-flight hormones. This state of chronic “hyper-arousal” persists for many survivors throughout their adult years as well. Research has identified alterations in cortisol levels in adult survivors of childhood abuse (Joyce et al., 2007). By highlighting the impact of child abuse on neuro-endocrine functioning and stressing the range of interventions and skills that can promote healthy neuro-endocrine function, health professionals can motivate survivor clients to engage in activities that reduce stress.

It is also important for survivor clients to understand human memory processes. It is particularly important to explain memory processes to those clients have previously received misinformation about 'repression' and 'recovered memories'. An in-depth outline of memory processes is not within the scope of this work; however, an important point will be made. Recall of traumatic memories before the age of 3 is difficult because both the laying down of memories and recall of events require language to name and describe the event (Burgess, Hartman, & Clements, 1995).

8. Teach clients adaptive coping strategies

Even though childhood coping mechanisms were functional at the time of the abuse, many are no longer constructive in present life situations. It is important to help survivors develop more adaptive coping strategies rather than risk making matters worse by getting rid of clients' maladaptive defences and leaving them with no coping strategies (Harper, 2007; Rothschild, 2003). Clients can be taught more adaptive coping strategies through self-care strategies, distress tolerance strategies, and arousal reduction strategies.

Self-care strategies. Self-caring activities and emotional self-soothing are important skills for survivors. They can be especially challenging for survivors who may have never learned to 'self-soothe' or 'self-care'. In neglecting, hitting, insulting or abusing a child, an adult sends a clear message to that child that he/she is without value or worth. Many abused children grow to adulthood believing that they do not deserve love, care or warmth. In addition, parents who abuse are often poor at soothing themselves and, consequently, at teaching their children to self-soothe (The Morris Center, 1995). Learning self-care can be a challenge for adult survivors of child abuse, since it requires survivors to develop a radically new understanding of themselves as human beings with the right to feel comfortable, safe and worth-while.

In neglecting, hitting, insulting or abusing a child, an adult sends a clear message to that child that he/she is without value or worth.

Distress tolerance strategies. Childhood abuse interrupts the development of a person's ability to identify and regulate their feelings (Gerhardt, 2004; Saakvitne et al., 2000). Hence, a number of trauma frameworks emphasise the importance of learning skills to regulate feelings (Briere, 2004; Linehan, 1993a; Saakvitne et al., 2000). Without adequate

'Best practice' guidelines for working with adult survivors of childhood abuse (Continued)

affect regulation skills, even small amounts of distress can be overwhelming and motivate avoidance (Briere, 2004). As previously explained, the over-production of cortisol may contribute to difficulties tolerating distress. The lack of childhood 'nurturing' experiences, or being taught self-care or 'self-soothe' strategies also contributes to difficulties tolerating distress.

Many mental health treatments focus on reframing distressing events and circumstances. They pay little attention to accepting, finding meaning for, and tolerating distress. Dialectical behavioural therapy (DBT) developed by Marsha Linehan (1993b) emphasizes learning to bear pain skilfully (p. 96). Distress tolerance skills depend on the ability to accept, in a non-evaluative and non-judgmental fashion, both oneself and the current situation. Although the stance advocated is a non-judgmental one, it is not one of approval: acceptance of reality is not approval of reality. Distress tolerance behaviours are concerned with tolerating and surviving crises and with accepting life as it is in the moment. Four sets of crisis survival strategies are taught: distracting, self-soothing, improving the moment, and thinking of pros and cons (Linehan, 1993b).

Clients are encouraged to think of the positive consequences of tolerating distress by imagining how good they will feel if they do not act impulsively.

For example, the survival strategy 'distracting' encourages clients to use activities when feeling distressed; such as going for a walk or listing girl's names with each letter of the alphabet. 'Self soothing' strategies encourage survivors to use their five senses. For example, look at the waves, listen to music, eat your favourite food, and touch soft fabric. 'Improving the moment' encourages strategies such as prayer and relaxation. 'Thinking Pros and Cons' involves encouraging clients to make a list of pros and cons of *tolerating* distress (i.e. not acting impulsively). The client is encouraged to focus on long-term goals, the light at the end of the tunnel, times he/she has successfully tolerated the distress (without acting out, being self-destructive or acting impulsively) and the pain has ended. Clients are encouraged to think of the positive consequences of *tolerating* distress by imagining how good they will feel if they do not act impulsively. Another list can be made of the pros and cons of not tolerating distress; that is, of coping by hurting yourself, abusing alcohol and drugs, or doing something else impulsive. Encourage clients to think of all the negative consequences of not tolerating their current distress, and acting impulsively (Linehan, 1993b).

Arousal-reduction tools i.e. always 'reduce the pressure'. In abuse in early childhood, the trauma

and shock of the abuse interferes with the ability to regulate emotions, causing frequent episodes of extreme/out of control emotions, including anger and rage (Linehan, 1993a). Arousal-reducing tools can assist survivors in regulating their emotions. As noted, a state of hyper-arousal is a natural response to a dangerous situation or threat. Many survivors of trauma remain in a constant state of alarm because the fight/flight response is triggered repeatedly (Giarratano, 2004), and without evident purpose (Cloitre, Cohen, & Koenen, 2006). A state of hyper-arousal may include feelings such as anger or anxiety.

A state of anxiety is common among trauma survivors being typically generated by experiences that are unpredictable, uncontrollable, or unfamiliar, i.e. the characteristics of trauma or danger. Anxiety ensures readiness for coping with an unidentified danger (Cloitre et al., 2006) and has an adaptive function. It may happen due to the many unidentified reminders of trauma in the environment, or because trauma causes survivors to psychologically, and biologically, adapt to 'living in a dangerous world' (Cloitre et al., 2006; Teicher, 2002).

Anger is usually a central feature of a survivor's response to trauma because it is a core component of the survival response in humans. Anger helps people cope with life's adversities by providing increased energy to persist in the face of obstacles. High levels of anger are related to a natural survival instinct (Chemtob, Novaco, Hamada, Gross, & Smith, 1997).

Symptoms caused by hyper-arousal include having a difficult time falling or staying asleep, feeling more irritable or having outbursts of anger, having difficulty concentrating, feeling constantly 'on guard' or feel like danger is lurking around every corner, overbreathing or hyperventilating and being 'jumpy' or easily startled (Giarratano, 2004).

When working with survivors of childhood abuse, it is important to use arousal reducing techniques or, as explained by Rothschild (2003), to 'reduce the pressure'. Rothschild (2003) draws on an understanding of the physiology of the brain, how it responds to danger, emotion and traumatic events, to illustrate the hazards of addressing traumatic material before the client is ready. She explains that traumatic memory can be easily triggered, accelerating hyper-arousal, a feeling of being out of control, intense physical symptoms and/or flashbacks. Triggers can be unpredictable. To feel safe survivors of child abuse need tools to help them contain reactions to therapy and triggers, and to halt the out of control acceleration of hyper-arousal. Being able to apply the brakes helps clients in daily life, and also gives them the courage to address difficult issues

Arousal-reducing tools can assist survivors in regulating their emotions. As noted, a state of hyper-arousal is a natural response to a dangerous situation or threat.

'Best practice' guidelines for working with adult survivors of childhood abuse (Continued)

(Rothschild, 2003). Rothschild (2004) stresses the importance of never helping clients call forth traumatic memories unless the therapist and client are both confident that the flow of anxiety, emotion, memories, and body sensations can be contained.

Grounding exercises can be helpful when clients, in response to some triggering stimulus or memory, experience sudden panic, flashbacks intrusive negative thoughts or dissociative states.

Arousal-reduction strategies help clients have control over their traumatic memories, rather than feeling controlled by them (Rothschild, 2004). Knowing when to 'apply the brakes' is as important as knowing how. The timing can be gauged by watching for physical signals of autonomic system arousal transmitted by the client's body, tone of voice and physical movements (Rothschild, 2004). When the client turns pale, breathes in fast, takes panting breaths, has dilated pupils, and shivers or feels cold, the part of the nervous system activated in states of stress (i.e. the sympathetic nervous system) is aroused. Stress hormones are pouring in. These symptoms mean it is time to calm the client down. When a client sighs, breathes more slowly, sobs deeply, or flushes the part of the nervous system that is activated in states of rest and relaxation, the parasympathetic nervous system, has been activated, and stress hormone levels are reducing (Rothschild, 2004).

Arousal reducing strategies include 'distracting your thoughts', 'grounding' and 'breathing control exercises'. Exercises designed to distract can be helpful when attempting to reduce states of hyper-arousal. For example, encourage clients to observe what's happening around them, to list objects near them, look at a painting on the wall, think of a girl's name that begins with each letter of the alphabet, name the objects in a room, etc. Grounding exercises can be helpful when clients, in response to some triggering stimulus or memory, experience sudden panic, flashbacks intrusive negative thoughts or dissociative states (Briere & Scott, 2006). Grounding exercises help refocus the client on the immediate, external environment. For example, exercisers can include encouraging the client to feel their arms in their chair, their feet on the ground, etc.

In regards to breathing control exercises, increased respiration is one of the body's fight/flight responses. Trauma survivors whose response is firing too rapidly can chronically over-breathe. This can lead to hyperventilation and may contribute to panic attacks in some people (Giarratano, 2004). Controlled breathing techniques are used to slow the respiration rate. Our breathing rate has an impact on our heart rate, blood pressure and the rest of our body. Breathing at the correct rate slows the bodily processes, lowers arousal, and in turn reduces tension and stress. Slowing the breathing rate is an effective method of turning off the 'fight/flight' response. The

breathing rate normally increases in the presence of a perceived threat. It is helpful to use controlled breathing techniques at the first sign of anxiety or panic. It might be helpful for clients to use these techniques before tackling difficult situations, and anytime they are feeling tense or anxious.

9. Teach clients to monitor their thoughts and responses

Cognitive Behavioural Therapy (CBT) can be an effective tool with trauma survivors. CBT works with cognitions to change emotions, thoughts and behaviours (Corey, 2005). The goal is to understand how certain thoughts cause stress and make symptoms worse. CBT for trauma includes learning how to cope with anxiety and negative thoughts; managing anger; preparing for stress reactions; handling future trauma symptoms; addressing urges to `self-soothe' with alcohol or drugs and communicating and relating effectively with people (National Centre for PTSD, 2008). The CBT model, when used with survivors of child abuse, usually focuses on the 'here and now' rather than on revisiting the trauma itself (Henderson, 2006). For example, it might be helpful when working with survivors to explain that many adult reactions and responses are grounded in childhood ones, and that some are helpful and others not. To help your client to respond in an age-appropriate manner in the here and now, clients can ask themselves: Does this response fit with old patterns of self-rejection, or is it self-caring for me now? What am I feeling and why? How is this connected to the past?

10. Teach clients interpersonal and assertiveness skills

A child should not need to equate his/her dependence on an adult for nurture, safety, love and connection with taking a risk. Once betrayed however, attachments and interpersonal connections require risking disappointment and perhaps shame, neglect and/or abuse. In adulthood, survivors of childhood abuse can find it risky to make connections between their past and present, their thoughts and feelings. Most survivors need the support of interpersonal connections to restore meaning and wholeness in their lives (Saakvitne et al., 2000).

Impairments in interpersonal relationships are of crucial importance for understanding the effects of child abuse on mental health outcomes. Research consistently shows that child abuse is linked with difficulties in interpersonal relationships. In a study by Collishaw et al. (2007) almost half of adult who report histories of child abuse showed significant abnormalities in interactions with peers in adolescence. At the same time, peer relationships in adolescence emerged as one of the strongest predictors of resilience within the abused group. This study found that only those individuals with good relationship experiences across childhood, adolescence and adulthood are likely to demonstrate resilience. Collishaw et al. (2007) explain that children who have experienced abuse are less likely to bring positive expectations or interpersonal strategies to a relationship. Instead they may see others as untrustworthy and unpredictable, and relationships as a potential source of conflict rather than a source of support and enjoyment.

In addition to teaching clients distress tolerance strategies, a core component of DBT is teaching clients interpersonal response patterns (Linehan, 1993a). These skills are very similar to those taught in many assertiveness and interpersonal problem-solving classes, and include: effective strategies for asking for what one needs, saying no, and coping with interpersonal conflict. Linehan (1993b) suggests that it is helpful for interpersonal skills' training to focus on situations where the objective is to change something (e.g., requesting that someone do something) or to resist changes someone else is trying to make (e.g., saying no). The aim is to maximize the chances that a person's goals in a specific situation will be met, while at the same time not damaging either the relationship or the person's self-respect (p. 70).

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‘Best practice’ guidelines for working with adult survivors of childhood abuse (Continued)

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Acknowledgments: The author would like to thank Dr Cathy Kezelman for her invaluable support in editing this work.

ACA

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Leslie Balmer PhD

Dr Balmer is a registered psychologist in private practice with Fleming Vigna Balmer in Ontario, Canada. She has over twenty years experience in the assessment and treatment of children, adolescents, and adults in a variety of settings. Dr Balmer specialises in working with trauma victims who have suffered the death of a loved one through accident, suicide, or murder. Dr Balmer incorporates art, games, and play into her treatment of children and teens. She has published articles on childhood and adolescent bereavement and has lectured and facilitated training workshops in Canada, the United States, South America and Europe. She is a member of the International Work Group on Death, Dying, and Bereavement.

Stephen Fleming PhD

Dr Fleming is a professor in the Department of Psychology, Faculty of Health, at York University in Toronto, Canada. The author of numerous book chapters, articles, and presentations on the grief experience of children, adolescence, and adults, he has lectured in Canada, the United States, South America, Asia, and Europe. In addition to teaching graduate and undergraduate courses on the Psychology of Death, Dr Fleming served on the editorial boards of the *Journal of Palliative Care* and *Death Studies*. He currently is Secretary-Treasurer of the International Work Group on Death, Dying, and Bereavement.

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Presented by Leslie Balmer PhD

In this workshop, Dr Balmer will introduce participants to the private worlds of bereaved children and adolescents. The morning presentation will address general issues related to childhood grief and loss. The afternoon will address the topic of traumatic loss. During this segment participants will learn practical techniques and assessment tools for assisting children faced with the death of a loved one through accident, suicide or murder.

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Presented by Stephen Fleming PhD

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The Practice of Clinical Supervision

Edited by
Nadine Pelling John Barletta Philip Armstrong

Quality clinical supervision for counselling, psychotherapy and other mental health and related disciplines seldom occurs by accident. Rather it is the result of strategic planning by counsellors, administrators and supervisors working in partnership. The aim of such collaboration is to find a practical and appropriate process to support the counsellor in the workplace to achieve best practice in their everyday work. With attention to supervision, the emerging professional can be protected from the euphoria of a grand vocational adventure dissolving into the despair of a fading dream. This book is a state of the art summary of where supervision is today and what are some of the crucial themes we need to consider as supervisors, an invaluable update for the the experienced supervisor. Its scope and cross-professional application (counsellors, psychotherapists, psychologists, social workers, life and business coaches) ensures all who are interested in supervision can benefit from this book. It will will also be attractive to trainee practitioners who are beginning supervision and to trainee supervisors who are taking their first steps as supervisors. To cater for this wide audience, the various chapters blend contemporary research with modern models and up to date frameworks and practical tools applied to various contexts.

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RRP $49.95
ISBN: 9781921513312
AAP Item Number: 4-921513312
370 pages softcover

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Alcohol Dependence: A biopsychosocial review for practitioners By Matthew CornisContinuing Education and Critical Thinking - A Counsellor's Guide Part III By Dr. Travis Gee

This article, the second in a series on understanding research-related issues for counsellors, focuses on some basic ideas around the notion of probability. Although this is a difficult area, even for mathematicians, some clear thinking around what is meant whenever certain words are used never goes amiss, as sometimes, even the researchers can make mistakes with the meanings that can lead the reader astray.

Some Terms

You may see a variety of confusing terms and ways of using probability in different articles. You hear about "a 10% chance" or "a .1 probability," or "odds of 9:1." The first example, "an X% chance" refers to a percentage scale that ranges from zero to 100, and reflects the number of times out of 100 that something should occur. If, for instance, 10% of the population has a particular problem, and you were to randomly pick 100 people, then the chances of getting someone with that problem are 10%. If instead of referring to percentages, we put it on a decimal-based zero to 1 scale, it's a probability of 0.1. The percent expression is just 100 times the decimal expression. Odds are a bit different, though. If 10 people out of 100 have the problem, then 90 do not, and so the odds are 90:10 against (or 10:90 in favour). Dividing by ten we get less cumbersome odds of 9:1 (or 1:9) such as those in horse racing. However, by now, I think we can see that they all refer to the same situation, but are just different ways of expressing the same thing.

Types of Probability

Broadly speaking, there are two kinds of probability. One is subjective probability, and is fairly controversial, even though everyone seems to use it in some form or another. What is the probability that the next client through your door will be suffering from schizophrenia? Absent a detailed study of the rates of schizophrenia in the population, the likelihood that they live in your area, and the rate at which such people seek help from counsellors, you are left with a gut feeling. Perhaps you thought "about 1%" or "one in a million." This will be based on your experience, and will reflect your sense of the probability that such a thing would occur. It may even be accurate, although you could be off by a rather large margin (eg., 1% is 10,000 times more likely than "one in a million": try it on your pocket calculator: .01? .000001=).

Subjective probability still seems to suggest the idea of some number of events out of some number of tries, which is similar to the purer idea expressed in the second kind of probability, where we deal with counts, and counts alone: no gut feelings allowed (although allowing gut feelings to be led by objective information isn't necessarily a bad thing). The other sort of probability is based solely on frequency. If 10 cars out of 1000 on an assembly line have a particular defect, then the probability that you will buy one (assuming they aren't caught by inspectors) is 10/1000 or 1%. It is thus known as 'the frequentist model,' and depends on sample results to get estimates of probabilities (more of this shortly).

The frequentist approach is the model most widely adopted by researchers. When we find that out of fifty clients that walk through the door, five have a particular characteristic, we are tempted to say that 5/50 or 10% have it. Indeed, 10% of your sample *did* have it, but there are other things to consider when generalizing this from your sample to the world at large, which will be discussed below in the section on populations and samples.

Subjective probability still seems to suggest the idea of some number of events out of some number of tries, which is similar to the purer idea expressed in the second kind of probability, where we deal with counts, and counts alone: no gut feelings allowed.

Alcohol Dependence: A biopsychosocial review for practitioners By Matthew CornisContinuing Education and Critical Thinking - A Counsellor's Guide Part III (Continued)

Probabilistic Words

We often encounter probabilistic terms in everyday reading; 'probably,' 'likely' 'improbable,' 'unlikely.' However, if we think about the nature of probability as an idea that gets at the frequency with which we would expect something out of some number of trials, there are a lot of related words. Think of the word 'most.' For instance, it is often said that 'most abuse victims never report it.' It's worth clarifying what might be meant by 'most' as an example.

Finger Statistics (if you have 100 fingers).

Some probability statements can be analyzed by imagining a room with 100 people in it. For instance, suppose we have a random sample of 100 people, and suppose further that by some definition, 20% of the population from which they came could be expected to have an abuse history of the sort that we are researching. That means that we should have 20 people who have such a history, and 80 who don't (i.e., odds of 80:20 or 4:1 against it in a randomly-selected person). Now, if "most" don't report it, and "most" means 90%, then the 20 who have the history represent 10% of the ones who were abused (odds of 9:1 in favour of non-reporting), as for every one reporting abuse, there are 9 who did not. That would mean we have the 20 who reported it, and 9 for each of them, or 180, for a total of 200. But we only have 100 people in our imaginary sample, so "most" cannot possibly mean 90% (or more).

Sometimes it's worth doing a little "thought experiment" to figure out what must really be the case when evaluating a research finding.

On the other hand, if the real rate of abuse is 30%, but 20% report such a history, then of 30 cases, 10 did not report and 20 did. It would seem that 'most' in this case would mean "one in three" which falls a bit below the 51% mark that we would normally consider "most" to mean. With a little math, we can find that if 51% fail to report, then 49% report, and if our 20 reporters are 49% of some number, that number must be 41 (20?0.49=40.8, but we round off as there is no .2 of a person), making the rate of abuse - disclosed plus undisclosed - 41%.

If we only have 100 people, if *all* were abused, but only 20 reported it, then 80 did not. That means that if *everyone* was abused, then 80% failed to report it. That is the most that "most" can mean, but it requires a definition of abuse that is rather all-encompassing, and which raises the question of the possible pathologisation by the researchers of normal human behaviour. (That clarification points to the way in which finding one problem can lead to looking at another, and definitions are a key point which will merit an article to themselves later in this series.)

Symptoms, Inferences and Conditional Probability

Sometimes you read that something is a symptom of something else. In other words, if you see "X" suspect "Y" because Y is likely if X occurred. In the controversial area of "repression" (i.e., where someone ostensibly has no memory of some trauma because they have blocked it out), some have claimed that having no memory of a trauma is a "symptom" that the trauma was there (and especially traumatic).

Back to the room with 100 people in it. For simplicity, we'll grant some numbers that are often thrown out in that debate (and round them to even values so things work out nicely). Suppose that 30 cases ("1 in 3") experienced some trauma (which means that 70 did not). Suppose further that 30% of those 30 (9 cases, again "1 in 3") "repressed" the trauma (which means that 21 did not). As well, simply assume that no one in the room has come to have false memories of trauma (i.e., the probability of this is zero). Now, those 70 that did not experience trauma have no memory, because nothing happened to them, and so they look very much like the 9 who "repressed" it. So there are 79 with no memory, and 21 with a memory. The probability that someone experienced a trauma but is blocking it out is the proportion of cases with no memory who in fact experienced a trauma, or 9 out of the 79, or 11%. The probability that someone *did* not have a trauma, given that they have no memory, is therefore 70/79, or 89%. The *odds* of trauma, given that they have no memory, is therefore 70:9 (or 7.8:1) *against*. In short, having no memory of trauma is a symptom of *not* having experienced it, and not the other way around. As an exercise, what would the odds be if 10 of the 70 experienced false memories of trauma?

This is a simple finger-stats example of what is called "Bayes' Theorem," which looks rather scary as an equation when you google it on the Internet, but which really is just a way of writing the preceding paragraph in one equation. It addresses the critical idea of "conditional probability," which is very important in science, because it means the probability of one thing, *given that we know another*. As a silly example, consider the conditional probability of vaginisimus, given that the client is male. Did everybody get zero? As a further thought experiment, contemplate the statement "the probability that someone is dead, given that they've been hanged, is not the same as the probability that someone was hanged, given that they are dead." Two different pieces of information, two different inferences to make, and hopefully two *very* different probabilities....

Summary

There are many issues around probability, but many can be worked out fairly simply, often by imagining a room with 100 people in it and doing some simple calculations. Sometimes it's worth doing a little "thought experiment" to figure out what must really be the case when evaluating a research finding.

Probabilities are very much affected by the nature of the sample that we have obtained. In other words, how those 100 people came to be in the room is very important. This is a matter for the next issue in this series.

Dr Travis Gee is currently a lecturer at University of Southern Queensland (Springfield campus) in the psychology faculty and is an ACA board member and co-editor for cph (www.cphjournal.com).

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Researching the origin and nature of sexual preference: Nature & nurture revisited. Part 3

Abstract

Order — and our healing of disorder , is poorly understood by community though vital to counsellors and psychotherapists. Following Newton's science and natural history the medical model came to dominate community, scientific and religious understandings of health with its externalised *physic* (knowledge of nature). A psychological origin of healing & health with an internal referent is identified here in a cause & effect healing order. This uses a validated two-factor functional model of personality (see paper 2). This explains (a) sexual preference, (b) the action of freewill in healing, and (c) how spiritual development is blocked by pragmatic coping. This shows why spiritual development is moribund in Western culture, that is, why coping and dysfunction are instead common effects of absence of freewill. An enabling and unified solution is proposed to this socio-cultural malaise with its pre-empting assumptions and consequent harm.

Introduction

For want of better definition health is commonly defined as freedom from disease. Using pre-digital photographic analogy this definition of health is like a negative-image of a consequent positive photograph. A photographic positive is *real* whereas its negative is unreal, virtual, and *counterfeit*.

Counsellors, psychotherapists, educators, trainers etc, promoting two-way relationship can foster growth, identity formation and healing of disorder in individuals and groups.

A counsellor paraphrasing a client's verbal expression is instance of mirroring. Developmentally prior to [A] mirroring a parent is necessarily an infant's double. By doubling the parent establishes identity with the infant, this allowing the infant to bond in symbiotic relationship with the parent. Attachment theory and research shows the importance of this two-way connection. A child learns *to be felt* (doubled) in this psychosomatic first-stage of development and (usually) developing a sense of body inclusive of (immature) sexuality.

Counsellors, teachers, leaders etc, create rapport by accurately doubling their client (eg, individual or group), enacting their doubling role through listening, unconditionally, with genuineness and body posture. They are real, having *presence* to other; the client feeling *felt* and understood. Counsellors, psychotherapists, educators, trainers etc, promoting this two-way relationship can foster growth, identity formation and healing of disorder in individuals and groups.

Healing goes missing and living becomes morbid when *freedom from* (eg, dis-ease) is confused with *freedom* (ie, health). Clinically, clients experience this omissive angst-reality as psychological estrangement from self (dissociation) and social estrangement from others (disassociation). In their pervasive loss of confidence in self there also grows dissatisfaction with life as brutal, perhaps punishing. Where human freedom is wrongly equated by family, church, state and self with a reductionist freedom-from there might be liberation but that coping is without liberty. Coping, and *not-happy*, living can become obsessional-struggle. Struggling with too much journey and not enough destiny living becomes a worrisome problem: coping, even dysfunction. Begun early and readily internalised *as though reality*, coping — by going-with-people, going-against-people or going-away-from-people (Horney, 1945) — creates a virtual reality.

Liberation implies a former imprisoned, manacled or slave state; persecuted and persecutor, cowering and bullying: Role & counter-role. Liberation implies prior experience of not-free whereas freedom *is* freedom: *a rose is a rose is a rose* to quote Gertrude Stein. Liberty makes liberation possible: *I have a vision* said The Rev M L King. For many alive today liberty remains possible though improbable. Why are so many, often with so much, so unhappy?

Gay men and women have achieved, awakened by Stonewall in 1969, some of Gay Liberation's social equality vision. Like other minorities living in the *fight & flight*[B] mood of Western culture some individuals remain on-guard for the next homophobic mob-mentality. Behind an adult's coping-reaction likely lurks an earlier and deeply internalised learned dysfunction of (anaclitic[C]) depression: an outer or public counter-role (eg, fear of fear) and an inner or private role (eg, depression).

Anaclitic here refers to loss of relationship with self: a pervasive loss of self-connection, estrangement, archaically *fallen*[D] like Adam or Eve from being's unified presence. Adult gays were usually as children conditioned to be straight thus risking disconnection from their soul or psyche: losing-Eros for gay men. This primal-loss disposes children to grieving in (anaclitic) depression and coping that seems endogenous. Later, adult personality cannot fully emerge when self is manically denied its endogenous source. They live-out the disorder in dysfunction (psychosis) whereas in coping that loss & grief can normally be denied (neurosis). Disorder — the asocial and antisocial estrangement of the mentally disordered & the disorderly criminal — is effect: an objective expression of subjective estrangement.

Psychoanalyst Karen Horney MD (1885-1952) authored *Our Inner Conflicts* (1945). She proposed neurosis[E] consequent from learning to cope with *Basic Anxiety*. In other words children secondarily learn reactive or counterphobic coping identities & roles compensating their *loss of felt-ness* (double's nurture of identity); an original sin-experience or Basic Anxiety. Horney regards these complexes as neurotic, learned not innate; not predestined like Freud's *instinctual* and not *fallen by our human nature* per Catholic idiom.

Horney describes coping as a compensatory virtual-self countering experience such as absence of nurture (parental doubling); that is, losing-out creating grief (ie, existential angst[F]). A child ordained by nature to be gay can learn to (publicly) counter their negative social experience via coping whilst (privately) creating dissociative identity including asocial (flight) and antisocial (fight) roles. There, in coping, is the conditioned self and its virtual reality.

The closeted gay-man is a good example of coping. His counterphobic closeted-self (mania[G]) arises precociously as coping-adaptation (maladaptation) to his despairing experiences (anaclitic depression) causing his Basic Anxiety (mania). The end-cost of

coping is mortifying, parentification[H] blocking learning, identity and destiny from psycho-spiritual fulfilment in adult-identity.

A relational way of living, and understanding human nature & humane nurture, is required in culture. Much of the psychological literature objectifies, externalising nature & nurture. This paper describes and clarifies healing in a new order. This could transform our understanding and practice of nature-nurture and culture's current malaise.

Researching Order and Disorder

At our birth are we free? Are we entitled to freedom? Are we instead fallen, suffering by dint of nature and requiring an awakening liberation; a *coming out* before reaching freedom? Like a closeted gay-man (eg, bi-sexual) do we have need, can we *come out* from this stoic-suffering? At birth we are immature and, maladapting, we normally succumb to our problem-inducing culture. Its negative-nurture induces (mal-) adaptive coping and its reactive & reactionary mania, both mental (flight) and criminal (fight), for countering-disorder.

Without authoritative answer *don't know* uncertainties can be replaced by authoritarian and colonizing certitude, albeit problematically. Catholic antigay sentiment and culture's bully group-demand characteristics can parentify a child's personality around fight and flight's bully & cowering role-system. The child subjectively creates their own (private) living-role; *and* (mal-) adaptively a (public) counter-role or introjection mimicking their basic anxiety experience of loss via neglect-abuse. The closet-gay and bi-sexual are exemplars of this loss of identity (diffusion and foreclosure) in asocial and antisocial learning.

Without proper nurture the living spirit of the at-risk child (eg, *sissy* boy) can become further demonised by an imperialist and negating introjection of homophobic parentification. A child thus precociously loses their innocence (ie, estrangement or Lost Boy). Their immature personality is colonised by a counterphobic role to cope (eg, as closet-gay) with living the lie of the infantilised (depressed) self. Closet gays unwilling join the satanic cult of fearing fear.

Clinical experience shows that introjections are deeply unconscious, sometimes deeply troublesome. Socially constructed they create unconsciousness. Neglected and abused children can become neglectful and abusive parents and driving the intergenerational satanic cycle of neglect & abuse.

Gay men can as children internalise that they are heterosexual and that, somehow, they are female and/or feminine. Early wrong-learning and confusion æ introjecting false social sex role æ creates obsession and interfering with subsequent learning. In not *coming out* closet-gays instead cope with their socially induced error of *heterosexualised* parentification (mania) thus risking neurosis. Some transgender identity (ie, DSM transsexual) seems an attempt whilst risking psychosis[I] to play-out a double bind feminised parentification.

Order and disorder necessarily addresses freewill. This existential dilemma in Western culture was researched in the context of sexual preference (Franklin, 1988). What is this healing order valuing freewill and where conversely being lost & fallen in the Time Delusion[J] causes unreality and disorder, dysfunction and coping? Does being gay arise freely in truth and consequent order? Is being gay of order and therefore indeed existentially lawful?

Men and women struggle with culturally induced duality (eg, sexism). In *coming out* gay men and women struggle with another culturally induced duality: what is & is not real? Is being-gay real? Internal and external: which theory is true? Which is deluding creating coping and psychosis? The research outcomes are summarised:

Sexual Identity:

- A man's social sex role including biological male identity, boyhood, masculinity and manhood is unrelated in cause & effect with his sexual preference.
- A woman's social sex role including biological female identity, girlhood, femininity and womanhood is unrelated to her sexual preference.
- Genetics and social learning – conventional nature & nurture theories – do not explain sexual preference.

Gender Identity:

- Being-male (psychical male gender-role; Eros) gay men and straight women have a consequent sexual preference for men.
- Being-female (female gender-role; Psyche) straight men and presumably lesbians have a consequent sexual preference for women.
- In preferred sexual relationship the *other* appears to double *self* in positive identity: this relationship of similarity is true of both straight and gay couples.

This explains sexual preference as originating internally. Which theory of reality explains sexual preference? A scientific test was devised.

1. It showed that sexual preference is existential, expressing nature's male or female I am psychological identity. In innate freewill, and like a photographic-positive, sexual preference is *positively* explained as a subject-object operant in a unified theory of reality.

2. One theory of reality is *true*: real. The other is virtual: *counterfeit*. Being gay is innate, god-given; neither fallen nor counterfeit. This shows a first-principle of relationship: *like attracts like*. This natural law of the double – the parent's ability to role reverse with the child and creating identity – is writ first on the philosopher's stone. This explains that Eros (and Psyche) is prime to Logos: relatedness is prior to emergent difference, subject prime to object, double prime to mirror, chaotic-order prime to man-made mess. This subject-object order explains both heterosexuality and homosexuality: mythologically *in the beginning is Eros* (and Psyche). Now, scientifically *in the beginning is subject*, not object. Difference, like Aesop's *Hare* (& Tortoise) and mirroring, is secondary. Developmentally, in the beginning *the word* (logos) is second. In right order space flows into time: reality is archaic before it becomes ancient; immature before mature.

3. Some gay and straight participants were fallen into disorder's suffering. The second developmental factor – nurture – can lead to health. Or, in absence, to anaclitic disconnect and fall. Spiritually, health and

Neglected and abused children can become neglectful and abusive parents and driving the intergenerational satanic cycle of neglect & abuse.

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suffering when expressed in religious idiom are heaven and hell.

This explains disorder as an induced loss-model. We become lost in *original sin*, a deluded, nether, lower-order, dark, anaclitic, hellish, isolate, coping, neurotic, even psychotic and virtual world of segregation. Mankind's original sin and consequent suffering arises socio-culturally in the Time Delusion: a reversed, lower, and overly literal-order (physic paradigm) commonly used in science, education, health, politics, etc.

Societies, substituting that man-made, lower, brutal and satanic-order for a civilising and higher order (metaphysical paradigm) create instead a virtual *reversed order*: a profoundly confusing delusional-reality masking reality. Coping with that socially constructed and problematic world an unrelenting *freedom from* struggle may be highly valued. Language such as the war on drugs, the war on terror, the war on poverty, the war on … everything reflects an antagonistic culture in maniacal mood manufacturing for posterity its own mad-unreality.

Historically homosexuals have been seen as asocial and antisocial; deviants from social norms and breaking moral codes. However, this research shows that being gay expresses innate nature. Is instead its nurture deviant? Nurture was also put to scientific test. This developmental factor — spontaneity nurturing creativity — predicts order. And in loss of development or identity formation there, in Hell, grows grief.

Sexism and heterosexism are familiar outcomes of segregation creating (manic) power & (depressing) powerlessness.

Dual Consequences of Loss

The holistic and fallen worldviews were tested in the context of sexuality. The customary view of gay as fallen was shown to be not real. First because there is a lack of scientific evidence that was, again, shown here; secondly because gay is instead explained holistically. Notes 1-3 above summarise and demonstrate a new understanding of sexuality in this developmental order. Here is a healing order that is progressive, not reversed into disorder and not *backwards-looking* — not locked into Time — like Lot's wife.

Disorder arises in a human propensity (eg, Humanism) to create singularity and delusional reality (eg, paternalism). Disorder's duplicitous-offspring — the disordered & disorderly states of counterfeit consciousness — are socially-created, learned-socially and internalised (introjected) as though reality. The dual downsides of coping are:

1. Mental illness: loss of spontaneity internalised in relation with self.
2. Criminality: loss of spontaneity externalised in relation with others.

Coping 1: Mentally Disordered

Sexual preference expresses our male or female gender-nature. The contrary worldview that gay is deviant arises in a virtual reality. Karen Horney observed that in coping people normally live-out contrary worldviews. Closet-gays are here exemplar. Whether gay is deviant was put to scientific test (Franklin, 1988). Firstly, it showed the innate male gender-identity of gay men. Secondly, that deviancy is created in socially constructed theory (eg, Humanism). In essence that theory, whether religious or scientific, aborts the psychosocial for the social paradigm. In other words the external paradigm comes to dominant the internal; collectivism denies the individual as Echo is denied by Narcissus.

Coping 2: Disorderly Criminal

Must *fallen* be perpetually manufactured by society as though acting on God's behalf to test individual worth? That hubris of judge-mentalism creating suffering is mania worthy of Satan. It is however a man-made assault on spontaneity (eg, freewill), humankind creating the school of hard-knocks and other disorder-patterns institutionalising failure. Why for instance does *institutionalised paternalism* (eg, Catholic heterosexism) seek to block non-heterosexual human development? Why indeed does society act to create suffering? Were the Buddha, Christ, or Prophet alive today would they not ask this question they once addressed in person?

Criminality arises counter in a social context of abuse-neglect of power. Sexism and heterosexism are familiar outcomes of segregation creating (manic) power & (depressing) powerlessness. Other messy bipolarisations include racial, religious and ethnic divisiveness: socio-cultural segregations encouraging parentification in children who become in Time its exponent and its victim.

Humanism — containing a stoic-philosophy repressing and depressing individuation — arises socially in a cultural delusion defying innate order & consequent law. Without right-order a multitude of despotic-tyrannical singularities emerge. These are archetypically criminal and obsessionally one-factorial like Narcissus ignoring Echo.

Conclusion

Sexual preference is an operant of gender. I have described research identifying and testing two models of human existence: one is interactive, two-factorial and subject-object unified. The other is a singularity in the name of unity: a loss-model prophetically satanic causing confusion, division and dis-unity. In comparative test of these unified and unity models the former was validated and predicting the origin and nature of sexual preference.

The unity-model, often expressed in anti-gay sentiment promoting law & order, creates disorder because creativity without spontaneity and vice versa operationally defines disorder. At the macro-level this was similarly expressed in image by Einstein: *science without religion is lame, religion without science is blind* (Isaacson, p390). In other words the Rule of Law is first-based on right order.

Developmentally, difference is important in human individuation. However integrated difference *emerging developmentally from* (eg, growing manly from boyish) should not be confused with socially-created *difference created between* (eg, segregated

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masculinity & femininity). Relationship includes sameness (positive identity) and difference (negative identity): men who also are gay or straight. Counsellors, most notably in couples counselling, should not confuse individualism (eg, segregation) with individuation (eg, integration).

Like children confusing parental doubling and mirroring, societal confounding of eternal and chrononological time (ie, Time Delusion) causes confusion and subsequent disorder. Newton's clockwork-universe mirrors his Englishman's Stoic[K]-philosophy that sent colonial-roots deep throughout the world. In summary:

1. Psychological disorder has a known cause. Loss, through neglect or abuse, is experienced as existential angst (eg, Lost-boy and Loner identities) and its countering via coping (eg, Closet-gay counter-role) creates anxiety, depression and psychosis. *Coming out* from this spiritual death is a modern-day version of Christian resurrection into Life. Why does Catholicism reject this?
2. Induction of madness (mania) is socio-cultural. In its Time Delusion society *criminally* substitutes chronological time (physic paradigm) over eternal time (metaphysic paradigm). This creates a reversed law & order mind-set, an anti-progressive system of attitudes and beliefs (eg, neurosis; psychosis). That difference-mentality opposes innate order underpinning personality, human development and individuation. Anti-learning attitude helps explain why human & humane psycho-spiritual development remains generally moribund.
3. An enabling solution is implicit: reform society. This means *spontaneity nurturing creativity* and so redefining nature-nurture debate to developing human nature & humane nurture. Initially this means that instead of single-minded intellectual development we would highly value holistic identity formation across the lifespan.

Spontaneity is a freeing and civilising factor making that unified vision of a peaceful human & humane destiny possible *and* probable.

Western culture requires renewal. This implies for instance allowing a collaborative culture of order & law to emerge and develop. Imagine a collaborative instead of competitive world where the $X-trillion dollars spent by the USA on wars in Irag and Afghanistan instead could have been invested in education & health. Judaism, Christianity, Islam and other groups espouse their future fulfilment in a just & fair society. As creativity is to wild-human (ie, nature) so spontaneity is to humane (ie, nurture). Spontaneity is a freeing and civilising factor making that unified vision of a peaceful human & humane destiny possible *and* probable.

From a perspective of professional development what can a psychologist, counsellor or psychotherapist take from this trilogy? Here are three that might assist our challenging clients to move from being impersonal to becoming personal. First is developing a companionable role of double to the client, a reprieve from normal adversarial systems passing as social. Second is an ability to enter into the client's world with humility (eg, under-standing). Third is an ability to move spontaneously between subjective and objective states, unifying and healing religious & scientific realities.

Endnotes

Note[A] **double** (Oxford Dictionary)

2a a counterpart of a person or thing; a person who looks exactly like another. b an understudy.

5 intr. (usu. foll. by as) play a twofold role.

Note[B] **fight & flight**

Wilfred Bion (in Rioch, 1970) identified three *basic assumptions* in groups including **fight-flight**. This (pre-emptive) assumption can set a prejudicial mood to avoid the real work of the group and is expressed through individuals as counter-role (eg, mania) and role (eg, depression).

Note[C] **anaclitic**

Stedman's Medical Dictionary, 2nd Edition (2004): The impairment of an infant's physical, social, and intellectual development following separation from its mother or primary caregiver.

AlleyDog.com: This is a type of depression that occurs primarily in infants who have been separated from or lost their mothers or primary caretakers. If a child suffers from anaclitic depression there is a high risk of serious developmental problems both intellectually and physically. Although anaclitic depression has been reserved almost exclusively for infants, psychologists have found it in adults and even monkeys.

Note[D] **fallen** (author)

1. Implies a fall from heaven or grace and hence fallen by birth from initial unity. This loss-model, and hence atonement and redemption, is the usual meaning of *fallen*.

2. In Christian mythology God is incarnate in Jesus on earth. Jesus, including his gender-identity, is differentiated from a neuter-matrix which includes male and female as undifferentiated principles. Differentiating from neuter via identity formation this innate and now male or female creativity-principle taking human-form and nurture is a developmental model.

Note[E] **1. neurosis** (singular; Oxford Dictionary)

a relatively mild mental illness involving symptoms of stress (eg, depression, anxiety, obsessive behaviour) without loss of contact with reality, and not caused by organic disease.

2. neuroses (plural; Free Dictionary)

Any of various mental or emotional disorders … arising from no apparent organic lesion or change and involving symptoms such as insecurity, anxiety, depression, and irrational fears, but without psychotic symptoms such as delusions or hallucinations. No longer in scientific use.

Note[F] **angst** (Oxford Dictionary)

1 anxiety.

2 a feeling of guilt or remorse. [German]

Note[G] **mania** (Oxford Dictionary)

1 Psychol. mental illness marked by periods of great excitement and violence.

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2 (often foll. by for) excessive enthusiasm; an obsession (has a mania for jogging). [from Greek, = madness, from mainomai 'be mad': related to mind]

Note[H] **parentification** (author)

Social-learning process whereby children and others adopt-roles before they are emotionally or developmentally prepared; gay men who are not able to live-role without turning into a *pillar of salt*. Disavowed, the infantilized inner-child, psyche or soul becomes an *emotional orphan* (eg, anaclitic depression) socially defended to survive in a noxious environment by precociously developing **parent-like coping skills** (eg, counterphobic mania). See also *Megalomania normalis* in Sourcing Human Madness (Franklin, 2008).

This object-subject reversal causes socio-cultural delusion, personal & interpersonal confusion, and potential order becomes disorder.

Note[I] **psychosis** (Oxford Dictionary)

a severe mental derangement, esp. when resulting in delusions and loss of contact with external reality. [Greek psukhosis from psukhoo 'give life to']

Author note: A person (eg, closet-gay) in the Time Delusion of virtual reality stoically giving their life to further culture's reversed-order.

Note[J] **Time Delusion**

Confounding of eternal and chronological time confusing philosophy; physic paradigm usurping metaphysical paradigm. This object-subject reversal causes socio-cultural delusion, personal & interpersonal confusion, and potential order becomes disorder.

Note[K] **stoic** (Free Dictionary)

1. One who is seemingly indifferent to or unaffected by joy, grief, pleasure, or pain.

2. A member of an originally Greek school of philosophy, founded by Zeno about 308 bc, believing that God determined everything for the best and that virtue is sufficient for happiness. Its later Roman form advocated the calm acceptance of all occurrences as the unavoidable result of **divine will or of the natural order**. (Emphasis added).

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6. Buy on-line via secure Commonwealth Bank link
7. Instantly receive your policy schedule and tax invoice via your nominated email address

Visit our web site **www.rowlandhouse.com.au** to obtain further information about us. For all policy enquiries and assistance, please call our help desk on **1800 642 747.**

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Blogging: Share the Love By Dr Angel Lewis

Overview

This article examines blogging as way for ACA members to promote their practices and enhance their professional profiles.

Should you be writing a blog? What should you be writing about? How often? Will it really add any value to your professional life? And for many of us—how will we find the time? If this sounds familiar, it's because you're not alone. While GenY probably doesn't ponder these questions, busy adults trying to run a business or earn a living are likely to see activities such as writing a blog as just one more thing on a long list of 'to dos'. However there is much to be gained by doing this in terms of growing your professional profile and as I have found, in terms of self-development.

What Are Blogs?

Blogs are one of the earliest forms of social media. A blog is an online journal that is regularly updated with articles, links and commentary. The content reflects the interests and expertise of the author, and while blogging has long been a way for individuals to write and share personal journals, they have now been embraced by business as a way of connecting to clients and customers. If you decide to maintain a business blog, you are sharing your professional expertise and attempting to provide something of value to your readership. Your blog should be active and engaging, and provide content of value. This might include opinion pieces, links to interesting articles, videos or websites, writing tips relevant to your industry or businesss or sharing new research, findings or developments in your field of expertise. Put simply, if you're a cab driver then your blog had better have lots of cab content; if you're a counsellor, then it needs lots of mental health content. You get the idea—you write about what you know and what you want to be known for

Spend some time searching for other blogs in your industry and take the time to visit them and post comments as ths also makes you known.

Ideally, your blog will work on the principle of a two-way conversation between yourself and your readers and must be based on interaction and not just pushing out your message, so you should be engaging in online discussion with people who post opinions on your site. As well, the blog must be regularly updated. If you only add news or updates sporadically, there's nothing to keep readers engaged—and worse, it makes it look like you are not that invested or interested in your own business or product. Experts in this field recommend updating a blog a minimum of 2-4 times a week to keep it fresh and interesting and attract both new and repeat visitors, and it can take 4-5 months to attract regular followers to a blog. For this reason you need to genuinely enjoy any reading, writing and research time put into your blog, or it may begin to feel like a noose around your neck.

The professional blog is not an online soap-box for broadcasting random thoughts or discussing personal issues; nor is it just an opportunity to self-promote or advertise. There is nothing wrong with writing about what your business is doing, or upcoming events or programs, but this cannot be the lynchpin of your content. The key words to keep in mind regarding content are 'sharing' and 'adding value', as self-promotion should happen as a by-product of writing a good blog, and is not the sole reason for doing it.

While the language of a blog tends to be informal, be mindful of the fact that you never know who is reading it, so while you can be warm, friendly and engaging, this must be underlined by professionalism. As blogger Robert Scoble writes in his 20 tips to blogging, *'Your blog is your resume. You need one and it needs to have 100 posts on it about what you want to be known for'.*

Of course if you want to write a blog for fun then none of this applies, but keep in mind the world is reading, and if you blog under your real name and are racist, sexist, politically incorrect or critical of clients, competitors or colleagues, there is a chance that would-be or existing clients or employers may just read all about it.

There are many free blog hosting sites and they can be easily found with a Google search. Otherwise see your webmaster about having a blog page added to your own website. People do not have to be approved as a friend or made a member to read your blog and it is published on the Internet in the same way as a webpage with a web address. People without a website may choose to maintain a blog as a way of having an online presence, and whether this is linked to a website or not, a well written, interesting and engaging blog can be a relatively low cost way for any business or professional to build and maintain a reputation in their chosen industry.

Once you have established your blog, you need to make yourself known. Make a link to it from your website (if are hosting with a blogging service), that invites customers, clients and contacts to visit your site, put the address in your email footer or put it onto your business cards. Also spend some time searching for other blogs in your industry and take the time to visit them and post comments as ths also makes you known. I find Google analytics a very useful tool for measuring traffic on my blog, right down to how times a post has been read. This can be heartening if you have been faithfully posting to your blog for months without any feedback and feel like nobody is reading your contributions. Remember, people may not bother to post comments or make themselves a follower, but that doesn't mean they havent bookmarked your page or read it regularly.

Microblogging

Twitter is what is known as a Microblogging tool. Twitter's annual growth-rate in Australia in the past 12 months is said to have been 3,200%, with 60% of users 35-plus. It is regarded as an excellent source of word-of-mouth advertising, but the flip-side is that it can also generate negative press.

Once you have set up a Twitter account you can post up to 140 characters of information in a similar way to a text message, so users tend to adopt a fairly casual style. 'Tweets', as these communications are known, can be read online or via mobile phone. Once online with Twitter, the recommended strategy is to locate people who are associated with your profession, industry or cause—market leaders, those who work in the industry, those having conversations around the issues that interest you (.e.g health care, counselling)—and make a link to them (known as following). Just like blogging, Twitter works on engagement, so to become a part of this online

community and build up your own following you will need to make comments on what others have said, respond to remarks and engage in conversations and exchanges of information with other Twitter users interested in the same issues. Twitter has a tool called Tweetdeck that can be downloaded to enable filtering and searching of messages from likeminded people, to make it easier to link to them. If you are consistent, useful and interesting you should eventually build followers; however, it can take between 6–12 months for this occur. Professionals say that a person needs to tweet 4–5 times daily over this period, as any less than this will fail to foster engagement with other Twitter users.

Blog don't Blab

As blogging and tweeting become more pervasive, debates surrounding security and privacy continue in the face of sensitive information and private photos appearing on social networking sites the world over. Remember the old phrase 'loose lips sink ships', and be careful not to give away critical or inappropriate information about your clients or employer when blogging. While many organisations in Australia routinely ban any form of social networking access, they can't stop individuals posting sensitive information from their homes and personal computers, so the onus shifts to the individual to think about issues related to the confidentiality of others. Health care professionals should remember to keep names and identifying data out of blog posts if discussing case studies or situations encountered when working with clients, because even if you think you are making a seemingly innocent comment, it may be damaging to the individuals or business concerned. Earlier this year the US Marines banned all forms of social networking sites including Facebook, Myspace and Twitter as they consider them serious security threats.

At the end of the day is it worth investing your time in online publishing?

While blogging is free and your audience potential is vast, it is necessary to invest something—and that is your time and effort. Successful blogging requires the writer to come up with interesting posts suitable for the intended audience on a steady, regular basis. If you are prepared to do this, writing informative, useful articles can build trust and respect within your profession (even if you can't see all that writing actually bringing in any dollars), which can translate into a sense of expertise around your business or brand. Inviting colleagues to comment or dialog with you about what you have posted it is a great way to get feedback as well as engender a form of community and friendliness that comes from engaging in online conversations as yourself—all great ways to building brand 'you'. For anyone that is worried about posts being left on their blog that may be critical or damaging, all blogs have tools that allow you to moderate and choose what is published.

An unexpected by-product I have discovered from blogging is that it is a great way of continual self-development (or self development by default). Because I need to be disciplined about regular reading and research so I have something of value to write about, I am constantly learning and discovering new things. So the personal benefit to me is that I remain current, informed and knowledgeable in my field.

At the end of the day, your blog posts need to provide something of value (information, ideas, tips) and foster engagement and dialog with followers. People know when they are being sold to, and if your blog posts are nothing but a string of advertisements for your services, people will quickly lose interest. However if you are helpful enough, your social networking credibility (and therefore your professional reputation) should grow substantially as a result.

Angela Lewis blogs around IT and learning at:

Http://angelalewis.wordpress.com

Author Note: Let's foster our own community of practice: if ACA members would like to set up a blog and then send me the blog site address, I will collate these and publish a list of them in the next issue of the ACA Journal. The bloggers can link to each other's sites and the ACA community at large can then also visit the published list of blogs.

References

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<www.successbox.com.au/online-marketing/social-networking-for-small-business/>.

Robert Scoble's Blog at: http://scobleizer.com/2009/01/12/if-you-are-laid-off-heres-how-to-socially-network/

Twitter www.twitter.com

Dr Angela Lewis is a full member of ACA and runs her own successful I.T. consultancy www.angelalewis.com.au

ACA

Health care professionals should remember to keep names and identifying data out of blog posts if discussing case studies or situations encountered when working with clients.

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
Heide 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 8005 7707	MA Couns. (Psych.UWS), Grad Dip Couns.(Spo.Perf. Psych.ACAP) Dip T.A(ATAA), Cert IV Assess. Work. Train.(ISA), Cert IV Ret. Man. (ISA)	$150	Group and Phone by Nego
Thomas Kempley	Central Coast	0402 265 535	MA Counselling, Supervisor Training	$75 ind, $55 Grp	Face to Face, Phone, Group
Lyndall Briggs	Kingsgrove	02 9554 3350	Dip. Clin. Hypno., Clin Supervisor,Master Practitioner of NLP, Dip. Nutrition, Cert. IV Workplace Training & Assessment	$66	Face to Face, Phone, Group Skype(Web)
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	$90	Face to Face & Phone
Robert Scherf	Tamworth	02 6762 1783 or 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 (2hrs)
Lidy Seysener	Mona Vale	02 9997 8518	Cert Couns & Psychotherapy Prof Sup (ACCS), Masters NLP	$150	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 Carley	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	0428 218 808	Dip Prof Counsel (Workplace)(Realationships), Dip Career Guidance, Supervisor Training (AIPC), Cert IV Training & Assessment	$66	Face to Face, Phone, Group Web
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	Bondi Junction & Castle Hill	02 4566 4614	MA Applied Science, Supervisor Trg (AIPC)	$120	Face to Face, Phone, Group
Karen Daniel	Turramurra	02 9449 7121	Expressive Therapies & Sandplay Therapy, Supervisor. Traing., (ACCS)	$90 1hr/$150 2hrs	Face to Face
Rod McLure	Bondi Junction	02 9387 7752	Supervisor Training (ACCS), Psychotherapist	$110	Face to Face, Phone, Group
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	CMACA, BA Psych (Hons), PsyD Psych, NLP Trainer, Clinical Hypnotherapist, AIPC Supervisor	$120 ind/ $75 grp/2 hrs	Face to Face, Phone, Group Web
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
Deborah Rollings	Sutherland	0404 884 895	BA (Social Work)	$90	Face to Face, Phone, Group
Leon Cowen	Lindfield	02 9415 6500	M.Adult Ed, BA, B.Ed, Cert IV (train), Cert Supervisor: Cert. Counselling, A.D.C.O.,Clinical Member A.A.R.C & Clinical Member AHA, Accredited Marriage and Family Counsellor - Therapist - Supervisor & Trainer	$150	Face to Face, Phone, Group
Sandra Rutledge	NSW	02 4446 0452	CCC Supervisor training	$77	Phone
Susan Rosevear	Invergowrie	02 6772 9973 or 0428 752 347	347 Diploma of Counselling; Supervision training,	$50	Phone, Group, Face to Face
Gwenyth Lavis	ALBURY	0428 440 677 or 02 6026 6141	Professional Supervisor training(July, 2007); Graduate Diploma of Counselling (May, 2005) Advanced Dip of Counselling and Family Therapy	$85	Phone, Group, Face to Face
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 or 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 Supervison (Rel Aust)	$88 Ind $25 Grp	Face to Face, Phone, Group
Bob Pedersen	Hervey Bay	0409 940 764	Dip. Pro.Couns., Dip. Chr. Couns.	Neg.	Face to Face, Phone, Group
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 to $95	Face to Face, Phone, Group
Beverley Howarth	Mitchelton	07 3876 2100	Dip Prof. Healing Science, CIL Practitioner	$120	Face to Face, Phone, Group
Kaye Laemmle	Bundall	07 5570 2020	Dip Prof. Couns., Bac.Soc.Sci. Counselling, Realationships & Communication, SOA Supervision (Re.Aust)	$85	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	PhD, Psych Board Accreditation, Grad Dip Couns, Registered Psychologist	$130	Face to Face
Yildiz Sethi	Hamilton	07 3268 6016	B.Ed. Grad Dip Couns, Dip Hypnotherapy, B Ed, Grad Dip Couns, Dip Hypnotherapy, NLP Pract, Family Constellations, Brief Therapist, Prof. Sup, Educator ACAP	$80 Ind $40 Grp	Face to Face, Phone, Group
Dawn Spinks	Birkdale/Capalaba	0417 633 977	BA Hons (Psych & Education), MPH, MACA (Clinical)	$110	Face to Face, Phone
Dr. Jason Dixon	Grange	0416 628 000	PhD, M.Soc.Sc (COUNS), Cousellor Education and Supervision/Community Mental Health Counselling	$121	Face to Face, Phone, Dist (via video conferencing)
Dorothy Rutnarajah	Point Vernon	07 4128 4358	Master of Counselling	$110	Face to Face, Group
Catherine Dodemont	Grange	07 3356 4937	B SocSci (ACU), Mcouns, ACA accredited Supervision Workshop, TAA40104, Pre-Marriage Educator (Foccus), CMACA	$95	Face to Face, Phone, Sml Group, Long Dist, Phone
Edward Riley	Hope Island	07 5530 8953	B.Ed. MPA, Grad Dip SocSci (Counselling), MA, Clinical Membership, QAFT	$80	Face to Face, Phone, Group
Roni Harvey	Springwood	07 3299 2284 or 0432 862 105	Master Counselling, Dipl Appl Sci Comm & Human Serv, 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

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
Lyn Baird	Maroochydore	07 5451 0555 or 0422 223 072	GD Counsell, Dip Psych, SOP Supervision, Ma Soc.Sc (Pastoral Counselling), RN, Dip CCFT, Cert IV TAA	$77	Face to Face, Group
Sharron Mackinson	Caboolture	07 5497 4610	Dip Couns, Dip Clinical Hypnotherapy, NLP Pract, Cert IV WPA&ST	$80 Ind $25 Grp	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
Heidi Edwards	Gympie	07 5483 7688 or 0466 267 509	B.Bsc; CMACA; MCCA; Prof.Supv.(AIPC); Fac MHFA	$99	Face to Face & Phone
VICTORIA					
Deborah Cameron	Albert Park	03 9893 9422 or 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 or 0417 447 374	MA Prelim (Ling) BA, Dip Ed, Dip. Prof Counselling, Cert IV in C.Supervision Cert IV in TAA, MACA, MSCAPE	$90 Ind $35 Group	Face to Face, Phone, Group
Miguel Barreiro	Croydon	03 9723 1441	BBSc (Hon) Psychologist	$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
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
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 Swinsburn, 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
Berard 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	0428 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	Narrewareen Ferntree gully	03 9703 2920 or 0400 032 920	Dip. Appl Sc (Couns.) AAI, Prof. Sup (ACCS)	$70 Grp $20 Discnt for FVC membs	Face to Face, Phone, Group
Rosemary Caracedo-Santos	Ocean Grove	03 5255 2127	Dip Prof Couns, Cert IV Health Clinical Hypnosis	$66 Ind $35 Grp	Face to Face & Phone
Joanne Ablett	Phillip Island	03 5956 8306	M Counselling, Back Ed, Dip & Adv. Dip. In Expressive Therapies, Prof Spvsr	$80	Face to Face, Phone, Group
Zoe Krupka	Seddon	0408 880 852	Cert Prof Supervision	$100	Face to Face, Phone, Group
John Hunter	Kew East	03 9721 3626	Bach Counselling, Supervisor Trg	$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
Graeme Riley	Gladstone Park	0423 194 985	Master of Ministry; Graduate Diploma Pastoral Counselling; Diploma of Ministry; Clinical Pastoral Education (1891,1988,1987)	$75 Ind $100 Grp	Face to Face, Group
Rosslyn Wilson	Knoxfield	03 9763 0033 or 0422 120 114	Supervisor Training; Dip. Prof. Couns, Dip of Holistic Counselling, Dip of Expressive Therapies	$70	Phone, Group. Face to Face
Jenni Harris	South Yarra	03 9490 7599 or 0406 943 526	MA(MIECAT)Supervision; Adv. Supersion traning Nada Miocevic; Grad Dip in Experimental & Creative Arts Therapy	$80 indi $90 Grp	Phone, Group, Face to Face
Cheryl Taylor	Port Melbourne	03 8610 0400 or 0421 281 050	Certificate IV in Counselling Supervision-RTA &BECS; Dip of Teaching, Cert in Counselling an Psychotherapy, Accredited Telephone Counselling, Grad Dip in Christian Counselling, Neuro-Linguistic Programming	$88	Group, Face to Face
SOUTH AUSTRALIA					
Dr Odette Reader	Norwood	0411 289 869	Cert IV Training & Assesment, Adv Dip TA	$110	Face to Face, Phone, Group
Kerry Cavanagh	Adelaide	08 8221 6066	B.A. (Hons), M. App. Psych.	$130	Face to Face, Phone
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 Ter, Supervisor Trng	$100	Face to Face, Phone, Group
Anne Hamilton	Gladstone	08 8662 2386 or 0416 060 835	RN, RPN, MHN, Grad Dip H Counselling, Supervisor (ACA), Master NLP, Coaching and Timeline Therapy	$90	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 Benfredj	Glenelg South	08 8110 1222	Grad Dip Hlth Couns, Dip Couns and Comm, Adv. Dip. Appl. Soc Sc, Bed, MA	$90	Face to Face, Phone, Group
Carol Moore	Old Reynella	08 8232 7511	GradDipSocSc{Couns}; B Bus {HRD; Dip.Prof.Couns.Prof Super Trg.	$99/hr Ind $35/2hr Grp	Face to Face, Phone, Group
Dr. Chris White	Gilberton	08 8344 3837 or 0414 884 637	M.B.; B.S.; F.R.A.N.Z.C.P. (Ret); DSc. (Psych); C.M.A.C.A.; M.A.I.P.C.; A.M.I.T.A.A.; M.R.E.A.A.	$100	Phone, Group, Small Group, Face to Face, Long distance
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 9418 1439	Adv. Dip. Edu. Couns. M.A., Religion, Dip Teach	$80 $60 Con HltCareCrd	Face to Face, Phone, Group
Lillian Wolfinger	Yokine	08 9345 0387	Professional Supervision	$60	Face to Face, Phone
Beverley Able	Scarborough	08 9341 7981 or 0402 902 264	Registered Psychologist	$110	Face to Face
Deidre Nye	Gosnells	08 9490 2278 or 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
Hazel Jones	Currambine	08 9304 0960	Supervisor Training	$Neg	Face to Face, Phone, Group
TASMANIA					
David Hayden	Howrah	0417 581 699	Dip Prof Counselling, Supervisor Trg (AIPC)	$80	Face to Face, Phone, Group
NORTHERN TERRITORY					
Margaret Lambert	Brinkin	08 8945 9588 or 0414 459 585	Dip.T, B.Ed, Grad.Dip.Arts, Grad.Dip.Psych., B. Beh.Sc.(Hons).	$80 Ind $130 Grp	Face to Face, Phone, Group
ACT					
Brenda Searle	Canberra/Region	02 6241 2765 or 0406 376 302	Grad Dip of Community Couns., Adv Cert of Clinical Hypnotherapy, Dip of Prof.Couns, Supervisor Trg (AIPC)	from $50 to $80 (nego)	Face to Face, Phone, Group
Ingrid Wallace	Chisholm	02 6247 0655 or 0417 447 374	MA (Counselling), Grad Dip of Community Counselling, Adv. Practitioners Cert in Clinical Hypnotherapy	$100	Face to Face, Phone, Group
SINGAPORE					
Hoong Wee Min	Singapore	65 9624 5885	MA Social Science, Supervisor Trg	$100	Face to Face, Group
Laurence Ho Swee Min	Singapore	65 9823 0976	Masters of Arts (Applied Psychology), Grad Diploma in Solution Focused Brief Therapy	$70-$90	Face to Face, Group

Internet Resources for Counsellors 2010 Update

This document is an update of our 'Internet Resources for Counsellors' list which was last issued in January 2009. It contains websites that have featured in my Internet Resources columns published in the ACA Journal over the past few years as well as site addresses published in past issues of the ACA e-zine newsletter. This list is in alphabetic order based on categories, but as you will notice some could belong in more than one category.

While these Internet addresses were correct at the time of printing, readers are advised website addresses could change at any time and neither Angela Lewis nor ACA take any responsibility for these addresses remaining correct or in working order at any time in the future (the nature of the Internet being what it is). If members wish to suggest inclusions to this list, please email either Philip Armstrong or myself with any websites you would like to share with fellow members and we will be sure to include them in next year's update.

Addiction

Alcohol

Alzheimer's Disease

Anxiety, Panic Attacks/Disorder

Asperger's Syndrome

Addiction

www.sexaa.org. Home page of Sex Addicts Anonymous who advertise themselves as a fellowship of men and women who share their experience, strength and hope with each other so they may overcome their sexual addiction and help others recover from sexual addiction or dependency.

http://www.aa.org.au/. Alcoholics' Anonymous site with links to groups Australia wide.

www.gamblersanonymous.org.au. Offers help for compulsive gamblers and their families and friends. This site also includes programs, testimonials and other links to help in the gambling journey.

http://www.naoz.org.au. Website of Narcotics Anonymous, providing information about events and meetings in Australia.

http://www.adca.org.au/. The Alcohol and other Drugs Council of Australia (ADCA) is a national, non-government organisation representing the interests of the Australian alcohol and other drugs sector, providing a national voice for people working to reduce the harm caused by alcohol and other drugs.

http://www.addictionrecoveryguide.org/. The Addiction Recovery Guide.

http://ndarc.med.unsw.edu.au/ndarcweb.nsf/page/home. Website of the National Drug and Alcohol Research Centre (NDARC) of the University of New South Wales. Has links to publications and resources surrounding drug abuse.

www.netaddiction.com. This website deals specifically with Internet addiction issues such as cyber-pornography addiction, chat room addiction and eBay addiction.

http://psychcentral.com/netaddiction/. Provides some good information and articles on the topic of Internet addiction issues.

http://www.medicinenet.com/sexual_addiction/article.htm. MedicineNet.com is an online, healthcare media publishing company and this link gives an overview of sexual addiction.

http://www.webmd.com/mental-health/features/shopping-spree-addiction is an interesting link takes you to an article on shopping addiction from the WebMD website.

Alcohol

http://www.aa.org.au/. Alcoholics Anonymous site with links to groups Australia wide.

http://youth.wyndham.vic.gov.au/support/alcohol. Wyndam is a Victorian government service which offers withdrawal, rehabilitation supported accommodation and community programs for young people 12-21 experiencing drug and/or alcohol problems.

http://www.adca.org.au/. The Alcohol and other Drugs Council of Australia (ADCA) is a national, non-government organisation representing the interests of the Australian alcohol and other drugs sector, providing a national voice for people working to reduce the harm caused by alcohol and other drugs.

Alzheimer's Disease

www.alzinfo.org. The Fisher Center For Alzheimer's Research Foundation is an American Body headed by a Nobel prize winning scientist. The site provides information on treatments and research as well as having a strong focus on education and awareness.

www.alzheimers.org.au. Website of the peak Australian body providing support and advocacy for the Australians living with dementia.

www.alzheimersonline.org. Queensland based not-for-profit community organisation whose is to help maintain the quality of life of people diagnosed with dementia and their caregivers.

Anxiety, Panic Attacks/Disorder

www.anxietyaustrala.com.au. An independent site which provides information about anxiety disorders, the treatment options, psychologists around Australia who treat anxiety disorders, group therapy & workshops, support groups, articles, resources and links to other sites.

www.ada.mentalhealth.asn.au. Anxiety Disorders Support and Information (ADSI) is a program of the Mental Health Association NSW Inc and includes information on anxiety Agoraphobia and panic attacks.

www.panicattacks.com.au. This website is run by the Panic Anxiety Disorder Association Inc. (PADA Inc) a consumer organisation representing people who have an anxiety disorder. It provides articles and links related to panic attacks and anxiety.

http://psychcentral.com/disorders/anxiety/phobias.html. PsychCentral's website provides a huge range of free information related to various anxiety disorders.

www.panicanxietydisorder.org.au. Panic Anxiety Disorder Association.

http://www.socialanxietyassist.com.au/. Shyness & Social Anxiety Treatment Australia provides information about social anxiety, the treatment options, psychologists around Australia who treat social anxiety, group therapy & workshops, support groups, articles, resources and links to other sites.

Asperger's Syndrome

http://www.ninds.nih.gov/disorders/asperger/asperger.htm. The National Institute of Strokes and Neurological Disorders probably has the most comprehensive information I was able to find.

http://home.vicnet.net.au/~asperger. The home page for families with a member suffering from Asperger's Syndrome in Australia.

http://www.udel.edu/bkirby/asperger/aswhatisit.html. An organisation called 'oasis' functions as an information and support portal for sufferers and their families.

www.artzoo.com/health/autism.htm An easy to read overview of Asperger's.

http://www.aspergerssyndrome.net/. Links to the first 6 chapters of a book related to ADHD, written that was written by a clinical psychologist.

Autism

www.autismsupport.org.au/. The Autism and Aspergers Support Group homepage.

www.autismsa.org.au/html/about/family_support.htm Website of Autism South Australia, a support group for carers of people with Autism or Asperger syndrome www.exploringautism.org The Exploring Autism website is the collaborative effort of Autism Genetics Cooperative, a group of researchers and clinicians working with the help of families with children affected by Autism to find the genetic causes of Autism.

www.autismvictoria.org.au/parents. Help and advice for parents with an Autistic child.

Brain

www.brainfoundation.org.au. An Australian site with details and information on headaches and Acquired Brain Injury. It is very comprehensive, with carer education and support plus referral and information services.

www.heachaches.org. An American site that seeks to address headache suffers with causes, treatments and self-management techniques.

www.braininjury.org.au. The Brain Injury Association of Queensland is the peak disability organisation in Queensland for those living with acquired brain injury.

The Brain Injury Centre website offers a range of holistic approaches to brain injury http://www.braininjurycentre.com.au.

Cancer

http://www.nbcf.org.au. Website of the National Breast Cancer Foundation.

www.cancer.org.au. National non-government cancer control organisation with the aim of facilitating prevention, research, support, and care

www.cancerbuddiesnetwork.org. The stated objective of Cancer Buddies Network (CBN) is to help everyone find that special buddy on the internet for the purpose of sharing, caring and supporting each other through the ups and downs of their personal experiences.

www.prostrate.com.au. Website of the Prostate Cancer Foundation of Australia (PCFA).

www.pcsog.org. Prostrate cancer support group based in the City of Onkaparinga, South Australia.

www.ncahs.nsw.gov.au/support/index.php?pageid=835&siteid=189. An initiative of the NSW Government, this Cancer Support Group Directory has been prepared by the North Coast Area Health Service.

http://www.health.act.gov.au/c/health?a=da&did=10049549. An ACT Government health service which provides psychological, social and practical support and referrals for adult cancer patients, their families and carers.

Caregivers and Caring

www.carers-sa.asn.au. Website of the Carers Association of South Australia.

www.facsia.gov.au/internet/facsinternet.nsf/disabilities/carers-nav.htm. Details Commonwealth Government programs and initiatives to support carers and provides links to other areas of Government involved in carer assistance.

http://www.rdns.asn.au/. Website of the Royal District Nursing Service. It provides information about their services, questions & answers about home care, current relevant news articles and links to other services.

http://users.sa.chariot.net.au/%7Eozcarers/welcome.htm. OzCarers is a privately run support group for Australian caregivers.

www.mhca.org.au The Mental Health Council of Australia (MHCA) worked with mental health carers throughout Australia in early 2008 through its Carers Engagement Project. Read the reports 'Out of Hospital Out of Mind' (2003) and the 'Not for Service' (2005)

Charitable Organisations

St Vincent DePaul – www.vinnies.org.au
The Smith Family – www.thesmithfamily.com.au
The Salvation Army – www.salvationarmy.org.au
UNICEF – www.unicef.org.au

Child Abuse

www.napcan.org.au. National Association for the Prevention of Child Abuse and Neglect is a national, independent, charitable organisation working as advocates for children who experience abuse or neglect.

www.ispcan.org. The International Society for Prevention of Child Abuse and Neglect.

www.kidshelp.com.au. Australia's only free, confidential and anonymous 24-hour telephone and online counselling service specifically for young people aged between 5 and 25.

www.childwelfare.gov/can/. While this is an American site, it offers a wide range of free material and information on from the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services on the topics of childwelfare, abuse and prevention.

www.asca.org.au .ASCA is a national organisation which works to improve the lives of adult survivors of child abuse throughout Australia.

http://www.aifs.gov.au/acssa/research/csa.html. Research papers on the topic of adult survivors of child sex assault, collated by the Australian Institute of Family Studies

Churches

The Catholic Church in Australia – www.catholic.org.au
The Anglican Church in Australia – www.anglican.org.au

Autism
Brain
Cancer
Caregivers and Caring
Charitable Organisations
Child Abuse
Churches

Internet Resources for Counsellors 2010 Update (Continued)

The Assemblies of God in Australia – www.aog.org.au
The Baptist Church in Australia – www.baptist.org.au
The Lutheran Church of Australia – www.loa.org.au
The Uniting Church in Australia – www.uca.org.au
The Presbyterian Church of Australia – www.presbyterian.org.au
Wesleyan Methodist Churches - www.wesleyan.org.au

Church Services Online

www.i-church.org. Website for those that are unable to attend a church service or prefer an alternative form of worship. People from all denominations are welcome and there are daily web-cast services.

Crime Survivors

www.SurvivorsInAction.com. Survivors in Action is a non-profit national advocacy group that supports victims and the families of victims of any crime, including domestic violence, identity theft, elder abuse, cyber-staking, child abuse, rape and sexual assault. Find them at

Dating/personal relationships

www.awareconnections.com. Relationships website dealing with 'holistic' dating.

www.rsvp.com.au. Dating for Australians.

www.thirdage.com. Website for dating and relationships for older Australians.

Dementia

www.dementiacareaustralia.com. Dementia Care Australia (DCA) is an independent information and education organisation specialising in supporting both people with dementia and their carers; be they family members, professional carers, employers or friends.

www.health.gov.au/dementia. Australian Government Department of Health and Wellbeing provides this comprehensive guide to Dementia.

www.psychology.org.au/publications/tip_sheets/dementia. Understanding Dementia by the Australian Psychological Society.

Depression

www.beyondblue.og.au. Australian organisation which provides information about depression to consumers, carers and health professionals.

www.blackdoginstitute.org.au .The Black Dog Institute is an Australian educational, research and clinical facility offering specialist expertise in mood disorders including depression and Bipolar Disorder.

www.depressionNet.com.au. Site run by non-health care professionals, who describe their web site as for 'people like us' - people from a variety of backgrounds who live with depression.

www.bluepages.anu.edu.au. This website provides information, resources and links about depression for consumers. It is produced by the Centre for Mental Health Research (CMHR) at the Australian National University (ANU) and CSIRO Mathematical & Information Sciences (CMIS) with the assistance of an Advisory Board and feedback from consumers and health professionals

www.mentalhealth.asn.au. The Mental Health Association NSW Inc is a non-government organisation and registered charity funded by NSW Health; while it is based in NSW it provides links to resources in all other states.

http://www.healthinsite.gov.au/topics/Postnatal_Depression. An Australian Government initiative by the Department of Health and Ageing. This specific link will take you to a range of articles on postnatal depression. Note the further links on the right of the page to depression and the mental health of women specifically.

www.crufad.com. The Clinical Research Unit for Anxiety and Depression is the website of a group of researchers and clinicians from St Vincent's Hospital Ltd and the University of New South Wales in Sydney, Australia who are concerned with anxiety and depression.

www.depnet.com.au. Depnet is an interactive depression website providing information and support for people with depression and aims to assist in improving the everyday life of people affected by depression.

http://www.aolhealth.com/condition-center/depression/latest-updates. America Online (AOL) hosts an entire page devoted to the latest news on depression, loads of links and articles

Diabetes

www.diabetescounselling.com.au. This site offers online counselling for people with Type-1 diabetes. It is a free service and includes referrals and discussion forums. It may be of interest to members who are exploring the online counselling concept.

http://www.dav.org.au/content.asp?rid=530. Website of Diabetes Australia, which works to provide a community network for people with diabetes.

Divorce

www.aifs.gov.au/institute/links.html . Australian Institute of Family Studies website. Has links to publications and related sites on, building relationships, step-families, coping with change, coping with divorce, parenting and getting married.

www.health.nsw.gov.au/mhcs/publication_pdfs/5360/BHC-5360-ENG.pdf. NSW Health Department publication on how separation or divorce affects men's health.

www.dadsindistress.asn.au Dads in Distress is a not for profit Australian support group for men who are dealing with the trauma of divorce or separation.

Domestic Violence

http://www.whv.org.au/packages/domestic_violence.htm. Women's Health Victoria provides an annotated bibliography of selected quality resources about domestic violence against women.

http://www.thewomens.org.au/SexualAssault .The Centre against Sexual Assault is a unit run by the Royal Women's' Hospital in Victoria. Their website provides a comprehensive source of information; including statistics, definitions and availability of education and training.

www.aic.gov.au/publications/proceedings/27/dear.pdf. Australian Institute of Criminology report on domestic violence and co-dependency.

www.dvirc.org.au/. This agency is funded by the Department of Human Services Victoria, Australia. It

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is a statewide resource centre for information about domestic violence.

DNA Testing

http://www.dnanow.com/ausmain.htm. This Australian site offers DNA testing kits.

Dyslexia

www.dyslexiaanswered.com.au. Easy to understand information on Dyslexia and an overview of the Davis Dyslexia Correction® Program.

http://www.interdys.org/ takes you to website of The International Dyslexia Association (IDA), a non-profit organization dedicated to helping individuals with dyslexia, their families and the communities that support them.

Eating Disorders

www.eatingdisorders.org.au. Website devoted to supporting people whose lives are affected by eating disorders, as well as working to inform the community about these disorders, run by a not for profit foundation.

www.cedd.org.au/. The Centre for Eating and Dieting Disorders is an academic and service support centre resulting from collaboration between the University of Sydney and Sydney South West Area Health Service. It is funded by the Mental Health and Drug & Alcohol Office, NSW Department of Health.

www.healthinsite.gov.au/topics/Eating_Disorders. Links to information about eating disorders such as binge eating, bulimia and anorexia nervosa.

http://www.nlm.nih.gov/medlineplus/eatingdisorders.html. Link to MEDLINEplus, Eating Disorders website of the National Institutes of Health National Library of Medicine.

www.anad.org. The National Association of Anorexia Nervosa and Associated Disorders (ANAD)

http://www.psychology.org.au/publications/tip_sheets/12.5_2.asp. The Australian Psychological Society (APS) Website, containing a tip-sheet on understanding and managing eating disorders.

Face Blindness

http://www.disabilityresources.org/FACE-BLIND.html. Face Blindness is a fairly rare neurological condition in which sufferer's are either unable to remember faces or have an impaired ability to do so. Given the psychological problems this may cause suffers, the link may be useful for learning more about the condition.

Families

www.facs.gov.au. Website of the Department of Families, Community Services and Indigenous Affairs (FaCSIA).

http://www.anu.edu.au/cmhr/changingfamilies.php. Australian National University's Mental Health Research website focuses on family and community health information.

www.Familyrelationships.gov.au. 'Family Relationships' is an Australian government initiative, providing a comprehensive suite of links for parents, adolescents, grandparents, caregivers as well as family dispute resolution providers. This website also provides a downloadable information kit (available in 15 different languages) on the key changes to the family law system. This is a good one to bookmark.

http://www.aifs.gov.au/institute/afrc6papers/alex.html this link located on the Australian Institute of Family Studies website, takes you to an excellent academic paper focused on coping with the transition to parenthood.

www.vaft.asn.au. Victorian Association of Family Therapists (VAFT) is an association of professionals with a shared interest in Family Therapy theory and practice.

http://www.anzjft.com/. The website of the Australia and New Zealand Journal of Family Therapy. As well as an excellent articles link that allows you read a number of journal articles online, there are conference links and various other resources.

Gambling

www.gamblersanonymous.org.au. Gamblers' Anonymous offers help for compulsive gamblers and their families/friends. Includes programs, testimonials and other links.

www.gamblingresearch.org.au. This is the Gambling Research Australia Website and Clearinghouse. The objective of the Council is to minimise the adverse consequences of problem gambling via the exchange of information on responsible gambling measures and by acting as a forum for discussion and facilitation of the development of an effective interventions framework

Gay and Lesbian

http://www.rslevinson.com/gaylesissues/. General information on gay and lesbian issues

www.australianmarriageequalilty.com. Australian Marriage Equality (AME) is a national organisation working for equal marriage rights for all Australians regardless of their gender or sexuality.

http://law-library.rutgers.edu/SSM.html. This site carries links and information on same sex marriage for countries around the world.

http://www.groups.psychology.org.au/glip/ The Australian Psychological Society website aims to provide information regarding lesbian and gay psychology in Australia.

Grief

www.grief.org.au. The Australian Centre for Grief and Bereavement is an independent, not for profit organisation funded through DHS and bills itself as the largest provider of grief and bereavement education in Australia. Their website has details of a free bereavement counselling service, links to many other grief related web sites, and details on projects conducted by the Centre.

www.nalagvic.org.au. National Association for Loss and Grief (Vic). NALAG is a not-for-profit association of individuals and organisations working in partnership with government and other organisations.

www.betterhealth.vic.gov.au. The Better Health Channel is a Victorian government initiative created to provide up to date online health information. There is a search box located on the right side of the website and if you type in 'grief and loss' you are taken to a

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Grief

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directory of articles. Click the first link for 'Topics, Details' and you are then able to access links to a Q&A on grief and loss as well as articles on loss of a baby, death in hospital, suicide and many other related areas.

www.grieflossdiscovery.com. This website is run by a woman who lost her 18 year old son in a car accident some 15 years ago. She does not claim to be a mental health professional; however she offers links to grief support and articles and poems as well as her 50 point list of positive actions to help through the grieving process.

Grief from Loss of an Animal Companion

http://www.avma.org/communications/brochures/euthanasia/pet/pet_euth_faq.asp

For many people their dog or cat is a valued member of the family and losing them through old age, illness or some other type of accident can cause real sadness. The American Veterinarian Medical Association deals with this topic in a caring and respectful way at:

Groups, Dynamics, Counselling

A good start on the topic can be made with this brief but succinct overview of counselling in groups, provided by the premier American library site Eric Digests. This article focuses on the key aspects of the subject without overwhelming the reader. http://www.ericdigests.org/1994/group.htm.

This very comprehensive resource for facilitation and group dynamics (plus many other interesting topics) is provided free of charge in a library format http://www.managementhelp.org/grp_skll/theory/theory.htm.

The UCLA / School Mental Health Project operates a clearinghouse link that provides a huge amount of free resource material. Click on this link http://smhp.psych.ucla.edu/qf/grpcounseling.htm and then follow the links to topics such as 'how to get the most out of group counselling', 'group counselling for people with mental retardation' and 'group counselling and psychotherapy.

Healthcare, Online

www.mydr.com.au is a multi-linked site of relevant and interesting health information for Australians, including a comprehensive medical dictionary.

http://www.drs.org.au/ is the website for the Doctors Reform Society of Australia.

http://www.abc.net.au/health/library/default.htm. A searchable health database maintained by the ABC.

HIV/AIDS

www.aidsportal.org. The AIDS Portal is an internet platform which provides tools to support global collaboration and knowledge sharing among new and existing networks of people responding to the AIDS epidemic.

www.aidsinfo.org. Information, research and articles on HIV/AIDS compiled by the US Department of Health and Human Services.

Homelessness

www.mindaustralia.org.au works in Victoria and South Australia to offer a range of services to assist people in their recovery from a mental illness and to secure safe and stable accommodation.

Incest

www.siawso.org . The Survivors of Incest Anonymous (SIA) website publishes and sells incest survivor related literature and publishes a quarterly bulletin.

www.isa.asn.au. The first Western Australian non-government organisation to deal specifically with child sexual abuse and post-traumatic stress disorders in later life. The Incest Survivors' Association Inc. (ISA) is an association for survivors, friends of survivors, and those affected by incest and childhood sexual abuse.

http://www.cmc.qld.gov.au/asp/index.asp?pgid=10739. Link on the website of the Crime and Misconduct Commission of Queensland leading to information for victims of child abuse.

Indigenous Mental Health

http://www.aihw.gov.au/indigenous/health/mental.cfm. Data on indigenous Australians and mental health provided by the Australian Institute of Health and Welfare.

Indigenous Portal

www.indigenous.gov.au. The Australian government portal for resources, contacts, information, and government programs and services for Aboriginal people and Torres Strait Islanders.

Mental Health, General

http://www.connects.org.uk/ This site is a worldwide, forum for the sharing of information by people whose lives are touched by mental health problems and/or learning disabilities.

www.sane.org is the web-link of SANE Australia, a national charity working for a better life for people affected by mental illness through SANE campaigns for improved services for and attitudes towards, people affected by mental illness.

http://www.mentalhealth.asn.au/resources/web.htm. Mental Health Association of NSW. Also has links for all other Australian states.

www.sane.org. SANE Australia is a national charity working for a better life for people affected by mental illness.

Medical Dictionary

www.online-medical-dictionary.org. An online medical dictionary containing definitions of equipment drugs and pharmaceutical drugs.

Meditation

www.buddhanet.net/meditation.htm contains a listing of meditation centres around Australia, complete with times and descriptions of activities.

www.meditationcenter.com. Online meditation centre offering site by step instructions on meditation and relaxation techniques.

Music therapy

www.kundalini-dance.com. Kundalini dance claims to improve physical and emotional health. The basis for it is in Tran tic yogic traditions, chakra healing and sound and dance movement therapy.

www.mh.org.au/sitesnandservices/musictherapy/default.htm

The Royal Melbourne Hospital in Victoria, considered a leading teaching hospital, is now running a music

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therapy program. The program is active in oncology, palliative care, bone marrow transplant and the eating disorder unit

Near Death Experiences (NDE).

www.nderf.org is probably one of the largest and most comprehensive. NDERF describes itself as "a non-profit group devoted to the study and sharing of the Near Death Experience and related phenomena.

http://www.iands.org/. This is the website of the International Association for Near Death Studies.

OCD

http://ada.mentalhealth.asn.au/ocd.html. The Anxiety Disorders Alliance has some helpful reading for patients and family of OCD sufferers.

http://psych.curtin.edu.au/clinics/ocd.htm. Curtin University of Technology's OCD Treatment program.

www.ocfoundation.org. Website of the Obsessive-Compulsive Foundation.

Parenting/Children

www.raisingchildren.net.au. The NetGuide magazine have awarded the Raising Children Network website their '2008 site of the year award'. Funded by the Australian federal government, this site aims to provide up to date information to help parents raising children, with sections for newborns, toddlers and school-aged children, which sections on aspects such as health, nutrition, play, learning and discipline.

www.singleparentbible.com.au. A free online magazine for single parents which includes information on dating, advice for single parents and lots of general information and help is located at www.Parentline.com.au. 'Parentline' is a Queensland and Northern Territory service, funded by the Queensland Department of Communities, Northern Territory Department of Health and Community Services and BoysTown in Brisbane.

www.singlewithchildren.com.au. The website of The Single Parent Family Association Inc (SPFA) which operates 'Single with Children'. Single with Children is a non-profit organisation, run by volunteers, that provides adult and family social activities and functions single parents and their children within the Sydney and Central Coast areas.

http://www.childandfamily.com.au/. The Centre for Child and Family Development promotes awareness and understanding of the emotional life of children and adolescents, and how this affects their behaviour and future development. The Centre runs training programs on child and family development for all professionals who work with children, adolescents, parents and families.

www.parenting-ed.org. The Centre for Effective Parenting is a collaborative project run by the University of Arkansas and the Arkansas Children's Hospital. Their searchable website has a large database of information on parenting, including downloadable PowerPoint presentations in 10 one-hour modules for parents on topics relevant to children's education.

http://www.facs.gov.au/family/early_childhood_pip/volume1/sec7.htm.

Link to The Federal Australian Government's Department of Family and Community Services latest report on parenting entitled 'Parenting Information Volume 1.

www.earlychildhoodaustralia.org.au. Website of Early Childhood Australia, with links to journal articles and abstracts.

http://www.edfac.unimelb.edu.au/ceiec/. The Centre for Equity and Innovation in Early Childhood (CEIEC) was established in 2001 as a specialised early childhood research and teaching centre within the Department of Learning and Educational Development at the University of Melbourne.

www.pwp.freeyellow.com. Parents without Partners home site with links to local branches.

www.singleparentbible.com.au. A free online magazine for single parents which includes information on dating, advice for single parents and lots of general information and help.

www.Parentline.com.au. 'Parentline' is a Queensland and Northern Territory service, funded by the Queensland Department of Communities, Northern Territory Department of Health and Community Services and BoysTown in Brisbane.

www.singlewithchildren.com.au The Single Parent Family Association Inc (SPFA) operates 'Single with Children' Single with Children is a non-profit organisation, run by volunteers, that provides adult and family social activities and functions single parents and their children within the Sydney and Central Coast areas

Pharmaceutical benefits

http://www1.health.gov.au/pbs/. Provides information on the prescribing of pharmaceutical benefits by medical practitioners and the supply of pharmaceutical benefits by approved pharmacists, approved medical practitioners and approved hospital authorities

Pituitary

www.pituitary.org. Website of Pituitary Network Association (PNA), an international non-profit organization for patients and families of those with pituitary tumors and disorders.

www.pituitary.org.uk/index.htm. The Pituitary Foundation provides information and support to those living with pituitary disorders, including patients, their relatives, friends and carers.

Post traumatic Stress Disorder (PSTD)

www.health.qld.gov.au/cchs/Em_Behaviour/post_traum_stress.pdf. This link will take you to a factsheet on PSTD prepared by Queensland Health.

www.acpmh.unimelb.edu.au. The Australian Centre for Post Traumatic Mental Health at the University of Melbourne undertakes world class trauma related research, policy advice, service development and education and has some new free resources available for practitioners.

www.vvaa.org.au/ptsd.htm. The Vietnam Veteran's Association's link to PSTD resources and information.

Rape

http://www.brissc.com.au/. Website of BRISSC, The Brisbane Rape and Incest Survivors Support Centre for women.

Near Death Experiences (NDE).

Parenting/Children

Pharmaceutical benefits

Pituitary

Post traumatic Stress Disorder (PSTD)

Rape

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www.secasa.com.au/infosheet/infosheet_5007.pdf. Links to an information sheet on working with recent rape survivors created by the South Eastern Centre against Sexual Assault (Victoria).

www.nswrapecrisis.com.au The New South Wales Rape Crisis Centre is a statewide 24 hour telephone and online crisis, support and referral service for anyone who has experienced sexual violence.

Reiki

www.reiki.net.au

Relationships, General

www.relate.gov.au. An Australian commonwealth government initiative, this website bills itself as being for information on 'relationships family, and life'.

Relaxation

http://relaxationemporium.com. Think link leads to the Relaxation Emporium, which is full of information on managing stress and finding ways to relax.

Reiki

Schizophrenia

Self Harm

Self-help mental health therapy programs

Seniors

Sexual Violence

Stockholm Syndrome

Substance Abuse

Teenagers /Young Adults

http://tinyurl.com/29so4U. The Heart of Healing website has a heap of interesting things to read related to relaxation, mediation and stretching. A lovely bonus is to be found in their 'listening room' link as there you can download a free mp3 audio file called 'A Mini Relaxation Break', which is the first track of one of their CDS.

Schizophrenia

www.sfnsw.org.au/schizophrenia/sch_hme.htm . Factsheet produced by The Schizophrenia Fellowship of NSW.

www.schizophreniaresearch.org.au. Home page of the Australian Schizophrenia Research Institute.

www.schizophrenia.com. This is the website of an American non-profit web community dedicated to providing high quality information, support and education to the family members, caregivers and individuals whose lives have been impacted by schizophrenia.

Self Harm

http://www.sane.org/information/factsheets/suicidal_behaviour_and_selfharm.html. Suicidal behaviour and self-harm fact sheet produced by SANE Australia.

http://www.suicidehelpline.org.au/?id=gettingthroughthehol. Suicide Help Line's website had a lot of helpful articles, including 'understanding suicide', 'understanding self-harm' and 'coping with suicidal death'.

http://www.headspace.org.au/default.aspx?page=176. Australia's National Youth Mental Health Foundation fact sheet on self harm.

Self-help mental health therapy programs

Australia National University's 'Moodgym' program aimed at 'delivering cognitive behaviour therapy for preventing depression' (Moodgym 2005) is located at

http://moodgym.anu.edu.au/

http://www.med.monash.edu.au/mentalhealth/panicoonline/. Monash University's online resource and treatment program for people with panic disorders.

Both of these Australian initiatives are currently free for use. The Beyond Blue organisation, (http://www.beyondblue.org.au/) is also planning a free service to be called 'e-couch', available shortly.

Seniors

www.seniors.gov.au. Government website which lists services, programs and initiatives currently available to Australian senior citizens.

www.aboutseniors.com.au. Deals exclusively with senior's issues.

Sexual Violence

see also Rape www.casa.org.au/ CASA Forum works towards the elimination of sexual violence through community and professional education, informing government policy, advocating for law reform.

www.sass.org.au/. Sexual Assault Support Service Tasmania.

www.secasa.com.au. South Eastern Centre against Sexual Assault, a sexual assault and rape crisis centre located in Victoria, Australia. This site contains information on sexual assault and child abuse.

www.thewomens.org.au/SexualAssaultInformation. Website of The Australian Centre for the Study of Sexual Assault.

Stockholm Syndrome

http://www.salvationarmy.org.au/reports/Women&Domestic_Violence_Counselling_Standards.pdf . A report by the Salvation Army on domestic violence discusses Stockholm Syndrome and how it links to domestic violence.

http://familyrightsassociation.com/info/stockholm/syndrome.html

http://en.wikipedia.org/wiki/Stockholm_syndrome. Wikipedia has many links and a good background on this syndrome.

http://www.drjoecarver.com/stockholm.html. Links to an online article by an American clinical psychologist on loving an abuser.

Substance Abuse

See also ***'Addiction'***

www.buyoyancy.org.au. The Buoyancy Foundation of Victoria is a foundation set up to help people who have been abused or who abuse substances to manage self-care.

http://www.drugstrategy.central.sa.edu.au/index.html. The South Australian government's Drug and Alcohol Services Council. A lot of links, articles and information.

http://www.addictionrecoveryguide.org/. The Addiction Recovery Guide.

http://ndarc.med.unsw.edu.au/ndarcweb.nsf/page/home. Website of the National Drug and Alcohol Research Centre (NDARC) of the University of New South Wales. Has links to publications and resources surrounding drug abuse.

Teenagers /Young Adults

www.mindaustralia.org.au supports those recovering from mental illness with a focus on the young and homeless in Victoria and South Australia.

www.headspace.org.au is the website of Australia's National Youth Mental Health Foundation. The foundation's mission is to deliver improvements in the mental health, social wellbeing and economic

participation of young Australian's aged 12-25. It aims to provide help, support and information for young people who may be experiencing mental health and/or drug and alcohol issues.

www.inspire.com.au. The Inspire Foundation is a nationally accredited not for profit organisation delivering three national programs to a target audience of 1625 year olds.

www.reachout.com.au. Website of the Reach Out! Program, which provides online information and referrals to help prevent youth suicide and provide support to young people to get through tough times.

http://www.community.nsw.gov.au/html/parenting/teen.htm. The NSW Department of Community Services (DoCS) is the NSW Government agency responsible for community services; this links focuses on teen issues.

http://youth.wyndham.vic.gov.au. Youth Services for Victorian residents. Offering counselling, youth programs support for young mums, youth alcohol addiction and personal development programs.

Vietnam Veterans

www.vvaa.org.au. Vietnam Veterans Association website, which also contains comprehensive information on post traumatic stress issues http://www.vvaa.org.au/ptsd.htm.

Women's Wellbeing

An online partnership between Tetley Tea and the Jean Hailes Foundation (has produced www.tetleywellbeing4life.com.au. This website is full of comprehensive information for women around physical and emotional wellbeing.

www.Menopauseinstitute.com.au . Menopause questions and answers and symptom identification.

http://www.menopause.org.au/. Website of the Australian Menopause Society.

http://health.act.gov.au/c/health?a=da&did=10051295&pid=1062375024. Link to the Mental Health Services for Women in the ACT.

Miscellaneous

Thesaurus: www.thesaurus.com.

Telephone Calls over the Internet

www.skype.com. Use your broadband to make free calls to other people worldwide who have also downloaded Skype.

Australian Post codes: www.auspost.au/postcodes/

Time Management

An excellent site full of time management skills techniques, free templates and tools, tips and training is located at www.businessballs.com.

An interview with a time management expert, plus many related links can be found at http://stress.about.com/cs/workplacestress/a/aa031202.htm

Business Ethics

http://www.web-miner.com/busethics.htm. Directory of resources related to business ethics includes articles, publications, and case studies.

Help with Your Computer www.techguy.org is a website is run completely by volunteers and paid for by donations and sponsors, so there is no charge to the user. It is a forum style website that allows people to post questions and get expert answers that others can then scroll through and read. Because it is large, I would probably recommend you use their search facility to locate your own area of interest.

Map Search www.whereis.com.au is a map search website that will provide you with step by step instructions for how to reach your desired location as well as providing a map. Also try Google maps which I find even better by going to www.google.com and clicking the 'maps' link.

Goal Setting The University of New South Wales has an introduction to goal setting and links to a goal setting tutorial available at:

http://www.careers.unsw.edu.au/careerEd/planning/act/goalSetting.aspx

Latrobe University in Victoria also has a comprehensive section on goal setting advice in their counselling section at:

http://www.latrobe.edu.au/counselling/goalsetting.htm

The Goals Guy' at www.goalsguy.com provides a huge amount of free information, while also offering the opportunity to purchase his books and guides.

A 'Goal School' is located at www.goal-setting-guide.com. It has a step by step goal writing tutorial and some inspiring motivational quotes. Another site focused on helping you set personal goals is located at

www.mindtools.com/page6.htm

http://www.stmarys.qld.edu.au/goals.htm.

St Mary's International College in Ipswich, Queensland offer a free and comprehensive page on goal setting techniques.

Finding People Using the Internet

You may find these sites useful if you are trying to locate old friends and acquaintances, or if you are doing a family tree:

Aussie School Pals at www.schoolfriends.com.au, OzReunion at www.ozreunion.com.au and the Missing Persons Register at www.personsmissing.org

Social Networking

www.facebook.com

www.myspace.com

www.youtube.com

Neither Angela Lewis nor the ACA gain any financial benefit from the publication of these website addresses and readers are advised that websites addresses in this document are provided for information and learning purposes.

ACA

Vietnam Veterans

Women's Wellbeing

Miscellaneous

Journey of transformation from novice to counselling practitioner to sage – walking in a sacred manner By Dr Ann Moir-Bussy

The following paper is taken from Ann's workshop on this subject which she presented at the joint ACA/PACFA conference in 2009.

Abstract

As counselling practitioners we are striving always to develop professionally and to provide better services and interventions for clients. We move from the novice learning stage to becoming practitioners, and as we pass through mid-life and enter the autumn years, there are inner and outer challenges that we are required to face if we are to grow into the wisdom of the sage, leaving footprints that will enhance the ongoing development of the counselling profession. It is well acknowledged that personal development must go hand in hand with professional development if we want to bring integrity to our work with our clients. As a novice we struggle to understand and integrate theories, making sure we are not caught up in counter transference and projection on our clients; as we progress our client's issues often mirror our own and challenges us to face ourselves and continue dhe journey of transformation. Counselling is not just a career, or about work- it is who we are and how we live each day that we bring to the counselling room and to our clients.

Introduction

The manner with which we walk through life is each man's most important responsibility and we should remember this every new sunrise… and walk in a sacred manner (Crow Holy Man – Plains Indians)

The journey to become a counsellor often begins with some desire or dream to help others. Recently I was interviewing a group of Chinese undergraduates who wanted to join the Counselling and Psychology Department to study to become either counsellors or psychologists. "Why study counselling and not some other course?", I asked. "Oh, my friends always come to me with their problems and they tell me I am a good listener"; "I like to help other people and solve their problems for them". "There are so many problems facing young people today, like drugs, stress, the economic climate, and I want to help people and rescue them from this". These were some of the responses from budding novices of the counselling profession. How many of us thought that we too, could help, or rescue other people, without realizing that first we were the ones who needed help and needed to be rescued from our own self-importance.

The Novice

As novices in the field we lacked professional experience and knowledge and tried hard to learn and remember and mimic the micro skills, and the advanced skills, in order to prove we could be a counsellor. We learnt to understand the theories developed across the last hundred years in particular places and contexts, and also used their language and their interventions. We relied heavily on our teachers, mentors and supervisors, while they also impressed on us, that we need to know ourselves and heal ourselves if we are going to help others. As Skovholt (2001) says, "The novice is trying on new clothes and new ways of being in the world to create a *practitionerself*" (p.74). The novice is trying to match particular theories and interventions with his or her own personality, while everything is coming from others and the cognitive map has been developed by someone else.

The most difficult journey for the novice is the internship or placement during which the novice is constantly being evaluated by clients and supervisors. It is a steep learning curve, for not only is the practitioner-self emerging, but at the same time personal struggles entwine with the novice's journey. Examples of such struggles from novice counsellors in this stage included relationship problems, parental or family problems, the death of a parent, work place issues and so on. Each of these experiences is an invitation for the novice counsellor to transform his or her own self rather than try to change the other person. Suler (1993), who explores psychoanalysis from an Eastern perspective, says that "the transformative process always occurs in relationship. It may be relationship to nature, a ritual, a household object – anything in which 'otherness' manifests itself, including a thought or perception being examined by the observing self" (p. 161). If the relationship with supervisors, teachers and clients and oneself is a dialogic one, then this transformation process is enhanced.

Each of these experiences is an invitation for the novice counsellor to transform his or her own self rather than try to change the other person.

The dialogic relationship is one in which one's own meanings and the meanings of others are engaged in a conversation. In previous research Moir-Bussy (2006) explored this notion of dialogue within training. She cites Gergen (1999), who wrote that in the successful conversation:

> *[conversationalists] are thus bound to one another in a new community … [it is a] … transformation into a communion, in which we do not remain what we were. In effect, the fusion of horizons takes place in the interchange between reader and [the other]. The result is … a new creation. The successful interpretation, then, brings forth new worlds (pp.144-145).*

This is the heart of counselling. The transformation that takes place is not just within the client; if it is truly a dialogic relationship, the counsellor is changed too. Counselling training should not be just about helping the student to develop skills and knowledge about theories. Information and knowledge are not enough; they have to be grounded in practice. Jarvis (1992:148, cited in Martin, 2001:3) observes that 'there is a profound difference between knowing and having knowledge'. Knowing is to participate in the creation, not just digest others' material. Cortwright (1997:57) notes that 'therapeutic work is facilitated when the psychic field supports and enhances the client's self-exploration'. In other words, the

therapist's own psychic or inner work with his or her own consciousness is what provides the psychic support needed for the client. The goal of all counselling and psychological development is to attain the maximum degree of consciousness possible (Edinger, 1984:35). The more physically aware the therapist is, the more he or she is able to be present to the client: 'Empathy may be limited only by the therapist's self-awareness (Cortwright, 1997:59 in Moir-Bussy, 2006, pp.52-53). Knowing, rather than just having knowledge, is crucial for the novice to learn.

This aspect of journeying continues from the novice stage throughout the whole of the counselling practitioner's life. Yet at the end of the training period the novice suddenly realizes the journey is just beginning – again… as they move into the world of counselling practitioner.

The Counselling Practitioner

What changes at this stage? In reality, one is still a novice. David Whyte (2001), poet and writer, says that 'Work is where we can make ourselves; work is where we can break ourselves. It is a making and an unmaking that can never be measured by money alone' (p.2). The counselling practitioner has to find a niche – an agency or a private practice to be able to develop as a practitioner. Depending on the context or place, this can be either easy or difficult. In places like Hong Kong, where the counselling profession is not fully recognized or accredited by the Governmant, new counsellors compete with the social work profession and with psychologists, and if they do get offered a position, find they have to submit their ideals of counselling to the requirements of the social work agency. Some new school counsellors struggle to fulfil their role as they have no room that is set apart for counselling and no real counselling practitioner position, but instead are subjugated to the social worker's demands.

In his latest book, David Whyte (2009) recognizes that most people undergo three marriages. The first is to their partner, the second – to their work and the third to their self. Of the second, work, he notes

> *The greatest questions that touch on personal happiness in work have to do with the ability to hold our own conversation amid the constant background of shouted needs, hectoring advice and received wisdom. In work we have to find high safe ground from the arriving tsunami of expectation concerning what I am going to DO. Work, like marriage is a place you can lose yourself more easily perhaps than finding yourself. It is a place full of powerful undercurrents, a place to find ourselves, but also a place to drown, losing all sense of our own voice, our own contribution and conversation (p. 24).*

He continues that 'work is a constant conversation…the back-and-forth between what I think is me and what I think is not me; it is the edge between what the world needs of me and what I need of the world' (p. 26). This is a continuation of the conversation that began as a novice and now, this is the world of work into which the counselling practitioner dives, having just learnt to swim. It is a time for the counsellor to learn to go beyond the repetition of techniques – necessary in the initial stages for fluidity and spontaneity. 'One has to transcend technique so that the art becomes what the masters called an "artless art" that arises out of the unconscious' (Suler, 1993, p. 201). Interestingly, when one transcends technique, one becomes like the new novice again, unhampered by the demands and voices and rules of others, able to continually recommit to the work that 'constantly surprises us' (Whyte, 2009, p.29).

Growing self-awareness is imperative for the counsellor-practitioner. Cortwright (1997) notes that

> *Much of the work of being a therapist is about taking care of and of fine tuning this instrument of consciousness, as consciousness deepens and opens, whatever tools, theories, and techniques the therapist uses automatically become more effective. To bring greater consciousness, greater light to the emerging clinical material allow those techniques or approaches the therapist is trained in to be used more creatively, intuitively, empathically.* ***There is nothing so clinically relevant as consciousness skills and development that deepens one's presence*** *(p. 59).*

The process of coming to consciousness is akin to Jung's process of individuation. Finding our own voice, wrestling with our own destiny, conversing with our own work and relationships are all part of this process. Whyte (1994) argues that we bring more life and vitality into the orgranizations we work for when 'we refuse to make their goals the measure of our success and start to ask about the greater goals they might serve, and when we stop looking to them as parents who will supply our necessities' (p. 280). He also questions what kind of work are we involved in if we cannot live our own life and continue to hide from oneself (p. 292). Rumi (1997), Sufi mystic and poet, puts this beautifully:

> *Keep walking, though there's no place to get to.*
> *Don't try to see through the distance.*
> *That's not for human beings. Move within,*
> ***But don't move the way fear makes you move*** *(p. 278)*

Some new school counsellors struggle to fulfil their role as they have no room that is set apart for counselling and no real counselling practitioner position, but instead are subjugated to the social worker's demands.

Transformation

There are no demarcation lines between counselling-practitioner and sage. They are not distinct phases, rather, the one journey. Transformation is an ongoing process. As we move towards this wholeness, we do so not in a straight line, but on a path with many detours and dead ends where we have to retrace our steps and find another path. We have to journey into the woods, away from the known highways. Henry David Thoreau expresses it like this:

> *I went to the woods because*
> *I wished to live deliberately*
> *To front only the essential*
> *Facts of my life, and see if I could*
> *Learn what it had to teach*
> *And not, when I came to die,*
> *Discover that I had not lived*
> *(In May, 1988, p. 32).*

Journey of transformation from novice to counselling practitioner to sage – walking in a sacred manner (Continued)

James Hillman (Hillman and Ventura, 1992), was in fear that psychotherapy was in danger of becoming just another ideology and that many counsellors bury the core inner message of their counselling work under the concrete of 'isms'. In other words, we create ideologies to find answers, instead of holding the conversation within our own hearts. There is the story of a young trainee trying hard to become a Buddhist monk. The harder he tried, the more irritable he became. When he sought help from a wise old Buddhist monk, he was told, "Stop trying to be Buddhist – just be Buddha". In this early stage of transformation we also need to remember to stop trying to be a good counsellor – just be ourselves.

Using the metaphor of fire (Leider & Shapiro, 2004), we recognize 'that there comes a time when the flames have settled into a comfortable glow. The fire is steady, burning warmly, and in no danger of going out any time soon' (p. vii). Sitting in front of a log fire is very meditative, and this is precisely what the counsellor practitioner needs to be able to do quite often. All of our great religious and contemplative traditions advocate the necessity for silence and stillness if we are to tap into the inner voice of the Self and allow that voice to come to life. Blatner (2005) terms this 'wisdom-ing', going beyond knowledge and skills and maturing one's own emotional self-leadership. 'Wisdom-ing involves the courage and discipline to frequently call oneself into question, and to do the equivalent of a periodic 'virus scan' on one's computer' (Blatner, 2005:31).

He would rather know if a person can experience deep feelings or emotions of abandonment or despair and continue to live "in the world with its harsh need to change you".

David Whyte voiced questions which came out of quiet contemplation and such a conversation with himself. His poem Self-Portrait (1992) is challenging for all counsellors in the stage of transformation. He is not so interested in whether or not there are gods. He would rather know if a person can experience deep feelings or emotions of abandonment or despair and continue to live "in the world with its harsh need to change you". His challenge is to live with longing and deep love day by day amidst the experience of 'sure defeat' (p. 10).

What we are learning is a balance between stillness and action. The Chinese principles of yin and yang show that stillness and action are embedded in each other. Suler (1993) notes, that 'in the martial arts and psychotherapy, one seeks motion within stillness and stillness within motion. A quiet outward appearance encloses an inner core of dynamic awareness' (p.200).

The transformation to Sage

As noted earlier, transformation is an ongoing process and one can never say that we have arrived! While we are developing and growing in our counsellor-practitioner role we are also ageing. The poet Yeats (1965-1939) expresses beautifully what wholeness implies for the older person:

> *An aged man is but a paltry thing*
> *A tattered cloak upon a stick, unless*
> *Soul clap its hands and sing, and louder sing*
> *For every tatter in its mortal dress.*

Singing as we age is about enlightenment, about becoming conscious of who we really are. The Sage was a person recognized for their wisdom. In Roget's Thesauruas (1998, p. 79), terms equated with aged and aging include such words as *mature, mellow, no chicken, past one's prime, long in the tooth, getting on, one foot in the grave.* However, they also equated the sage with *intelligence and wisdom* (1998, p. 498), and the term sagacity implies *discernment, judgment, discretion, level headedness, long sightedness, and awareness*. Does this sound like consciousness? In the novice stage and early counsellor-practitioner stage we were busy building an ego-identity; the challenge now is to live consciously and walk in a sacred manner. For the Lakota Indian women, it is a time to give back and be of spiritual service to their people. To do this they connected with their inner gifts and gave back what they had learned to future generations.

Different authors and varying traditions have metaphors to help us. James Hollis (2005) speaks of first recovering our personal authority, and second, discovering a personal spirituality. In other words we address the larger questions of life and no longer live subjugated to 'received values which delude, divert, or diminish us' (p. 186). Leider and Shapiro (2004) want us 'to claim our place at the fire' and enter into the circle of vital elders who have been the source of wisdom in society since time immemorial' (p. vii). The say we must address the four questions of "Who am I?; Where do I belong?; What do I care about?; and What is my life's purpose? (p. xiv). Angeles Arrien (2005) challenges us to open and go through the eight gates of wisdom, from the initiating silver gate, through the white pickett gate, the clay gate, the black and white gate, the rustic gate, the bone gate, the natural gate and finally the gold gate. Each gate represents a new deepening of the conversation with ourself, our work and our life. It is a process that does not happen overnight. Towards the end, 'soul claps its hands and sings and louder sings for every mortal tatter in its dress'. Lao Tsu, ancient Chinese philosopher has a wonderful statement about the sage:

> *The sage practices non-action,*
> *She teaches by not speaking.*
> *Achieves in all things while*
> *Undertaking nothing.*
> *Creates but does not take credit,*
> *Acts but does not depend,*
> *Accomplishes much while not claiming merit,*
> *Because she claims no merit*
> *Her work will last forever* (Lao Tsu, 2005, p. 61)

Ralph Metzner (1980) speaks of ten classical metaphors for transformation and one or other may appeal to each person differently, but they all describe this journey from novice to practitioner to sage or wisdom. They all express that it is HOW we LIVE, that will benefit our clients the most. His first one is from dream-sleep to awakening (p. 49). He notes it is akin to moving from illusory self images to self-realization. Somewhat like those 'ah ha! moments we all have. A second metaphor is from imprisonment to liberation and he tells the story of Osiris in Egyptian mythology. Osiris is locked into a coffer by his 'dark brother' – the coffer becomes a tree, and then part of a building and Osiris (the self) is embedded in the wood. Spirit is imprisoned in matter and has to be

freed (p. 53). Another is from fragmentation to wholeness – a metaphor often used in counselling. Still using the myth of Osiris, Metzner (p.54) notes that when Osiris is released, cut up and scattered, it is the feminine principle that reassembles him. This is a metaphor describing how we too need to collect our scattered selves and remember who we are in our source. Other images that Metzner uses are from separation to oneness; from being on a journey and arriving at a destination – for example Demeter searching for Persephone; Jesus in the desert for 40 days, the search for the grail; from being in exile to coming home; from seed to flowering tree and from death to re-birth. The important thing to remember is that there is no clear demarcation between stages – it's rather a circular process and we move in and out.

One of my favorite images which represents this long journey from novice to sage is that of the Ox-Herding Pictures (Myokyo-ni, 1996). We have all spent many moons learning the art of counselling and psychotherapy, reading books, attending lectures and workshops, but if we forget the journey to becoming who we really are, the journey of letting the ego decrease and the true Self emerge, we may end up knowing everything there is to know about theories and isms, but never have wisdom. The Ox herding pictures originated in the 12th century, painted by a Zen Master of China called Kaku-an Shien. He also wrote the remarkable poems that go with the pictures. In the 15th century a Japanese Zen priest painted another set of pictures. There are many versions of the story. The story in the pictures and poem is a story of individuation, a story of moving from novice to sage. It is a story of integrating the bull or ox energy within us.

The poem begins with the young novice searching for the ox/bull he has lost. His head is going one way and his feet the other. This is very much the experience of the counselling novice. I am sure we have felt like this, split – holding on to one side of ourself and ignoring the other. We are disconnected from our own wisdom and listening to others' voices telling us where to go. We read more, looking for the answer, begin new spiritual disciplines. 'It is like using one leg to walk on and we become even more split as we leave the other leg behind' (Myokyo-ni, 1996, p. 30). As Dante said, 'in the midst of my life I found myself in a forest dark for the straightforward way was lost to me".

Somewhere we realize suddenly that we haven't actually lost the bull – we looked outside, but not inside. When we start to look inside we begin to see the footprints of our bull. Our head and our feet seem to be going in the same direction, but we are still striving and trying to impress. We have to stop blaming others – the establishment, the work, other people. Rather, we become inwardly aware and recognize that the bull that is ranting and raving is inside me. If we can let go of the defence screens behind which we hide, we will discover more traces. This is a journey that involves the HEAD and the HEART. It is a journey that involves a discipline of being honest with ourselves, of letting go of the wants of the ego and of being patient, rather than snapping at anyone. As we go inwards, so can we help clients to do the same.

In the third picture we finally glimpse the bull, this is when we awaken consciousness and find instinctual wisdom. .. the bull/ox is inside oneself. However, no sooner do I find it and it disappears again. Myokyo-ni (1996) says 'the moment I want to hold, to look, to inspect – he is gone. This is rather frustrating. It also indicates how split I am from myself' (p.62). This is somewhat akin to the head knowledge we acquired in our novice stage, but the experience is not yet there. Sometimes there is fear because we don't understand why we can't find enlightenment. We feel overwhelmed by the darkness, want to give up. However, we have found our ox. Spiegelman (1987) says, 'once seeing him, once knowing that he arises from our inner search, our reflection and meditation, our fantasy and dream, we can then know the sun is warm and a soothing breeze blows. The willow sings for nature is in harmony with the divine' (p. 59).

We now try to catch the bull with our intellect, with our old way of conceptualizing and thinking. The bull is stubborn and does not have a bridle, we are still not friends. The bull wants to run away again. In Jungian parlance, this is the stage where we are overtaken by our shadow, where we act, it seems, totally out of character, the release of energy is both creative and destructive. In counselling, this may be the stage we get caught up in counter transference and projection. Or we can become arrogant – that we have all the answers, that we can change the world, change the establishment; after all we are enlightened. How do we gentle our bull? We need to learn humor. It cannot be done with the ego alone. It is a spiritual discipline as in Zen training, and it has to be undergone reverently.

Taming our bull requires meditation, stillness, breathing in and balancing our energies, breathing out and letting go of control.

> *Catching the Bull is to so say 'yes' at the moment of impact, and with a deep in-breath give house room to this tremendous energy that has soared up – letting it fill me, enduring the charge, Refused or deluded, it is and acts as the bull; but in moments of danger, it is suddenly with us, helper, friend and guardian that take over. So, making the body large as possible – hence the in-breath – and saying yes to it, is giving it house room (Myokyo-ni, 1996, p. 72).*

Spiegelman notes that the 'habit of intellectualization, or conceptualization… is extremely difficult to get rid of' (1987, p. 63). Thinking too much in the head is what caused the split in the first place. Now we have to engage the heart more. Remember how difficult that was when we were filled with theories and techniques we had to remember. Taming our bull requires meditation, stillness, breathing in and balancing our energies, breathing out and letting go of control. If the reins are too tight the bull will become stubborn; too loose and it will run away again. This is again the concept of yin and yang – a dynamic balance.

Riding the bull home is the sixth picture. Finally we find some inner harmony and peace. We no longer act , pretending with outside manners. Our knowledge can be lived in a natural way because we have now an experience. We no longer have to cling to theories or' isms'. We can be ourself. In the picture the man is playing a flute as he rides the bull home. This is about being in the present moment. It reminds me of the journey of Parsifal searching for the grail. When he

Journey of transformation from novice to counselling practitioner to sage – walking in a sacred manner (Continued)

comes back after long struggles he can answer the questions "Whom does the Grail serve"? and reply, "The Grail serves the Grail King" and KNOW that the Grail King is his true self – he is at home. He now rides the bull with no hands – in other words he is no longer dominating or controlling what is happening in his life. The journey is not complete but home is everywhere. We cannot stop and say I'm here – the journey must continue.

In picture seven there is an interesting development for the bull seems to have disappeared again. Actually he has not really gone at all – rather, he and the man have become one. It is a time to rest for a while before the next phase of the journey. Again it reminds me of Dante's Divine Comedy. After Dante's enormous struggles as he traversed through hell and came to know his dark side, he then had to climb the mountain of Purgatory. He could rest but he could not look back. If he looked back down the mountain he would fall back. He could only look upwards and move on. He also had to learn to balance his endeavors, day and night. Half the journey could be spent in climbing and half the journey had to be spent in resting. How fitting for counsellor practitioners – working and resting. How often we forget this and try to work more than rest.

Living mindfully and allowing ourselves to experience each moment and converse with what is occurring in and around us, gradually leads us to a quiet calm and way of being in the world that is powerfully warming for others.

Now is a wonderful picture of an empty circle. The novice begins the journey wanting to be someone – to be a good counsellor, someone people like and will search for. The circle however, is centreless: the centre is everywhere. This is a definition of the divine. Spiegelman (1987) says, 'God is a circle whose centre is everywhere and circumference nowhere' (p. 72). We have arrived at the unknown - a time to empty out all our knowing. How quickly the ego again gets in the way. This mystery of unknowing is central to all great religions. It is an experience of the higher self. Maslow says 'they are moments of ecstasy which cannot be bought, cannot be guaranteed, cannot even be sought' (1971, p. 46).

Hawao Kawai in *Buddhism and Psychotherapy* (1996) says this state of no-thing or of 'emptiness' does 'not signify an empty world of no things, but rather a world that contains infinite possibilities for 'being'. *Emptiness*, in the Dharmic world of Principle, is pregnant with the dual meaning of nothingness and being' (p. 100). This casts the picture in a different light. One is lost in the mystery of nothing and everything. To experience everything we have to let go of being someone. How hard this is for most of us. If this can become part of our living how present we will be to those who come to us for assistance on the journey. I think we return to this place many times on our journey.

If we can sit with the previous stage we come to the point of reaching the course or returning to the origin. Emptiness is not the end of the process. Life is a cycle or circular and is ever expanding. Death and rebirth is an ongoing cycle. There is a Chinese phrase "wu-wei" which is usually translated as non-action or non-doing. It actually means returning to the origin, to the source, which is returning to our own self and living in harmony with all that is. We still haven't arrived anywhere – we have simply returned to the beginning. We are no longer trying to push the river or to force things to happen.

In the final picture we have the ordinary man back in the market place, but with arms full of gifts, bestowing them, and he shows great gentleness. I love this picture of the sage. He is not a great writer of books or well sought after conference speaker. This man no longer worries about what others think of him. Rather he is concerned with compassion, being with others in love and understanding. Being compassion – he is not trying to convert anyone, he is just being himself. Laughter bubbles out of him – there is a joy because he is at home in the universe.

Mykoko-ni sums this up beautifully:

> *…the great being does not interfere with anything. He just goes with his broad smile, with his big sack, and with the precious basket containing the mystery, with the lid carefully closed. Whatever is around him suddenly starts blooming. We being of the stature of the little lad in the picture, starting the long journey with a beginner's heart, we hope, actually we can be sure – that as our training continues, we will meet such a great being, however fleetingly, and from that encounter be moved, inspire to take the next step and the next. (1988, p. 141).*

Conclusion

The journey of transformation from novice to sage is a journey towards wholeness and it depends on our 'willingness to question beliefs that perpetuate self-limiting concepts' (Vaughan, 1985, p. 34).It is a continual process of 'changing and dying to former identifications' (p. 34). Mindfulness and awareness can be cultivated at all levels – physical, emotional, mental, existential and spiritual. Living mindfully and allowing ourselves to experience each moment and converse with what is occurring in and around us, gradually leads us to a quiet calm and way of being in the world that is powerfully warming for others. Whyte (2001) talks about having courage on the journey, arising from the old French word cuer, meaning heart. Walking in a sacred manner is walking in a heartfelt fashion. We need fire at the center of our conversation (p. 4). Sometimes we have to crawl through our experiences on our hands and knees in order to understand them (p. 9); what is crucial is that each of us engage in this lifelong journey if we are going to leave footprints for future counselors. Maybe it can be summed up in the words of the poet John O'Donohue (Cited in Whyte, 2005, p. 35):

I would love to live
Like a river flows
Carried by the surprise
Of its own unfolding.

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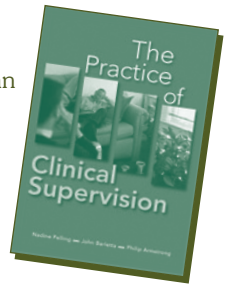
ACA

After Dante's enormous struggles as he traversed through hell and came to know his dark side, he then had to climb the mountain of Purgatory.

Book Review

The Practice of Clinical Supervision



Reviewed by Nadine Pelling, John Barletta, Philip Armstrong

Australian Academic Press, Bowen Hills Qld.
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At last, a professional resource that hits the nail on the head and actually addresses thoroughly all the critical elements of Clinical Supervision without 'all the boring bits'. **The Practice of Clinical Supervision** is an essential resource that should be in every serious counsellor's, psychotherapist's, psychologist's, social worker's, and allied mental health professional's key reading list who are currently in clinical supervisory practice or who are in training.

The format of the text is brilliantly clear and succinct, particularly encouraging mental health professionals engaged in the provision of clinical supervision to be mindful, discerning and professionally informed of what it means to be a supervisor not only in theory but also in professional practice.

All chapters have a supportive and educational focus addressing the important issues that can potentially cause the mental health professional the most anxieties including administrative and marketing considerations as a clinical supervisor, ethical issues in the clinical supervision of evidence-based practices, models of supervision from theory to practice. There is a wealth of information in each section with website links, templates which takes the guess work out of what professional expectations there are as a Clinical Supervisor.

The authors of each chapter are well respected academics and mental health professionals who not only share their wealth of professional knowledge through evidence based research but also impart their wisdom in a very honest, practical and realistic fashion. Case studies, counsellor and supervisor competence, the positives and the pitfalls of clinical supervision, the approaches, processes and interventions to facilitate supervisor/supervisee development and learning, cross-cultural factors and applied specialities within supervision. The Practice of Clinical Supervision covers all the important issues that really matter in professional practice and at the same time, empowers the reader to strive for excellence.

I highly recommend this text to all mental health professionals, not only those who are supervisors now in their professional fields, but to also all who under currently undertaking undergraduate and postgraduate studies, and particularly supervisees who are seeking a

The Practice of Clinical Supervision

Book Review (Continued)

supervisor now and are concerned about making an informed decision.

The Practice of Clinical Supervision is essential reading.

Catherine Dodemont B.Soc. M.Couns.
Senior Counsellor
Relationship Educator Pre-marriage (FOCCUS)
FPCQ President

A Healing Conversation: How Healing Happens

Written by Neville Symington

A leit-motif is weaving itself steadily through the entire book: ***"How is it that someone who has a problem is able to resolve it through conversation with another?"***. Psychoanalyst Neville Symington lays himself open to anything but 'certainty' and closed questions: he is expecting rather potent, constructive criticism, so we, ourselves, are from the very beginning called into the unique role of participants to and agents for a powerful exchange.

A Healing Conversation: How Healing Happens

What on earth prompts people to start looking for a therapist in the first place – is it that they feel they 'have a problem'? And yet no, no such 'pale, intellectual and tepid' expression – 'having a problem' – can and does send people into the consulting room. People rather incriminate 'suffering', 'distress' and 'agony' as triggers for such epochal decision – opening oneself up in the presence of another. An inquiry, however, into more palpable motive people invoke when seeing therapists reveals the ordinary gamut of daily lot: fear of illness and death, separation, inability to conceive due to emotional imbalance, lack of love, fear of over-emotionality, etc. Truth is, argues Symington, these people, our clients, do not really know why they came into therapy. One cannot possibly just tumble in the consulting room to say: "I'm here, doctor, but I don't quite know why!" – "There is distress but at the heart of it is a clouded darkness. I do not know the wherefore of my distress" (op.cit.p.5)

It seems, however, that the whole idea of 'problem', its prospecting and investigating reveals dissolving of layers after layers of emotional and spiritual sub-strata, to favour rather intellectualized enough manners and modes of detachment. And yet it is in this alembicated geology of inner reasons prompting one to look for another that hope lays for a cure to one's soul and eventual alleviation of one's 'problem'.

The author argues also around two main hypotheses to validate the act of seeking therapy: 1) We invest the 'other' with knowing better than we do; 2) The act of communication is itself in possession of a unique quality – illuminating and revealing healing sui-generis. And yet, again, the 'knowing' seems problematic indeed: the assumptive diagnostic of the *"I know that the source of my patient's distress is in her mother dying while giving birth to her"* is but inapt to accounting for more than 'a piece dissociated knowledge that has no curative effect' (p.7) Upgrading 'knowledge-ability' cannot therefore be the condition for getting to the root of the problem – Freud realized himself the enormity of such assumption. Symington, on the other side, very aptly and subtly builds up toward a rather simple and clear rule of thumb here: *the way that something exists in the unconscious is not the same as the way that something exists at the level of the consciousness*. Communication, thus, as a function of 'illumination', preserves challenge in the very possibility that one has within oneself a 'piece of knowledge' of which one may remain completely unaware.

The clinician, argues the author further, bears the blame for trying to explain away patient's problems by formulating a content that in the end proves dissociated from the very core of patient's diegetic issues. Every 'issue' presented in the consulting room – no matter how highly abstract or 'intellectual', has at its core an emotional and personal quality. In a procrustean attempt to have the patient forcibly fitting 'models' it is nonetheless revealed a crass lack of emotional depth; however, invariably and unavoidably if one wants one's patient to be thoroughly reaping all the benefits of an all encompassing and illuminating act of comprehension may offer, depth of understanding and of feeling must all be there.

And yet, what is 'emotion', asks Symington rhetorically. Commonly conceptualized as a 'body state', the notion of emotion must be understood as a rather 'non-sensuous' entity: it cannot be seen, smelled, touched, heard and tasted; it has no 'sensuous background' (Bion). The 'scientisation' of emotion comes but at a high price, in emptying and rendering redundant that miraculous 'link between people' whose fabric is the same with that of relationship. The author's search for a definition proper for 'emotions' encounters fresh deployments where 'imaginative reconstruction' becomes a modus operandi for us humans, caught as we are in the very act of trying to understand and even be able to 'see' reality. Recent research showed how the visually blind (blindness due to lesions on the occipital or parietal lobe) are still able to distinguish between a happy and an ugly face (!).

Symington's effort here becomes at once superbly intellectual and wisely simple, never impoverished by repetition, superfluousness or boredom. His straightforward resolution that "Through conversation with another the one who is suffering and creates suffering for others is able to form images through which she is able to actively embrace the hated elements within" (p.117) opens up for inspection the very notion of 'mind' with its being substantially a relation and one that has no sensuous quality (p.3).By extension emotions, as the basis of mind are themselves 'part of the stuff of the universal' down to literally the invisible atoms and their internal constitution. The art of conversing as a healing act thus appears as enabling emotions as vehicles linking us humans to each other and to the source of it all. Symington's all-embracing aperture is indeed vast and his vision is solidly established as a joint effort; says he: "I cannot myself imagine a more stimulating piece of research than a team made up of physicists, chemists, biologists, philosophers and psychoanalysts whose aim would be to deepen our understanding of this basic mind-stuff that permeates the structure of the universe from the atom to the human being, with

each discipline bringing forth information from its own object of inquiry.

This is not 'another' book on emotions, but rather a signal that the need for a holistic view cannot wait and is now more urgent than ever.

Reviewed by Aurelia Satcau, a Registered Counsellor and Educator, with academic degrees in Cultural Studies, Linguistics, Film Theory and Education. She is also a writer and her research interests spread along using 'Symbolic' techniques in therapy: Astrology, Dream Analysis, Archetypes, Bibliotherapy and Cinematherapy.

Gift of Tears: A practical approach to loss and bereavement in counselling and psychotherapy

Written by Susan Lendrum and Gabrielle Syme (Routledge) 2nd edition, 2004

First published in 1994, this is the second edition, following new research and giving contemporary examples of the effects of loss. Recognising from their own experiences of loss and grieving that the presence of others and knowledge of the grieving process were the two elements vital to their own healing, Susan Lendrum and Gabrielle Syme have focussed on 5 aspects of dealing with loss in this book.

Part 1 explores how infants learn to deal with loss through their early experiences of being nurtured.

Part 2 focuses on death – a particular form of loss – and offers trainee counsellors and others involved in helping someone who is experiencing loss, some insights into the grieving process. Topics covered include the differences which can occur between males and females, between different cultures and religious groups and between societal expectations, which can change over different periods of time. This section also covers children's grief – expressed directly through their 'gift of tears' – and the need for adults to accept, understand and allow children to grieve.

In Part 3 the authors focus on skills and strategies which counsellors can use in their sessions. Through hypothetical scenarios they explore how to initiate, conduct and conclude typical sessions. A chapter is specifically devoted to practical strategies for working with children.

Part 4 explores the complex issue of dealing with anger and guilt in grief counselling.

In Part 5 the professional needs of the counsellor are addressed, including the process of referring clients to other professionals, and the need for supervision.

This is a very user-friendly text as evidenced, for example, by the dot point summaries at the end of each chapter. There are practical exercises throughout, designed to give the counsellor insight into his/her own responses to loss, in order to develop empathy with people with whom s/he may work.

Although this is a British publication and some resources listed are specific to Britain, there are resources, websites and recommended reading lists in the appendices which are also immensely useful in the Australian context. There is an author index as well as a subject index, making the information in this text extremely accessible.

I recommend this book to trainee counsellors because of its thoroughness in providing a readable background and summary of what is known today about the process of loss and grieving. In addition, I believe that any practitioners working in this field will perhaps find among the practical suggestions of strategies, helpful addition to their current repertoire.

Reviewed by Caroline Hardie (BA, Dip Ed, Dip for Teaching the Deaf, Dip of Prof Couns)

A Parents Guide to Learning Difficulties: How to Help Your Child.

Author: Peter Westwood.

A Parents Guide to Learning Difficulties ensures that the reader, if they take both the time and effort to read this book will be able to use this exceptionally well written book as a guide, for themselves and their children. The author ensures immediately that he identifies with the reader within the first two chapters of the book. Ensuring that the reader fully understands that the author speaks not only from his professional experience but that the author also speaks from his own personal experience as he to also had learning difficulties which were identified around the age of 11 years old.

The book moves swiftly, but clearly to ensure that the reader can identify with the many current social and environmental issues, affecting children with learning difficulties, today.

One of these issues mentioned is the teaching methods used today within the Australian school system. This teaching method is referred to as "Whole Language Approach" – this is when the teaching or use of phonic skills is frowned upon. Also mentioned within the first several chapters in the book are other useful references of information, which allows the reader to see how learning issues can impact greatly on the child – An example of this is information is - "Failure Syndrome" – I found this information extremely helpful as it has allowed me to see how a learning issue can affect the child's confidence, in many different ways. Reading about Failure Syndrome enables the reader to see how the child can then develop avoidant behaviour patterns. This also allows the reader to appreciate the information and tools mentioned in the book and see the need and the value to go back to having Direct teaching in the school and how simple this can be fixed as mentioned in Chapter 6. Chapter 6 - (General Principles Of Learning) - gives great and clear examples and tools on how to address these issues, and how to utilise better learning and developing channels/systems for these children and parents.

What I liked most about this book, was the simple yet clear information and tools the author has used to

Gift of Tears: A practical approach to loss and bereavement in counselling and psychotherapy

A Parents Guide to Learning Difficulties: How to Help Your Child

Book Review (Continued)

express his concern with the current issues children and parents today are facing with learning difficulties, and how these issues can be addressed.

An exceptionally well written book easy to carry in a bag or car, allowing the user to pull out for use or reference at a moments notice if need be.

Overall an excellent book/ guide, that has been written clearly and in Layman's terms for people from all backgrounds to be able to read and apply.

Hope to see these books being utilised in all schools, libraries in the immediate future.

I give this book a 9/10.

Reviewed by N Channing

Revitalizing Retirement: Reshaping Your Identity, Relationships and Purpose

Revitalizing Retirement: Reshaping Your Identity, Relationships and Purpose

Author: Nancy K. Schlossberg, American Psychological Association 2009, 241 pages

You work all those years thinking about the moment when you can put your feet up for good and take it easy. But then what? I've read enough research to know that if you see retirement as the end, things may go downhill for you very quickly. So I was keen to read Nancy Schlossberg's book Revitalizing Retirement, intended for people approaching retirement as well as those already retired who could be happier.

Schlossberg's book addresses the importance of creating a retirement that matters and is one of happiness, through the development of a psychological portfolio. She draws on Rosenberg's work on mattering, highlighting an individual's need to matter to other people as well as ourselves. Apparent throughout is the work of Positive Psychologists, which helps the reader understand what it means to be happy in retirement.

The book is divided into three sections: The Key to a Happy Retirement, How Others Have Found Happiness and Create Your Own Happiness. Each chapter ends with a segment called It's Your Turn, where the reader gets to apply what they have learnt to their own life, through a series of tips and questions. If you recommend this book to a client, you can easily explore these questions together.

The first section introduces mattering, happiness and the psychological portfolio, which is broken down into identity, relationships and purpose. Schlossberg elaborates further on these aspects in section two: how they may change and what the reader can do to reshape and revitalise each of them. Somewhat confusingly, despite being called How Others Have Found Happiness, this section is not just about other people. Furthermore, people's stories are used to illustrate her ideas throughout the book and not just in section two. Finally, section three helps the reader continue to build on their portfolio, as they confront roadblocks, address possibilities and follow her guidelines.

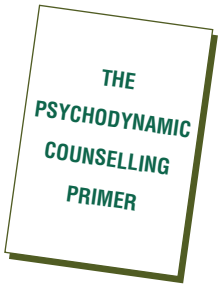
Since the stories she uses are central to the book, I would like to raise two concerns I have with them. The examples are frequently successful professionals, who have had great careers and are now facing transition. Not everyone will relate to these people. Secondly, such people had impressive networks, connections and resources to aid them, which many readers may not have access to. However, any good therapist working with a client in transition will be able to adapt the concepts in the book to their client's unique situation.

Revitalizing Retirement is clear, highly readable, and full of useful information that gives the reader plenty to think about. For some it will help them think anew about what retirement means, so they are prepared psychologically. This will enable them to be excited about the future and ready to face change. Schlossberg is clearly somebody who cares about her subject and wants the best for her reader.

Reviewed By: Julia Barnard BSc (Hons), BA (Hons), DipPsych, DipProfCouns.

The Psychodynamic Counselling Primer – a concise, accessible, comprehensive introduction

The Psychodynamic Counselling Primer – a concise, accessible, comprehensive introduction



Author: Mavis Klein

Published by PCSS Books 2006

There is a lot in a name. In every particular field of therapy there are names that hold huge weight. Melanie Klein (1882-1960) is such a therapist and author – a pioneer of child analysis and heavyweight in Psychodynamic Theory. As a psychodynamic counsellor and therapist, I was naturally excited to read and review a book written by a "Klein" but alas, as it transpires, Mavis Klein is no relation!

Mavis Klein is however vastly experienced in this area of therapy and has put together a solid, if sometimes slightly dull, text designed for counselling students seeking to familiarise themselves with this branch of therapy. It only runs to 124 pages so is perfect for a quick read on the background of psychodynamic theory, as well as an outline of major theorists, beliefs, structures and processes. PCCS Books have published this book within their series of primers offered as "an authoritative synopsis" on counselling theories including Person-centred, Integrative, Experiential, Contact Work, Focusing-Oriented, and Cognitive Behaviour Therapy. It is printed in the United Kingdom.

What is psychodynamic counselling? Mavis Klein describes it as it "refers to those forms of counselling which assume the existence and power of the unconscious mind and concern themselves with the elucidation of motives through the dynamic interaction between counsellor and client". Well, I think I prefer Michael Jacobs' explanation from a similarly sized book "Psychodynamic Counselling in Action" (Sage 1998) where he writes "the primary purpose…is to help clients make sense of current situations; of feelings and thoughts evoked by those situations; of

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Book Review (Continued)

memories associated with present experience…and of the images that appear in fantasies and dreams. From this wealth of material…counselling attempts to form a picture, representing not just the way in which the client relates, or wishes to relate to others, but also the way the client relates to her- or himself."

Psychodynamic therapy has its roots in Freudian psychoanalysis, bolstered by later theories, evolutions, and interpretations including Jungian (Carl Jung), Schizoid and Depressive Position (Melanie Klein), Object Relations Theory (Karl Abraham), Ego Splitting (Donald Winnicott, with the "good enough mother" concept), Attachment Theory (John Bowlby), and Self Actualisation (Abraham Maslow) among others.

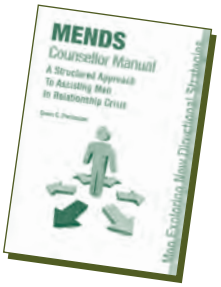
This book purports only to deal with psychodynamic counselling – short term, accepting of the client's current situation, often solution focussed – as compared to psychodynamic therapy – which is longer term, of deeper focus, and where success is found played out in the complexities of the relationship between therapist and client. As Mavis Klein so nicely states here "psychodynamic counselling is something of an oxymoron…true psychotherapy probes and pummels at the deepest levels of the psyche".

Unfortunately there are only two excerpts from client sessions included in the book, so while it is accurate in offering a "succinct guide" on theory and academic summary, it is lacking in practical examples. If you are after some juicy real life psychodynamic ideas, best explore and read Bruno Bettleheim and of course, Melanie Klein, among many others.

Reviewed by Tracey Mansted
PGradDip Couns MACA (Clinical non-pract.)

MENDS: Men Exploring New Directional Strategies

MENDS: Men Exploring New Directional Strategies



Author Owen Pershouse:
Publisher Australian Academic Press, www.australianacademicpress.com.au

MENDS Counsellor Manual takes you through a Structured Approach To Assisting Men In Relationship Crisis.

Over the years I have realised just how much help men who are separating or recently divorced need and just how much help there is not. Men, particularly those who have a job are disenfranchised by the system as they rarely qualify for subsidised help and are left to fend for themselves. Unfortunately many of these males do not have the necessary life or coping skills to be able to work through the issues that separation and divorce throw up particularly when children and assets are involved. There are dozens of cases in Australia that reflect that men in this situation are more liable towards self harm and/or harming others. Many men carry internalised anger around with them for many years undermining any possibility of forming new functional relationships. Children also become victims as they also become separated from their fathers as separated couples plunge into a vortex of dysfunction.

MENDS is a 12 session structured program that deals specifically with this group and includes a bevy of information and fact sheets for the client. What impressed me the most with this program was not only the broadness of subjects but the emphasis on the father - child relationship. Many of examples in the manual will ring true with men who have been unfortunate enough to have experienced a poor separation and/or divorce especially issues to do with the Child Support Agency and ex-partners who put up barriers to accessing children. The good news for women is this program also deals with the males responsibilities in relation to children and financial support. The author has maintained a good balance between dealing with the negative impact of separation and divorce and coming to term with responsibilities both financial and emotional as well as how to maintain a functional relationship with the ex-partner for everyone's benefit.

As a counsellor I would recommend this manual for anyone who works with or is exposed to males who are or going through a separation/divorce. The structure of the program ensures every detail is dealt with thoroughly and in a logical sequence. The CD that comes with the book enables the therapist to ensure the client is informed and aware of each of the processes, what they are meant to achieve and how. If you have never tried a structured program this is a must and if you do use structured programs I would suggest it is worth getting a copy of this manual to compare programs.

Reviewed by Philip Armstrong, a Fellow of Australian Counselling Association, Associate Fellow of Australian College of Health Service Executives and is the Clinical Director of the Clinical Counselling Centre that delivers various clinical programs.

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