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When a Graduate Qualification is not a Graduate Qualification

The last three months have been very hectic with the restructure of ACA being completed in July. This process saw an overhaul of membership categories with significant changes being made with the introduction of four levels (1 to 4) for Practicing Members. These levels now replace the previous categories (qualified, professional and clinical) and are based on a combination of qualifications, client contact time, post-qualification time in the industry and supervision hours. Members reading this article should not be tempted to draw parallels between the previous categories and the present levels e.g. Clinical is equivalent to level 4 this is akin to comparing apples with oranges and is about as accurate.

The one glaring issue we have come across when assessing qualifications is where do Graduate Diploma's sit. Entry as a Level 3 or 4 member requires an applicant to hold a minimum degree qualification, being either a 3 year bachelor's degree in counselling or a 2 year Masters of Counselling. Many members have questioned why we have not recognised Graduate Diploma's as being sufficient as a standalone qualification for level 3 or 4 as these are theoretically classed as being a post graduate qualifications. The problem is most members who hold a graduate Diploma of Counselling do not hold an undergraduate qualification. The big question we have asked ourselves "This is post graduate qualification of what?"

ACA cannot assess Grad Dip of Counselling as being equivalent and definitely not higher than a 3 year degree under the present circumstances.

What we have discovered or more accurately confirmed is something we have always believed and that is this is a significant mislabelling of this qualification. The blatantly obvious problem with undertaking a grad Dip of Counselling in Australia is that the Universities that deliver them in the main do not require the applicant to hold an undergraduate qualification in Counselling. Nor do they have a mandatory requirement of any previous counselling experience. With no mandatory underpinning pre-requisites in counselling needed before undertaking these courses these qualifications become an entry qualification not a graduate qualification in the eyes of a professional body such as ACA.

The majority of Graduate Diploma's actually have as their first units of study in first semester an introduction to counselling or counselling 1 and in second semester counselling 2 as core subjects. These subjects are introductory subjects that counsellors would learn in their 1st year of study at the degree level. If this was a graduate course it would stand to reason the student should have already completed these subjects at the undergraduate level and have needed to apply these skills and knowledge at the coal face for several years before being eligible to complete graduate training. ACA would assume that a student would already be deemed competent and practiced in applying counselling prior to undertaking a graduate course in counselling. There is little rationale in a course being offered at the graduate level that does not require the student to have completed relevant undergraduate studies in the subjects being taught. It is difficult to see these courses as nothing more than revenue raisers if they are pitched as graduate qualifications for registration purposes.

These are certainly not courses that graduate the student at a level higher than a comparative graduate of a Diploma of Counselling and certainly not a three year degree in Counselling. The other issue that these courses bring into contention is time of study. Graduate Diploma's are generally offered as 8 or 12 unit courses run over 12 months full time. To suggest a 8 or 12 unit 1 year course with no pre-requisites is equivalent or higher than a three year degree that includes either 24 or 48 units (including field placements in year 2 and 3) is simply not sustainable. If units and time are taken as part of the yard stick in establishing where these courses fit they struggle to measure up against 18 month and 2 year Diploma's that have over 12 core units (not including electives) of study let alone 3 year degrees.

The technical equivalent (AQF level 8) to the graduate Diploma delivered through higher education is the Vocational Graduate Diploma (Voc Grad Dip) which is delivered through the Vocational sector. When measured against Voc Grad Dip's, Graduate Diploma's still do not stand up as an equivalent. Voc Grad Dips require the student to meet mandatory pre-requisites of relevant qualifications and/or a minimum of 2 years industry experience. Voc Grad Dip's also run for a minimum of 2 years and include more than 12 core units. If Universities want graduate Diploma's of counselling to have any real standing in this industry they are going to need to introduce mandatory pre-requisites before allowing students to undertake them. Unfortunately ACA cannot assess Grad Dip of Counselling as being equivalent and definitely not higher than a 3 year degree under the present circumstances. There is a need for Universities and Higher Education course providers to be more transparent in differentiating between Grad Diploma's that are aimed at consumers who wish to learn advanced communication skills as an accompaniment to other skills and those who wish to increase existing counselling skills and knowledge at a graduate level.

In the meantime ACA has determined for membership purposes Grad Diploma's in Counselling are delivered as an entry level qualification and not at a graduate level. This determination does not apply to any Graduate Diploma of Counselling that has a pre-requisite of counselling qualifications (this does not include basic psychology, social work or behavioural degrees) and industry experience, if there are any out there.

ACA

On Psychoneuroimmunology – Part 1 By Aurelia Satcau

"To be mortally ill in the 20 century is to be swept into the confluence of thousand of years of unfinished business between religion, science, philosophy, commerce, politics and technology" (Marc Ian Barasch: *"The Healing Path"*)

(Following the *Motto* above, we can only extend the now defunct 20 century to the present one, facing the millennium of ever more vertiginous change)

In perfect *synergism*, as Divine (Natural) Law affirms a perennial, intrinsic and indestructible connection between any part of Nature and the Whole (Organic Being), so does any part of our immune system correlate with our brain via the nervous system or, more subtle even, by a 'chemical language' uttered by an army of neurotransmitters and hormones which one neuroscientist of fame, Candace Pert, called 'molecules of emotion'.

The term *Psychoneuroimmunology* was coined in 1975 by Dr. Robert Ader, Director of the Division of Behavioural and Psychosocial Medicine at the University of Rochester, New York. In an experiment, Dr. Ader fed mice with saccharine while simultaneously injecting them with a drug (*cyclophosphamide*) meant to cause havoc to the immune system. While saccharine had no real physiological effect, the drug was meant to attack the immune system by suppressing its function as protector. The mice, in consequence, developed a series of tumors and infections. Dr. Ader's decision to withdraw the drug but keep administering the saccharine proved lethal when the mice died of tumors and multiple infections after receiving just saccharine alone. The conclusion was now inevitable: there must be a link between stresses on the organism and the latter's interpretation of it in terms of producing corresponding ailments in the form of disease. The reverse is also true: at the shock of getting a bad prognosis or the diagnosis to a certain illness, the whole mental-emotional system may be irreversibly affected. Dr. Ader's experiment survived as the first clinical evidence of the effect the mind exerts upon body function.

The mind-body connection is not new. Its sophisticated, intricate architecture, however, continues to fascinate us and there is growing evidence that it could simply be inseparable from the state of disease or well-being. The search beyond mainstream (*allopathic*) treatment is now prompted by the marching on of non-conventional therapies and a philosophy based rather in holistic practices and the precept of old that preserving an optimal mind and soul is the key. In the case of 'God vs. Us' (ridiculous and deplorable dichotomy), some expressed the inability of grasping a *synergistic* quality to the relation between 'whole' and 'part' and the beauty that we are made in God's image, more, that we are of the same 'nature'. *Synergistic* properties are themselves the expression of the benefic cooperation between different entities for a positive outcome where the total effect is greater than the sum of its parts. God possibly needs us as much as we need God.

The newcomer *Psychoneuroimmunology* (PNI) carries thus an indisputable aspect of spirituality, as mind and soul (emotions) can never be far from the realm of the spiritual. Clear signs of a new paradigm are now evident and a few delineations under the heading PNI (*Psychoneuroimmunology*) on the Internet reveal a plethora of assumptions and applications on the concept. Yet its core truth remains rather simple and despite specialization of terms and a prolific view, it mainly means the relation established between our mind, emotions and the immune system, expressed as either illness or health.

PNI has its roots as far back as ancient Eastern and Western healing traditions, while modern application and research into the field continue to give its contribution. A more technical overview of PNI reveals the following schemata: Emotions (Psyche) + Neuro (logic) System (*brain, spine, other nervous system organs*) + Immune System (*thymus, spleen, lymph nodes, lymphatic vessels, tonsils, adenoids, bone marrow*).This aggregate manages a decisive link between binaries like health and illness, with recovery and healing from conditions along a complicated spectrum from benign to terminal. The bio-feedback between mind and body is invariably bi-directional in that a two-way street is expected to host traffic altogether for hormones, thoughts, feelings, synapses, even existential aspects (our own private and unique lives) among other minute but crucial blueprints of our humanness and aliveness. A continuum is thus claiming the state of dis-ease as a very serious affair with healing being a state of the art indeed.

Amazing and to some still 'unexplainable' cases of remission and recovery from terminal immuno-system conditions can now be read into the tapestry of positive response due to a vigorous and self-conscious personal frame where the patient went to great length to remedy disturbances and eventually recover their health. Yet this amazing process is rather a covert event, subtle and complex, happened deep in the recesses of our own Psyche and with the full accord of a (sub)conscious mind determined to win at all costs.

This amazing process is rather a covert event, subtle and complex, happened deep in the recesses of our own Psyche and with the full accord of a (sub)conscious mind determined to win at all costs.

Thus spirituality and all the orchestration we architect while journeying through life happen to have a decisive say in the course of most ultimate of illnesses. Healing's reign of power lays precisely in this active and passionate participation to life, in the holding of high standards and ideals, in the brave agreement that we lay bare the flow of emotions when they threaten to inundate, knowing intuitively that only so can we obtain new paradigms of growth and self-accomplishment.

Periods of heavy emotional involvement and unresolved stress and anxiety (i.e. exam periods for students) prove a powerful immune-suppressant, based on mind-states and emotive-behavior tensing and exposing our systems to self-inflicted trauma or at least pathological disbalance. It is now accepted that a loss of control over one's residues of negative emotionality and faulty patterns of thinking and behaving may alter the immune-system's main scope: *homeostasis* – that is, managing to maintain the organism's state unchanged and self-sufficient – an entity unresponsive to outside disturbances, totally self-absorbed and lucrative to the management of a monumental inner edifice which still makes our pride as humans and as living creatures after all. In short, it keeps us strong. The role of emotions and negative cognitive patterns, however, in disturbing *homeostasis*

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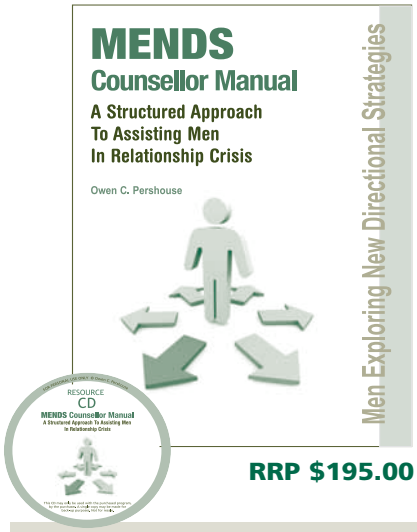

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On Psychoneuroimmunology – Part 1 (Continued)

and weaken immune-defenses makes the object of interest in PNI with the accompanying cohort of modalities to help patients gain awareness of their own emotional and mental life, so much unseen and yet so powerful.

There are spectacular findings, where the individual's stamina and self-mobilization against the worst prognosis and scenarios following a course of illness, prove once more the paramount task of emotionally unlocking life-long, repressed feelings and self-defeating inner promptings. One article on the Internet titled "Psychoneuroimmunology: Towards Self-Empowerment in the New Millennium" recognized how profound the physiological aspect becomes mediated by an increased level of neuro-psychological activity - with stress and anxiety, but also grief and the inability to cope with life, figuring high. Argues the author, Dr. I. Weinberg : "Clearly, if mind states have such an important part to play in the origin and perpetuation of disease states such as infections and tumors, this needs to be addressed with at least as much importance as the physical (end-organ) manifestation. In fact satisfactory treatment of the final manifestation of the disease (the tumor or the infection) requires that the origin of the negative process (usually seated at the level of psycho-social activity) be neutralized and positively enhanced as well". Thus the self-empowerment of patient reaches unprecedented levels since it is now clear that patient is the one to best decipher the complicated frame at the very onset of illness; patient alone (be it consciously or less so) can thus retrieve and evidence stages of disease advancement in uncharted territory, when enemies at the gate launch their first strike. The theory that body 'knows' and body 'remembers' becomes here perfectly valid and it is this corroboration of an 'intuitive' soul and the objective reality 'out there' – the imminence of diagnosis and the pathology in manifestation - that may well be the trigger of those mobilizing forces from a suppressed and debilitated immune-system now regaining vigor in its leap to normality.

As mentioned before, the role of communication between various links in this phenomenal operation of either invasion of lethality or remission and recovery, represent the 'psychoneuroimmunological' forces at work. As much as the mental-emotional triggers (such as stress, anxiety, prolonged and uncontained grief, etc) may disturb balance in our body, so external factors (such as news of a diagnosis with fateful and grim prognosis of terminality and insolvency) may bring the mental-emotional duo in utter shock so that, in a vicious circle kind of effect, the system would have no choice but to collapse further and quicker under burdens residing deep within the Psyche.

Now numerous examples already found their way into articles and papers, books and lectures on terminally ill patients regaining strength and defeating illness more or less 'bare-handedly' so to say, with the sole help of 'intangibles' such as the will to live, determination, creativity, passion, exploring and empowering the self to the point of positive self-sufficiency and self-sustainability.

The abstract reconstruction of the source of malaise is a private affair as much as dreams are and in this sense we remain indeed sole recipients of the sacred secret at the origin of both health and disease. As Dr. Gerd Hammer, the ill-fated German cancer-researcher and originator of a unique cure insisted, there is always a reason behind any occurrence of disease and cancer in particular must be related to an event-based traumatic shock of, apparently, ulterior insolvency – the trinity *organ-brain-psyche* becomes, by extension, precisely the *locus* for shock-waves reverberating simultaneously and it is this correlation which reinforces the very essence of PNI, the neuro-immuno-psychic link, the concomitance of emotion (generated by the event) and physio-psychological effects in the form of various ailments and even serious pathology. Hammer's theory of cancer is based on a tripartite formula when an unexpected, traumatic event followed by an instant shocking of the system may instantaneously induce consequences at no less than three levels simultaneously: brain, Psyche, organ.

Giving credence to the argument that abrupt revelation of diagnosis of incurable, terminal or at least serious illness to patients may be lethal, a vicious circle is thus created, bringing things closer to a point of no return due to the immense sensitivity of human psyche. In the link between mind-emotions-body each member of the triune will reinforce the other in total tandem, generating a chain reaction of bio-chemical events where the system is let open to powerful inducements – shocking news, traumatic occurrences, unresolved inner conflicts.

A 'must read' author in the field is Marc Ian Barasch whose own journey is testament to the fact that we can, as some of us managed already, extricate ourselves from most horrific ordeals such as cancer. His insurgent insubordination to follow orthodox ways took a quote different route: he instead chose to immerse himself into his own 'dark and unknown interior', of which to speak would mean to have Marc Barasch tell us his dreams. But we have touched here the fascinating yet still obscure area of dreams and dreaming, and should stay with it for a while.

For some time prior to the onset of diagnosis the author is haunted by nightmares, so graphic and minute, whose sole purpose was waking him up to the invisible and mute advancement of a dormant but mortal inner army, hostile to its own encampment.

The 'language of dreams' is basically uttering the exact words, images and narratives our 'mind-body-soul' wants us to know. For some time prior to the onset of diagnosis the author is haunted by nightmares, so graphic and minute, whose sole purpose was waking him up to the invisible and mute advancement of a dormant but mortal inner army, hostile to its own encampment.

In Tibetan tradition three are the chief types of dream we should be concerned with: dream of past memories, dream signaling warnings on current, albeit imperceptible, bodily ailments, and most astounding and illuminating of all, dreams based on 'memories of the future'. Together with symbols, archetypes, myth and the like, dreams occupy a central position as important triggers of both the conscious and the subconscious mind. In the sisific effort of restoring faulty inner lines of communication, we inevitably recover dreams as signposts for what *was, is* and *is to come* as reflected by the sophisticated filter posed by the mind-body-soul link. Messengers whose content is so personal that we afford to forget them without loosing them – it is scientific fact now that the

On Psychoneuroimmunology – Part 1 (Continued)

(sub)conscious mind speaks through dreams also, most creatively and sometimes in utterly undecipherable manner.

Referring to dreams Barasch affirms: "Since the beginnings of all things are small, so, it is clear, are those of the disease. It is main fact that these beginnings are more evident in sleeping than in waking moments" for "…the immune-system can function as a sensory organ signaling the central nervous system about non-cognitive stimuli such as bacteria, tumors, viruses and other toxins within the body" (104). And since the dream makes a substantial aspect of the link between inner and outer landscapes, the 'D-state' (the state of disease) becomes subject to increased attention from scientists and members of the spiritual circles alike. Its common denominator must be found in an undying fascination we all have with the sur-real, the undisclosed, the unexplained, the 'mystical', the more so when its impact is made in our own private yard, our body, our temple.

Engaged himself with the deciphering of dreams and dreaming Jung emphasized the role of symbolic language of dreams as remarkably expressive of remnants of thinking and feeling susceptible to effacement and confusion and escaping censorship during waking daily life, when menial tasks of living gain importance. An interesting juxtaposition here is the dichotomy around, on the one hand, language as instrumented in waking, conscious life – an 'abstract' language', and, on the other hand, that used in dreams - a pictorial, representational and utterly discursive kind of monologue filtering in most personal aspects of life of which it is expected that we share a common view.

The meaning of a dream will not be found in some theory about dreams: it is right there, in the dream itself.

In a straightforward take Calvin Hall – the American psychologist and experimental dream researcher and at one time director of the Institute of Dream Research in Santa Cruz - concludes, after processing over 10,000 dreams of ordinary individuals: since dreams are pictures expressing the content and workings of mind during sleep, "anyone who can look at a picture and say what it means ought to be able to look at his dream pictures and say what they mean. The meaning of a dream will not be found in some theory about dreams: it is right there, in the dream itself" (in Ann Faraday, *Dream Power*, page 135-136). Hall also established four distinct rules of thumb in interpreting dreams:

As a mere creation of dreamer's mind, her *Weltanschauung* (view of the world), including personal views of self, others, relationships, etc., dreams depict a subjective rather than objective reality and the 'truth' they express is constructed in relation to how the world, ourselves, the others, appear to us. The rule of thumb here is that one can never credit dreams outside one's own private realm, which leads directly to the second law of dream interpretation in Hall's view:

The dreamer must take charge of their dream world, the symbolism thus enacted with it, and the manner of encoding and decoding around this act of symbolization.

Dreaming is the expression of a time/space determination where dreamer's own existence in the reality of space and time is generating a shifting point, - ever mobile and in perfect accord with dreamer's ever new perception of the same objective reality.

Taking Jung's view on this, Hall suggests dreams should be analyzed in series rather than in isolation. A tapestry of motives, supplemented by an array of oniric occurrences – the dream 'events' – are best deciphered in a contextualized and structured format managing eventually the weaving of apparently disparate elements into a fascinating coherence.

On a more technical note now on the importance of dreams as seen from PNI's view, the phenomenon known as REM (Rapid Eye Movement) sleep deserves serious attention as it is during this REM period every night that signals are sent and received within the neuro-psycho-somatic channel. Not before 1953, however, was dreaming explored as serious as some of its pioneers achieved at the Department of Physiology at the University of Chicago when, like many other crucial discoveries, it came by pure accident. One of Prof. Nathaniel Reitman's graduate students was sequencing the dreaming period into sub periods of REM and NON-REM sleep when he observed bizarre movements of the eye during only one of the two sub-periods - the REM sleep, and at repeated intervals along the night. Sleeping babies were the subjects under scrutiny by Dr. Reitman's assistant. (*To be continued in the next issue*)

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Mapping Counselling Competencies for Professional Practice: An integrative, wholistic and contemporary model – Part 2

Three Primary Levels of Competency

Each area within the 14 core competency areas relates to three specific measures that can be addressed in different ways within any given training program. These are entry level competency; advanced competency; and expert competency. These three levels allow accreditation bodies and training providers to set realistic goals for outcomes in learning and attainment. Below is a working description of each level.

Entry Level Competency

The Clinical Counsellor at this level is able to handle all routine situations by applying the relevant competency to the situation in a way that is consistent with standards in the profession. They can function without supervision or direction, and within reasonable timeframes. The Counsellor can select and apply competencies in an informed manner. The Counsellor can anticipate outcomes in a given situation, and responds appropriately. The Counsellor is competent in demonstrating the range of measures and can be adequately rated on each major field of competency. They are able to assess and recognise unusual or difficult to resolve or complex situations. The Counsellor is able to take appropriate steps to address these situations based on ethical standards of practice. They are capable and prepared to seek consultation and/or supervision. The have capacity to review the research literature relating to difficult or complex cases and as a matter of standard practice. The Counsellor is also highly skilled in regards to appropriate issues and processes around referring the client on to other services.

Advanced Competency

The Clinical Counsellor working at this level has extensive experience and can demonstrate a nuanced comprehension and acknowledgement of interpersonal and clinical environments. Based on a long term commitment to practice resulting in seasoned perceptions that are able to quickly assess the dynamics of a case, the advanced clinician is able to make efficient decisions and to facilitate effective and timely treatment plans. They are able to discern the many aspects of a presenting situation while focusing in on important areas for client outcomes. The advanced clinician is competent in proceeding toward treatment outcomes and can work effectively with most unusual, difficult to resolve and/or complex situations. With appropriate training and preparation, these practitioners are able to engage in clinical

The Counsellor is competent in demonstrating the range of measures and can be adequately rated on each major field of competency.

Mapping Counselling Competencies for Professional Practice: An integrative, wholistic and contemporary model – Part 2 (Continued)

supervision and in the education and training of counsellors.

Expert Competency

Clinical Counsellors and Psychotherapist with expert competency are recognized as leaders in the field. The expert clinician is able to demonstrate excellent client outcomes and have normally developed one or several clinical specialisations. The expert clinician is recognised for contributing regularly to the advancement of the profession. They are often senior practitioners who engage in clinical supervision, and/or counsellor education and training, and/or to public and professional speaking engagements, conferences, and to original written contributions to the literature of the field.

Following the three levels of competency as described above, the model proceeds to describe the nature of the 14 areas of core competency. The best way to map this complex set of measures seemed to be a 'grid' into which the various parts of each competency area can be placed. By actually documenting these areas in a way that describes the required content or focus and application of the competency, we have provided a valuable baseline from which to construct counsellor education programs – as well as to lay claim to a process of possible accountability through a documented practice of education and training.

Conclusion

The Entry Level Core Competency Grid is designed for any program across the field to fill in their own measures relevant to each category. The information provided will assist in determining how each program can address the standards in their own unique ways. Additional columns or additional categories can be added to further define specific competency criteria for each component of curriculum. For others, certain fields of competency may take on less significance, and others will be fore-grounded. We see this as a natural and necessary expression of the diversity our discipline supports. Depending on the program emphasis, each field will be toned down or expanded accordingly. The Grid can be used for many purposes. Some of these purposes may be to:

1. express curriculum that currently exists,
2. evaluate and develop course content,
3. rate or assess candidates, and
4. form a basis for accreditation of programs.

For example, within a learning context, a 'Student Assessment Grid' can be generated from the information provided here that can be integrated throughout a curriculum, making setting assessment tasks and outcomes easier, while giving students a map through which to navigate during their program. What follows in 'Appendix One' are the content areas within the 'Entry Level Core Competency Grid.' As the nature of this paper is about tabling the model for discussion, this paper will end with an open invitation to members of the profession to consider what you wish to see as the future of our field, and how you would want the future education of counsellors to evolve.

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(Continued on Next Page)

Appendix One: Entry Level Core Competency Grid

Core Competency Field	Core Competency Criteria	Core Competency Measure
	Upon entry to the field of Professional Counselling and Psychotherapy as a full clinical member, and/or upon graduation from a four year Bachelor of Clinical Counselling or equivalent, the Clinical Counsellor and Psychotherapist will be able to:	
1. Counselling process	1.1 Demonstrate comprehension of counselling theory and skills	1.1.1 Specify theoretical approach
	1.2 Demonstrate adequate practical skills relevant to the approach under study	1.2.1 Core-micro-skills, which may include clear and concise communication; speaking in a way the listener can understand; conveying information; offering instruction or guidance when appropriate; demonstrating empathy; feedback meaning and feeling; open and closed questions; appropriate use of silence; appropriate use of confrontation; appropriate use of self-disclosure; using effective listening skills; differentiating fact from opinion; evaluating the meaning and significance of non-verbal communication; responding appropriately to non-verbal communication; attending to voice qualities during communication; responding appropriately to voice qualities during communication; showing and conveying respect and unconditional positive regard; exploring the full range of emotions; engaging client strengths; maintaining appropriate boundaries; identifying potential or implied conflicts whether overt or covert, verbal or non-verbal; identifying potential ruptures in the therapeutic relationship and taking appropriate steps to re-establish therapeutic alliance; using appropriate conflict resolution skills; following through on commitments to clients in a timely and efficient manner; monitoring the impact of self on others; maintaining congruence and authenticity between what is said and what is done; ensuring interventions are timely within the context of therapy; identify significance of action and non-action; attend to pre-therapy, in-therapy, between therapy changes; attend to contexts and influences; monitoring progress toward client goals or objectives; summarising in-session; offering a review of progress with the client periodically; changing the direction of therapy as necessary; identifying when to conclude therapy; engaging closure skills. 1.2.2 Contingency skills may include responding appropriately to: litigation, client emergencies, hospitalisation, suicide ideation, third party indifference, premature closure, lack of funds to pay for therapy, conflict and expressions of violence toward therapist. Identifying circumstances where referral is necessary may result from adequate planning for contingencies. 1.2.3 Evaluative skills may include gaining client feedback verbally, through written forms; engaging a therapist/client dual evaluation; developing a format and SASE for encouraging client post-therapy evaluation two weeks, one month, and three months after therapy ends; asking the client key questions such as 'on a scale of one to ten, how likely are you to suggest my services to a friend?'
	1.3 Demonstrate adequate interpersonal skills in facilitating the counselling process	1.3.1 Introduction and orienting of client to therapist's practice, therapist's education, qualifications and background; explain the scope of practice; describe expertise and limits of expertise; obtain consent and agreement; explain client's right to stop, pause, and/or refuse therapy at any time; documenting intake information; and providing client with adequate information on their rights and responsibilities as well as the rights and responsibilities of the therapist relevant to the model of therapy you employ; explain the limits of confidentiality; provide a copy

Mapping Counselling Competencies for Professional Practice: An integrative, wholistic and contemporary model – Part 2 (Continued)

Core Competency Field	Core Competency Criteria	Core Competency Measure
		of key procedural or administrative information or policies; respond to client questions 1.3.2. Establishing and maintaining core conditions, consistent with relevant theory and practice; troubleshoot difficulties as they arise in each case; engage in assessment, obtaining of information, and integration of multiple levels of information during therapeutic process; conduct an appropriate risk assessment 1.3.3 Explore client's issues or concerns; establishing a therapeutic focus; move through the therapeutic focus; maintain therapeutic relationship; structure and facilitating the therapeutic process; manage interruptions to the therapeutic process 1.3.4 Conduct appropriate referrals; conduct appropriate closure process; evaluate clinical practice; seek supervision; seek feedback on practice
	1.4 Demonstrate ability to self-reflect, analyse, and critique performance and the place of self within the therapeutic process	1.4.1 Self reflection; analysis; critique of performance; balanced articulation of self awareness; document ability to learn, develop, change direction during learning processes; document ability to maintain flexibility and openness to critique and critical feedback; articulate learning goals; show developmental plan
	1.5 Demonstrate ability to identify contexts where therapeutic strategies are contraindicated	
	1.6 Demonstrate ability to integrate knowledge of historical, philosophical, socio-cultural, and scientific foundations for theory and practice	
2. Relationship	2.1 Demonstrate adequate knowledge of theory related to couple counselling	2.1.1 Theory 1 2.1.2 Theory 2
	2.2 Demonstrate adequate ability to work within an established theoretical framework	2.2.1 Theory 1 2..2.2 Theory 2
	2.3 Demonstrate adequate practical skills relevant to the approach under study	
	2.4 Demonstrate adequate interpersonal skills in facilitating couple counselling	
	2.5 Demonstrate adequate knowledge of theory related to family counselling	
	2.6 Demonstrate adequate ability to work within an established theoretical framework	
	2.7 Demonstrate adequate practical skills relevant to the approach under study	
3. Group	3.1 Demonstrate adequate knowledge of theory related to group work and group counselling	
	3.2 Demonstrate adequate ability to work within an established theoretical framework	
	3.3 Demonstrate adequate interpersonal skills in facilitating group work and group counselling	

Core Competency Field	Core Competency Criteria	Core Competency Measure
	3.4 Demonstrate ability to apply appropriate leadership skills to group practice	
	3.5 Demonstrate ability to evaluate group therapy outcomes	
4. Diversity and culture	4.1 Demonstrate adequate comprehension of diversity issues and contexts in therapy	4.1.1 Across a range of areas including ability, age, class, education, ethnicity, gender, giftedness, health, immigrant status, indigenous status, language, personal identity, race, religious beliefs, sexuality, socio-economic status, and spirituality.
		4.1.2 Recognise how differences may impact and/or interact with therapeutic approaches.
		4.2.3 Adapt and adjust approach as necessary when working with diverse clients – and indeed, all clients
		4.2.4 Recognise how subtle or blatant, chronic or acute, experiences and/or perceptions of discrimination, prejudice, bias, and oppression negatively impact on people's functioning
		4.2.5 Acknowledge help seeking behaviours, and the barriers to accessing counselling services
		4.2.6 Acknowledge how the therapist's beliefs, values, and bias can negatively impact on clients, particularly diverse clients
		4.2.7 Identify, collect, and utilise resources for and with culturally diverse clients
	4.2 Demonstrate adequate use of socio-critical, historical, and political tools of analysis	4.2.1 Post-colonial; Feminist; Post-modern; Critical theory
	4.3 Demonstrate adequate comprehension of cultural issues and contexts in therapy	4.3.1 Multicultural or inter-cultural; Indigenous and traditional cultures; Ethnic and immigrant; Racism, prejudice, violence; Integration of self-culture and familial background in practice; Openness to inter-cultural dialogue, discourse, and challenging existing methods by new insights gained; Openness to working within linguistic and cultural references of clients, to learning their language, and to gaining cultural knowledge outside the confines of therapy; Facilitating appropriate co-therapy, interpretative services, support, and/or referral where the above is beyond the capacity of the therapist
	4.4 Demonstrate integration of knowledge regarding spirituality, religion, and meaning	
	4.5 Demonstrate integration of moral development, reasoning, rationality, and consciousness	
	4.6 Demonstrate personal and professional ability to acknowledge beliefs and values related to issues in therapy	
5. Professional ethics	5.1 Demonstrate adequate knowledge of relevant ethical codes within the profession, and the codes of allied professions	5.1.1 Specify codes
		5.1.2 Demonstrate ability to apply step-wise and complex ethical decision making processes within the context of therapy
	5.2 Demonstrate adequate knowledge of legal requirements nationally and in each state, particularly where the practitioner is residing	5.2.1 Specify National, My state, Surrounding states
		5.2.2 Demonstrate ability to apply legal frameworks to informed decision making processes within the context of therapy
	5.3 Demonstrate adequate knowledge of ethical and legal issues in distance therapy and supervision that cross political and national boundaries	5.3.1 Ethical guidelines for distance counselling
		5.3.2 Legal issues in distance counselling
		5.3.3 Ethical guidelines for distance supervision
		5.3.4 Legal issues in distance supervision

Mapping Counselling Competencies for Professional Practice: An integrative, wholistic and contemporary model – Part 2 (Continued)

Core Competency Field	Core Competency Criteria	Core Competency Measure
	5.4 Demonstrate compliance with all relevant legal requirements of training and service provision	5.4.1 Forms 5.4.2 Protocols 5.4.3 Maintain client records 5.4.4 Mandatory reporting 5.4.5 Documentation and case notes 5.4.6 Document clear boundaries between training practice 5.4.7 Ensure security of information when using email, internet, video, or other distance technology for counselling or supervision purposes, or for transmission of client data
	5.5 Demonstrate current knowledge of regulatory requirements and professional associations	5.5.1 Maintain evidence of current student-membership in a professional association 5.5.2 Maintain evidence of personal indemnity insurance and public liability insurance as appropriate for the training context verses the student's other practice
	5.6 Demonstrate participation in continuing education and ongoing professional development	5.6.1 Demonstrate record of professional supervision 5.6.2 Demonstrate record of lecturer supervision 5.6.3 Demonstrate record of peer-supervision 5.6.4 Demonstrate ability to identify circumstances where the therapist's own life experiences may compromise therapeutic effectiveness 5.6.5 Demonstrate ability to identify circumstances where the therapist's own life experiences may enhance therapeutic effectiveness
	5.7 Practice in a way consistent with the role of the Clinical Counsellor and Psychotherapist within the health care and social welfare sectors	5.7.1 Define the limits of competence and consult within these limits 5.7.2 Define the limits of competence as an educator or trainer and practice within these limits 5.7.3 Engage in group process, education, and therapy within the limits of defined competence 5.7.4 Demonstrate capacity to advocate for clients 5.7.5 Demonstrate capacity to speak and write to critical social and political issues on behalf of clients and the profession 5.7.6 Demonstrate capacity to write clear, concise, and accurate reports, presentations, and paper drafts for submission to disciplinary journals
6. Management & marketing	6.1 Demonstrate adequate comprehension of management theory 6.2 Demonstrate ability to work within an established theoretical framework in management and workplace supervision (as differentiated from clinical)	
	6.3 Demonstrate adequate practical skills relevant to the management approach under study	6.3.1 Employ sound financial management skills 6.3.2 Employ ethical advertising 6.3.3 Establish a fee schedule 6.3.4 Establish policy related to third-party payment 6.3.5 Establish policy related to client attendance 6.3.6 Establish effective business strategy to respond to client crisis

Core Competency Field	Core Competency Criteria	Core Competency Measure
		6.3.7 Establish procedure to deal with workload while away from practice, on vacation, or in the case of illness or personal crisis
		6.3.8 Demonstrate adequate comprehension of marketing guidelines for the profession
		6.3.9 Demonstrate capacity to develop a management and marketing five year plan to support clinical practice provision
		6.3.10 Demonstrate planning and time management skills
7. Clinical supervision	7.1 Demonstrate adequate comprehension of clinical supervision theory	7.1.1 Specify theory, and/or create and develop theory
	7.2 Demonstrate adequate comprehension of clinical supervision standards for practice	7.2.1 Specify standards, and/or create and develop standards
	7.3 Demonstrate capacity to engage in collegial and mutually supportive peer-supervision through one-on-one arrangements and through small groups	
	7.4 Demonstrate comprehension of the importance of supervision for competent practice	
	7.5 Identify sources for appropriate supervision	7.5.1 Articulate purpose, focus, and outcomes for supervision
		7.5.2 Agree on a contract for supervision
		7.5.3 Apply feedback from supervision to practice
		7.5.4 Identify when supervision is urgent
		7.5.5. Protect client confidentiality and rights while undertaking supervision
8. Self care	8.1 Demonstrate capacity for growth in self-awareness throughout clinical training and commitment to ongoing life-long learning	8.1.1 Keep a personal clinical learning journal
		8.1.2 Chart and/or document learning process for evaluative purposes
	8.2 Demonstrate ability to negotiate high-pressure schedules during the course of study and/or practice while maintaining self-care and personal health necessary for responsible therapeutic practice	8.2.1 Document monthly schedule
		8.2.2 Note times and activities undertaken for self-care
		8.2.3 Demonstrate capacity for self-care and self-growth by documenting related personal goals relevant to practice and life-long learning
		8.2.4 Demonstrate capacity to seek personal support when needed
		8.2.5 Build and regularly use and manage a personal and professional support network
		8.2.6 Maintain personal hygiene and appropriate apparel
		8.2.7 Respond to signs of burnout before this occurs, and recognise burnout as an occupational hazard
	8.3 Demonstrate capacity for self-evaluation and improving profession performance	8.3.1 Show how feedback from lecturers and/or supervisors is taken on board
		8.3.2 Initiate and seek out personal counselling and/or supervision
		8.3.2 Chart development of performance by making a 'mind map' of key moments of learning and how these were later incorporated in practice
	8.4 Keep a professional portfolio of practice and related information for career advancement, lifelong learning, and for quality assurance	8.4.1 As specified in training handbook or manual, and as required for evidence for professional membership and maintaining membership from time to time

Mapping Counselling Competencies for Professional Practice: An integrative, wholistic and contemporary model – Part 2 (Continued)

Core Competency Field	Core Competency Criteria	Core Competency Measure
9. Collegial relationships	9.1 Maintain professional relationships with peer trainees, co-workers, colleagues and appropriately disclose and/or document any conflicts of interest as they arise	9.1.1 Inform program coordinator of issues, gain advice, and possibly document issues as necessary 9.1.2 Maintain professional relationships within the health and social welfare sector relevant to your work, location, and context
	9.2 Take responsibility for your representing the training institution and/or professional body and/or employer in your clinical practices, and maintain high standards for professional behaviour and ethical conduct	9.2.1 Take responsibility for understanding and complying with complaints protocols, disciplinary, and suspension procedures
	9.3 Show by your identity and conduct as a clinical counsellor and psychotherapist an informed social and environmental conscience, demonstrating wider professional and collegial commitments to improving the human condition	9.3.1 Demonstrate capacity to take on collegial roles of social advocate and to engage in political debate and processes to improve client circumstances and social conditions for society and for the environment 9.3.2 Be willing to undertake an educative collegial role in your community of practice, and to engage in proactive leadership through collegial interactions that facilitate greater understanding and appreciation for the complex and vital role of clinical counselling within the allied health sector and within society
10. Applied research	10.1 Demonstrate ability to search, find, utilise, apply, and critique high quality research findings in clinical practice	
	10.2 Demonstrate ability to engage in and understand the connection between informal clinical research skills and formal research outcomes and their central role in all clinical practice	10.2.1 Apply ethical standards in informal inquiry as well as formal 10.2.2 Engage the scientist practitioner model by considering exploratory based qualitative and hypothesis based quantitative and/or empirical approaches that enhance clinical expertise, investigation, assessment, and treatment outcomes 10.2.3 Share theory or hypothesis with client when appropriate, using the investigative method as a means to monitor progress, keep and open mind, and to never assume the corner of truth on any client issue or circumstance
	10.3 Demonstrate adequate standards for clear, concise and professional writing of case notes, paper drafts, and presentations for workplace, seminars, and conferences 10.4 Demonstrate capacity to write from clinical practice and to contribute to the professional literature through various forums which may include published journals	
	10.5 Demonstrate capacity to integrate knowledge of research into practice	10.5.1 Decide the effectiveness of research findings in practice, as related to each case 10.5.2 Engage in critical analysis of research findings 10.5.3 Ensure ongoing access to on-line professional databases through universities for updated literature searches while in-practice, and access a wide range of sources including the internet 10.5.4 Use research findings to increase therapist's effectiveness and to disseminate findings into the therapeutic community
11 Clinical assessment	11.1 Demonstrate comprehension of theories of assessment and assessment approaches	11.1.1 Specify a range of theories and assessment approaches

Core Competency Field	Core Competency Criteria	Core Competency Measure
	11.2 Demonstrate capacity to analyse, critique, apply through informed evidence based principles different theories of assessment in clinical practice	11.2.1 Demonstrate assessment skills across a range of measures 11.2.2 Demonstrate adequate and critical knowledge of assessment tools, tests, and models 11.2.3 Demonstrate capacity for clinical assessment and diagnosis of mental illness and other disorders as appropriate for a clinical counselling role 11.2.4 Demonstrate capacity for developing a treatment plan and treatment regime appropriate for a clinical counselling role 11.2.5 Demonstrate ability to engage in consultation with other professionals including clinical psychologists, medical doctors, mental health nurses, and community care workers for the benefit of the client 11.2.6 Demonstrate ability to clearly define, negotiate, maintain, monitor, and manage the clinical counselling role and case treatment outcomes with complex and co-morbid variables
	11.3 Demonstrate ability to critique and further analyse clinical assessment skills in case analysis during clinical supervision	
12 Mental health	12.1 Demonstrate comprehension of national and state based frameworks for mental health provision 12.2 Demonstrate ability to work within a rights based framework to ensure safety, consumer and carer participation, health promotion and prevention, and privacy and confidentiality 12.3 Demonstrate comprehension of cultural issues as they relate to provision of mental health services, including showing capacity to critique dominant views and to take into consideration alternative cultural beliefs and practices throughout the assessment and treatment process 12.4 Demonstrate capacity to work within an integrated health care system, and to engage in systemic development to improve conditions of care for consumers 12.5 Demonstrate a comprehensive awareness of working within the delivery of care, including access, entry, assessment and review, treatment and support, community living, supported accommodation, medication and other medical technologies, therapies, inpatient care, planning for exit, and exit and re-entry	12.1.1 Specify
13 Distance Technology	13.1 Demonstrate integrated use of distance technology during training	13.1.1 Demonstrate use of many standard current technologies and/or hardware and/or software platforms necessary for integrated participation in the training context and/or in clinical practice, including intranet, internet, world wide web, public search engines, professional literature and professional journal search engines, electronic mail, blog, wiki, bulletin board, web CT, Sakai, videoconferencing, teleconferencing, chat rooms, and any other technologies as they come of age and that may be used as part of a training package from time to time
	13.2 Ensure that confidential data is protected during storage, and ensure that during transfer via regular mail or via electronic mail that data is secure	13.2.1 Edit case notes and mask identifying information to ensure all measures are taken to protect client's confidentiality 13.2.2 Ensure adequate security of backup systems for data storage

Mapping Counselling Competencies for Professional Practice: An integrative, wholistic and contemporary model – Part 2 (Continued)

Core Competency Field	Core Competency Criteria	Core Competency Measure
		13.2.3 Ensure policy and procedure for deletion and destruction of data in a timely manner under relevant legal guidelines
		13.2.4 Ensure all participant's consent is recorded on paper and verbally during the first five minutes of the recording wherever and whenever audio and/or videoconferencing or video storage in any media is used (i.e. videotape, digital CD, webcam, portable devices, audio cassette, digital audio, etc...)
	13.3 Where distance clinical counselling and related services are delivered to the public during the course of training, ensure that ethical standards are adequately addressed and that trainees are required to comply with standards	13.3.1 Where applicable, incorporate distance provisions into ethical and legal student agreements, agreements for consent with clients, agreements with agencies and/or supervisors, and ensure adequate indemnity coverage is maintained by relevant parties
	13.4 Demonstrate any necessary modification of core clinical skills for delivery via distance technologies, ensuring client ease and comfort	13.4.1 Demonstrate distance therapeutic skills through peer-practice and simulations to ensure familiarity with the perimeters of the technology
		13.4.2 Demonstrate understanding of the limitations of the technology being used in relation to the objectives of the therapeutic relationship
		13.4.3 Demonstrate modifications to the analysis of the therapeutic relationship within the contexts of distance provision of services
	13.5 Demonstrate relevant core clinical applied research skills essential during the uptake and implementation of new technologies in therapy	13.5.1 Report back to the training authority and/or agency and/or workplace in regular and timely fashion regarding troubleshooting and ensure regular and consistent documentation of analysis of the use of technologies and therapeutic approaches employed
		13.5.2 Seek out new information and keep up to date on developments in new technologies relevant to the therapeutic services provided
		13.5.3 Join any relevant associations and/or access relevant journals that provide services to counsellors and psychotherapists who practice via distance
14 Loss, grief and trauma	14.1 Demonstrate adequate knowledge of relevant theory and treatment approaches in loss and grief therapy	14.1.1 Specify
	14.2 Demonstrate adequate knowledge of relevant theory and treatment approaches in crisis intervention and trauma therapy	14.2.1 Specify
	14.3 Demonstrate integration of theory and practice in loss, grief, crisis, and trauma therapies across a wide range of cases	
	14.4 Demonstrate adequate knowledge and clinical practice in suicide assessment and intervention	
	14.5 Demonstrate adequate knowledge of issues of access and equity in relation to rural and regional crisis and trauma services, and longer term services for chronic issues of post-trauma recovery, loss, grief, and co-morbid factors like depression	

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Not Without My Wife: An Exploration of the Cuckolding Lifestyle

By Angela Lewis, PhD

So called 'kinky' sex is arguably one of the least understood forms of consensual adult sexuality, given the perception of deviancy and abnormality that surrounds it. The response from some health care professionals to previous articles I have written in this area exposed a gap in the understanding of alternative sexualities. This prompted me to spend the last 4 years researching the world of sexual fetishes and kinks, and the result is my forthcoming book, ***My Other Self****. As part of the work I was doing on female domination I spent the first half of 2010 researching within the cuckolding community and I was invited as a guest blogger on a well-known cuckolding website. These are the stories of the couples I met during this time. They live in ordinary neighbourhoods, have jobs, careers and children just like the next person, but very quietly lead far from ordinary sex lives. While there is no definitive data that quantifies the incidence of so-called 'kinky' sex, research suggests it is practised by 10-15% of the adult population (Brame 2000) and 14% of American men and 11% of women (Kleinplatz and Moser 2007, Janus and Janus 1993); figures that health care professionals can ill-afford to ignore or dismiss as marginal.*

How couples choose to conduct a cuckolding lifestyle, depends on the individuals involved.

For obvious reasons all names are pseudonyms and identifying data has been removed.

Sam and Elisabeth have been married for 7 years and have recently had a second child. She works in sales and he works in retail security. They are renovating their house, they enjoy all the usual 'couple' activities such as movies and dinners and they have a small circle of close friends. Sam is 27, tall, well-built and considered an attractive man. By his own admission, he is a self-confident, outgoing alpha male. Elisabeth is 25 with a curvy, feminine figure. Ask either of them and they will tell you they have a great sex life….together and vicariously through Elisabeth's casual encounters with other men.

Sam and Liz practise what is known as cuckolding. In days gone by 'cuckold' was a derogatory term for a man with an adulterous wife, but nowadays it is used to describe a man who consents to his wife's extramarital affairs—with the vast majority of these husbands (referred to as cucks), planning, aiding and abetting their wives' extra curricular activities. In a cuckolding relationship, the wife has sex with as many different men as she wants with the full blessing of her partner, while he remains faithful to her. How couples choose to conduct a cuckolding lifestyle (sometimes also referred to as hotwiving), depends on the individuals involved. The husband may be physically present during his wife's encounters, although whether he is allowed to watch depends on the wishes of the wife and the agreement of the woman's sex partner; but if present, he does not participate in the sex act.[1] If not present the wife is expected to share the experience through retelling events, texting photos during the event, having sex with her husband when she returns or by sharing physical evidence of a sexual encounter. Either the husband or wife may approach a prospective sex partner for the wife. This could be within the cuckolding community, among friends or through online advertising. While some couples will continue to have a sexual relationship themselves, it is anecdotally fairly common for this to cease or drop right off; the husband instead getting sexual relief from masturbating to his wife's retelling of events, or to photos or videos that the wife brings home to him.

When a man continues to have sex with his wife, it is commonly reported that his sexual enjoyment is the most extreme if he is able to have sex with her immediately after she has had sex with another man. This is reported as being far more intense and erotic than day-to-day sex and anecdotally many cuckolding husbands love to see evidence of sexual activity after their wives have been with another man. While Elisabeth uses condoms (both for sexual health and to avoid pregnancy), Sam also loves having sex as soon a possible after his wife has slept with another man. Andrew and Dianne who have been cuckolding for some 8 years and despite admitting they both should know better, they find this aspect so erotic that Dianne has recently stopped using condoms with her lovers so that Andrew can share in the other men's semen when she returns home. Andrew suffers no jealousy and no humiliation and finds it an extremely powerful experience:

> *The sex we have after she has been with someone else is just simply the best, it just seems so dirty, so taboo. I should know better, but I'm willing to let any man come inside of my wife's pussy now because I want to feel it again and again. There is something very powerful about knowing she has acted on her inner slut in such a profound way.*

Sam and Elisabeth's sex-life is also self-reported as being at its best now she is having sex with other men. They put this down to the fact that they are new to cuckolding and very much enjoying the attention she gets from the men she flirts with leading up to having sex and to the fact that they enjoy breaking the rules and doing something that is considered socially taboo. Identifying the taboo aspect of cuckolding as attractive was common to the majority of people I spoke with. In Sam's words:

> *This is like our completely 'irresponsible' taboo, its bucking the system, a "we'll do it our way type of outlet". It's kind of a way to blow-off steam and it makes us strong because it's something that we do together—it's like our dirty little secret.*

Sam and Elisabeth are currently 'interviewing' for a regular sex-partner for her and after placing an online advertisement are weeding through 400 applications—including one from a man who is

1 This is different from 'swinging', which involves a third person or another couple joining them in the sex act.

prepared to move locations to be nearer to them in exchange for a regular sexual relationship with Elisabeth. Locating and vetting casual sex encounters on an ongoing basis is a time-consuming business, particularly as they both have jobs as well as young children. As well, by taking this approach Sam feels they are also addressing the aspect of personal safety, which can be an issue when regularly coming into contact with male strangers, so for them this is a better option.

Sam and I began our conversation through a cuckolding blog, then moved to a more personal one-to-one dialogue where he revealed that he had gone to see a counsellor about work-related stress and was dismayed with the so-called professional's response when he disclosed his sexual interests. On volunteering the information that he and his wife were swingers but were about to embark on a cuckolding lifestyle, the counsellor murmured something about 'good on you' and moved quickly on— ignoring Sam's obvious need to talk about this part of his life and dismissing an opportunity for learning about a pursuit where there is an apparent lack of professional understanding.[2]

2 See Hoff (2009) 'Therapy Experiences of Clients with BDSM Sexualities' for some interesting data on the experiences of people who practice consensual BDSM and the reaction of their therapists.

Sam is a self-described alpha male in a job with a high level of responsibility and a number of staff reporting to him. He admits he enjoys power and control and realises this probably stems from his childhood when his mother routinely relied on him to be the man in a single parent household. When Elisabeth is with other men or texting and flirting with them he admits it does make him jealous, but he experiences this as arousing. Paradoxically both he and his wife subscribe to the view that sex is just sex and doesn't have to have an emotional attachments, and for them is enjoyed as a form of recreation—an aspect he acknowledges is always easier for men to understand. He also enjoys the aspects of control and ownership in the relationship. As he describes it:

> *As a guy I want everyone to want what I have and even after playing with her, they don't 'have' my wife, she's my partner in life not their's. The sex we have after is AWESOME and the same for days after. It's like I'm reclaiming her. It also keeps up a bit of competition, I know she's not going to leave me but she still has other options for sex so it just adds something to it. Every guy wants a perfect wife in the kitchen and a slut willing to explore in the bedroom, and I use slut in a good way.*

Talking about this lifestyle is understandably not something that the couples find they can do easily amongst family, friends and colleagues but the couples

Identifying the taboo aspect of cuckolding as attractive was common to the majority of people I spoke with.

Not Without My Wife: An Exploration of the Cuckolding Lifestyle (Continued)

and individuals who responded to my request for feedback on what cuckolding meant to them were overwhelmingly honest and soul-searching. It is common that couples talk about it between themselves long before they take any steps towards this lifestyle, often for a number of years before-hand. As Jinxypie, a self-proclaimed Cuckoldress who has made a career from her cuckolding adventures explained; at the heart of doing this successfully is that couples need to talk and talk about it—and then talk some more. She maintains that once couples embark on this sort of relationship it is very difficult to pretend it didn't happen, so they must be very careful to understand how each partner feels beforehand, and may feel afterwards.

According to those I met in the cuckolding community, men overwhelmingly instigate a cuckolding lifestyle. It is rare to hear anecdotes of women suddenly coming up with the idea of introducing new men into the marriage while the husband remains faithful. When the idea is initially canvassed, the wives generally have difficulty coming to terms with or understanding why their husbands would want to pursue such behaviour. A common fear (aside from believing it is unacceptable for married women to behave this way) is that it will lead to the end of the marriage; or that it is some type of trap that the husband is laying and if the woman goes ahead she will have failed the test and proven she is a slut. When a woman does try it, it is frequently after a lot of convincing and because she can see how important it is to her husband—though she may not understand his reasons and sometimes never does. Women who try it and find themselves encouraged and supported by their husbands overwhelmingly report enjoying their sexual freedom, particularly when they believe their husbands want them to be happy and fulfilled.

She loves her cuckolding lifestyle so much that she has now made a business from it,

Jinxypie is a good example: a 30 year old mother of four young children, she was introduced to it by her husband a few years into the marriage. She loves her cuckolding lifestyle so much that she has now made a business from it, as well as writing on the subject and giving advice to other would-be cuckolders. She sees her lovers on condition her husband is allowed to film them remotely. His enjoyment comes from the lead-up to the encounters, viewing the videos and discussing them with her in bed afterwards; hers comes from lots of sex and all the attention and adoration this lifestyle brings. While Jinxy and her husband continue to have sex, her preference is for men more endowed than her husband and she picks and chooses accordingly. They collaborate in creating and selling the videos, which her husband enjoys watching; and, as Jinxy says, everyone is happy.

A common outcome of the cuckolding lifestyle is that sex with the husband or partner generally drops off or becomes non-existent. For some men their desire shifts and they maintain that the woman's sexual gratification becomes their pleasure (i.e. she's happy, so I'm happy). In other cases, the wife becomes the source of inspiration for the man's masturbation fantasies—some liken it to having their own private porn star and creates a situation that allows him to have highly selfish sex during which he no longer has to provide her with attention. While Sam enjoys the 'private porn star' benefits, he and Elisabeth continue to have a strong sex life, with Elisabeth enjoying the attention and adulation of strangers and Sam very much enjoying the fact it is his wife the men are lusting after.

'Sissy Donna' is a married man and nominates the opportunity to be submissive as highly important. If at all possible, he likes to be present when his wife has sex with a Bull (slang used for the men who sleep with married women) as his pleasure comes from being dressed in some type of female underwear and masturbating while his wife and the other man have sex. He and his wife choose her partners together and penis size is also one of their criteria as he enjoys watching her with well-endowed men. Preferring men who are well endowed is fairly common, as can be seen by the advertisements couples place for Bulls For other men, the erotic thrill is tied to the intense humiliation they feel in knowing what their wives are doing while they wait patiently at home. The need for humiliation can be so strong that some men insist on performing oral sex on their wives afterwards (known as clean-up duty or a creampie), reporting a deep thrill in going 'sloppy seconds' that is more pleasurable than having penetrative sex. Some men do this as a way of showing appreciation to the wife for having had sex with another man, an attitude that is at odds with the view that cuckolding is done with the woman's pleasure in mind. While many women do practise safe sex, it has to be said that given the interest in creampies, sex without condoms is not unusual in the cuckolding lifestyle.

A commonly proffered reason for pursuing this lifestyle is based around the happiness of their wives, as many husbands believe a satisfied wife who is free to express her sexuality in whatever way she chooses makes her a self-confident, attractive partner. Some of the other reasons husbands gave for pursuing cuckolding were that they had esteem issues because of their penis size or sexual prowess, or that they did not have a high sex drive and becoming a cuck allowed them to satisfy their wives and preserve the relationship—and take pressure off themselves, as one older husband described:

> *This has been an ideal solution for us. My wife is beautiful and while I am not ugly, I am more the quiet, geek type and I've always worried about the day she finds someone better. While other men may worry that their wife is cheating because she is sexually frustrated, I can sleep soundly knowing that mine is satisfied every time she has sex because she can pick whoever she wants. I know I am first in my wife's heart, her best friend, her confidant, the one she turns to for comfort and support.*

For the man who has homosexual fantasies or is bi-curious, homoerotic thrills can be enjoyed by proxy, as watching his wife in the act provides a husband with the opportunity to experience homosexuality vicariously. When they are allowed to be physically present, some men will give oral sex to the wife's sex partner or touch him under the guise of pleasing the female partner; but they do not consider this a homosexual activity.

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2009 Time Table

City	Date	Month	Closing Dates (Enrolments & Payments)
Melbourne	6th - 11th	April	16th Feb
Brisbane	6th - 11th	July	16th May
Sydney	21st - 26th	Sept	8th Aug

Course Content

1. Working within a counselling supervision framework
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Assessments of your competency against the required Units of Competency include:

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

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Australian Counselling Association (ACA)

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

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

BOOKINGS AND ENQUIRIES

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

Not Without My Wife: An Exploration of the Cuckolding Lifestyle (Continued)

As cuckolding is based on the idea of the woman having lots of sex without emotional attachment because her main relationship is with her husband, those who do it successfully maintain that their relationships are more honest and grounded than the average marriage. She enjoys a rich sex life, he gets his pleasure from her activities and they both view it as giving something to the other. Cuckolding couples such as Sam and Elisabeth and Jinxypie and her husband, who believe they have managed to separate sex from other aspects of their relationship appear happiest, likening it to the usual give-and-take in normal sex or as a specific recreational activity.

As Jinxy points out, a Cuckoldress doesn't cheat on her husband; she shares everything with him and Sam and Elisabeth while still only in their twenties, also operate from a similar philosophy. While they remain guarded about their lifestyle to friends and family; they believe the trust and honesty they show to one another provides the foundations of their happy relationship.

While they remain guarded about their lifestyle to friends and family; they believe the trust and honesty they show to one another provides the foundations of their happy relationship.

In Conclusion

The people who were kind enough to share their lives and thoughts for this article are confident in their sexuality and function as worthwhile members of their community and society in general—and they are not looking to change those aspects about themselves. However community attitudes towards anything other than mainstream sexual practices remains deeply suspicious and judgemental and this sometimes extends to the mental health community. As a result, when people who enjoy a kinky or alternative sex life need to consult a counsellor around wider issues in their lives they can have problems finding practitioners who won't be disturbed or discomforted when clients disclose an interest in sexual practices that may be outside of the therapist's knowledge base.

While there is no expectation by these clients that counsellors and therapists have personally experienced practices such as I have discussed here; I suggest counsellors should have some knowledge of the different ways that people choose to express themselves sexually and have taken the opportunity to reflect on their own cultural, religious or familial values in relation to these issues. This means when someone like Sam walks into their rooms needing help, the counsellor can be open to discussing all aspects of the client's life rather than just the ones he or she may be comfortable and knowledgeable about exploring.

A very big thank you to all those who shared their lives for this article, in particular Sam and Elisabeth for giving me so many hours of their time. My Other Self will be available as a paperback or ebook from www.myotherself.com.au shortly, but in the meantime the Facebook page is easily located by typing in 'my other self'.

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Aboriginal Counselling Approaches To Mental Health By Kym Maree Dann

The challenge for western research and researchers is to engage research as an interface where conceptual, cultural and historical spaces interface or come alongside each other based on new relationships to knowledge, to research and to self[1].

Abstract

Issues faced by Indigenous peoples living in urban and semi-urban/regional areas have a commonality not just within Australia but across the globe, where upon the effects of colonisation and racism are irrefutable and equally undeniable is the strength of self-determination, resilience and the pride of Aboriginality.

Working throughout Australia in Aboriginal Community or as is culturally referred to as "country", I have notice that large disparities are evident in the delivering and understanding and providing counselling in the field of Mental Health.

Aboriginal people have view mental health differently to mainstream where there is a need to blend culture, spirituality and connection to country to ensure a holistic approach is incorporated in treatment plans and counselling sesssions.

My work as Koori woman with extensive experience in this area has inspired me to devote my thesis to this subject in the hope of working towards addressing

My work as Koori woman with extensive experience in this area has inspired me to devote my thesis to this subject.

1 Karen L Martin, Please Knock Before You Enter: Aboriginal Regulation of Outsiders and the Implications for Researchers, Post Pressed, 2007, p.3

these disparities through the promotion of Indigenous knowledge into Mental Health.

My research has been an ongoing work in progress over the past 16 years where upon I have worked mental health in the following regions and utilised this research to create my thesis. Interestingly although all different tribes and clans there are similiarities to the approaches we need to follow when making assessment of mental health condition in Aboriginal community.

Fortunatley I have been able to blend my research from the following regions, conducting over a period a prolonged period of over 16 years conducted throughout North Qld referred to as *Murri Communities*, NSW region which is where I have connection to country and referred to as *Koori Communities*, lastly where I am based currently in Northern Territory, *Yolngu Communities*, who inhabit North East Arnhem land region.[2]

My research questions the importance for mental health assessment and recovery for Aboriginal people suffering from a mental illness, most importantly it will draw attention to and recognize the interpretations and the meanings those diagnosed with a mental illness attach to their personal mental health experiences, often influenced by culture and provide the reader alternative explanations and understandings of mental health.

The question concerning Aboriginal mental health is embedded in a larger set of questions relating to culture and cultural differences, historical events, social and cultural change and coping mechanisms.

It is important at this point to highlight that mental health is viewed by Aboriginal people is based on current, historical and spirtual values and is a broad concept that incorporates the following aspects being:

Social
Emotional
Cultural
Physical
Mental well being of the individual
Mental well being of whole community[3]

Based on this, culturally appropriate mental health assessment and treatment tools need to be developed in mainstream mental health services with clear treatment strategies to focus in on the mental health of children, youth, men, women and elders within the community.

Background Information

I have over the years been witness to the absence of understanding and knowledge of cultural issues on the part of mental health service professionals which has and does have the potential to lead to misdiagnosis or underlying issues remaining unidentified.

Drawing on an example that comes to mind, when working in a correctional services setting I was alerted to a notification of concern that had been created by a mainstream psychologist who believed the Aboriginal subject was suffering from delusionary behaviors, auditory and visual halluncinations, flat affect and depressive symptoms, lastly the subject was observed taking down pictures of family in his cell and isolating from the main population, also the client would no longer respond to their name and appeared generally unresponsive.

The Psychologist relying on mainstream diagnosis felt that the subject needed to be placed in an Obs cell as they posed a risk of self harm due to the isolation and odd behaviors, as the subject was in a positive mental state only the day before. In mainstream practice this would be percieved as a client at risk but from a cultural perspective this is normal behavior.

Upon assessing the subject, I was soon able to determine that they had lost their family member the night before and had received notification whilst on the phone to family. Aboriginal people have strong connections to family, country and culture and as such out of respect the subject no longer would respond to his name as his name was also the name of the deceased and out of respect he would no longer utilise this name.

Aboriginal people have strong connections to family, country and culture and as such out of respect the subject no longer would respond to his name as his name was also the name of the deceased and out of respect he would no longer utilise this name.

He took down the photos not because he was intending on getting his belongings in order to self harm but to show respect for the deceased as it is tradtional practice to do this, he was also isolating because he needed time out to show his respect in his own way and what the pscyhologist percieved as delusionary behavior is quite normal in culture where our mob will talk to spirits and to themselves out of respect to the deceased. This would also account for the flat affect as he was grieving for his family member and placing him in a observation cell escalated his stress levels leaving him highly agitated and anxious as he percieved he was being punished for grieving.

This can become more complex when dealing with these issues or other mental health concerns on community as it is common for traditional healing practices to be utilised or incorporated into treatment plans.

Traditional healing practices are diverse and specific to individual communities and clan groups within all regions across Australia and may include traditional song, dance, food and bush medicines. Some communities predominately use traditional healing and healers which is essential for cultural and spiritual well being of individuals and the greater community.

The fact that many Aboriginal people choose to use traditional healers should be acknowledged by members of professional mental health services and incorporated to their mental health plans taking into account the individual's cultural and spiritual well being in diagnosis and treatment, and this may involve or require consultation and liaison with traditional healers.

The impact on Aboriginal social and emotional wellbeing as a result of wide ranging influences at individual, social and structural levels, is substantial and persistent. While data in this field is limited, it is widely acknowledged that Aboriginal people

2 Morphy, Howard, Ancestral Connections: Art and an Aboriginal System of Knowledge, University of Chicago Press, Chicago, 1991

3 Valmae A Ypinazar, Australian and New Zealand Journal of Psychiatry, Voume 41, Issue 6, June 2007, p.467 -478

Aboriginal Counselling Approaches To Mental Health (Continued)

experience higher rates of mental health problems than the rest of the population, and many Aboriginal people carry a significant burden of loss and bereavement from an early age, due in part to the high rates of mortality, illness, incarceration, deaths in custody and involuntary hospitalisation among people in their communities.

Treatment alone will not reduce the growing rates of mental illness and there is a need to enhance social and emotional wellbeing early in life.

In addition deaths by suicide are estimated to account for a much higher proportion of all deaths among Aboriginal people than the wider Australian population, in fact data produced in 2005, accounted for suicide of 4.3% of all Aboriginal deaths compared with 1.6% of deaths for other Australians (ABS, 2007).[4]

Difficult and protracted social and psychological circumstances including long-term and accumulative stress, ongoing anxiety, insecurity, low self-esteem, social isolation and feelings of lack of control over life, lead to the increased chances of poor mental health and premature death.

People who live, or who have previously lived in institutions such as prisons, children's homes or psychiatric hospitals, are particularly vulnerable. Social exclusion often resulting from racism, discrimination, stigma and hostility, results in limited community participation, education or paid employment, and ultimately in high rates of poverty and sometimes homelessness.

Promotion and prevention approaches

Promotion and prevention approaches to mental health ultimately seek to reduce all forms of burden by preventing or reducing the incidence, prevalence and impact of mental health problems and mental illness for individuals at all stages of life, family and communities.

Providing effective treatments for Aboriginal people with mental illness is essential and much more needs to be done to improve the provision of mental health care for Aboriginal people. However treatment alone will not reduce the growing rates of mental illness and there is a need to enhance social and emotional wellbeing early in life.

We need to build and maintain the resilience for families and community incorporating a holistic approach as well as assessing the individual to prevent problems from developing.

As mentioned earlier there is a need to ensure that promotion and prevention approaches work within a

4 Australian Bureau of Statistics (ABS), www.abs.gov.au 2007

holistic understanding of social and emotional wellbeing, and incorporate all aspects of wellbeing – physical, cultural, social, emotional and spiritual. The development of resilience is particularly important given the ongoing impact of serious disadvantage and poorer health outcomes for Aboriginal people.

While theoretical frameworks which describe the relationship between promotion and prevention approaches to mental health are relevant for all members of the population regardless of cultural background, there are some specific considerations relevant to Aboriginal and Torres Strait Islander people which should incorporate the following:

Aboriginal people have a higher proportion of people with mental health problems and mental illness than the general population, meaning we need to ensure that prevention approaches are more closely linked with an Aboriginal context rather than in a general context

At risk or selective prevention interventions may also be relevant to larger segments of the Aboriginal population than the general population and risk and protective factors may be defined differently in some cases based on a range of cultural considerations

Aboriginal Mental Health

Further elaborating on Aboriginal mental health I need to highlight that Aboriginal people have a diverse culture with a rich and compelling history. The impact of colonisation, legislation and the stolen generation created significant hardships and intragenerational trauma for Aboriginal Australians and these problems continue today and impact on Aboriginal people and their mental health, these issues include and are not limited to:[5]

continued grief and loss in the Aboriginal community
- **living in continual poverty**
- **loss of identity and culture**
- **chronic disease**
- **low self-esteem and self-worth**
- **incarceration**
- **premature death**
- **poor education outcomes**
- **overcrowding in family homes**
- **substance use problems**
- **sexual abuse**
- **domestic violence**

Managing Mental Health Problems

The impact of history continues today with problems such as anxiety, post-traumatic stress disorder and depression becoming more common in Aboriginal communities across Australia.

Successfully engaging Aboriginal people in support services requires a "whole of family" approach to working with Aboriginal people and their families. [6]

An example I'd like to draw on incorporates a program I have rolled out in my current position as Mental Health Coordinator in Arnhem Land. There is a high incident of what has been identifeid of a "psychotic outburst" or "drug induced psychosis", upon investigating I discovered that the clinic had provided mental health patients with medications but there was no follow up which incorporated family members and carers.

Resulting in the client returning home with medication and due to the high incidence of low literacy and numeracy skills many of the clients didn't understand instruction provided to them by the clinic and would either:
- **disregard taking their medication at proposed times**
- **sell their medication for gunja**
- **dispose of their medication**
- **over medicate**
- **take medication and use with illegal substances**

These actions resulted in the high incident rates of psychotic behavior and drug incuded psychosis, to combat this I have implemented a family integrated approach ensuring that mental health clients are visited by myself and an Aboriginal health worker. We sit down with the family in their home and speak to the patient, carer and other significant family members to ensure they understand what the above mentioned behaviors will result in and draw up a chart using Aboriginal symbols and interpret their daily dosage into their language onto a poster which we laminate and put in the carers room, patients room and fridge.

We also create a wallet sized poster so they have this with them at all times and in case of an outburst the responding person can check what meds they are on and what their dosage is, this has program which incorporates Aboriginal protocols has been a success and in 8 weeks has cut down on approximatley 30% of these outbursts.

Again it is important to draw on the the wellbeing of an individual is linked to the wellbeing of all significant others within the family unit.

It is important to draw on the the wellbeing of an individual is linked to the wellbeing of all significant others within the family unit.

Strengths of Aboriginal people

Aboriginal people are resilient and tolerant and are able to cope with adversity with the support of their strong kinship systems and their acceptance of diversity.

Aboriginal people respond to a "whole of family" approach as it acknowledges the importance of family and kinship. It is important to view mental health problems within the social and emotional context of their lives.[7]

Connection to the land is a central factor for the social and emotional wellbeing of Aboriginal Australians.

There are no formal guidelines or protocols in place currently in Northern Territory where I currently reside and practice for the assessment and treatment of an indigenous person who is suffering a mental health problem.

However, I do implement the following strategies when working with Indigenous Clientele and use these as a basis for educating Non Indigenous health professionals to incorporate in their treatment plans:

Set aside extra time as the interview is likely to take longer than usual. Aboriginal people will take

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5 Cynthia C. Wesley – Esquimaux, Ph.D, Historic Trauma and Aboriginal Healing, Aboriginal Healing Foundation, Aboriginal Healing Foundation, p.3

6 Government of Western Australia – Department of Health, www.health.wa.gov.au/mentalhealth/about_mental/mh_aboriginal.cfm

7 Government of Western Australia – Department of Health, www.health.wa.gov.au/mentalhealth/about_mental/mh_aboriginal.cfm

Aboriginal Counselling Approaches To Mental Health (Continued)

time to interpret from language to english and like time to cultivate their thought process before responding.

Explain your role, who you are and what it is you are doing in the community also explain the sort of things you are going to ask, especially if these are personal questions as they may want an elder or family member present

Remember that you may be viewed as a member of a culture that has caused damage to indigenous culture - anticipate some anger, resentment or suspicion and work through this accordingly with an open mind

Be careful about using direct questions as these may be perceived as threatening and intrusive and be met by a hostile response

Avoid using medical and other technical jargon, use plain english and break it down

Recognise that vague and non-specific answers may reflect the discomfort of the person being interviewed

Indigenous people may avoid direct eye contact, and this is regarded as polite within indigenous culture. You may also want to avoid direct eye contact as this may make the person feel uncomfortable or threatened

Be aware of the following cultural prohibitions:

Indigenous Australians may have much to offer in the treatment of mental health, social and emotional problems.

referring to a dead person by name

referring to certain close relatives by name, ask them what they would like you to call them and they will tell you

criticizing an elder (older people are treated with great respect within traditional cultures)

confiding certain personal information to a member of the opposite sex (men's and women's business are usually kept separate)

Criticizing members of the extended family (family loyalties are strong).

In assessing the mental state of an indigenous person remember the following:

Hallucinations may not necessarily be psychotic phenomena. For example, it is normal for the bereaved to see and hear the voice of a deceased family member. Other family members are also likely to share the experience, which is usually perceived as reassuring. These phenomena usually do not persist longer than a month after the relative's death.

Limited eye contact, and softly spoken and brief answers may merely indicate that the person is shy or being polite.

Anger and obscene language directed at you may reflect past experience by that person, or his or her family, of exploitation and hardship inflicted by members of your own culture.

Consider carefully the appropriateness of any cognitive tests that you use:

Take into account the education and living situation of the person being tested.

Tests such as counting backwards, spelling and remembering a sentence may be perceived as demeaning and precipitate a hostile response.

Conclusion

Working with Indigenous Australians requires special expertise and understanding of Indigenous mental health issues, and involves working with Aboriginal and Torres Strait Islander communities and Indigenous health and mental health workers and interpreters. The traditional healing practices of Indigenous Australians may have much to offer in the treatment of mental health and social and emotional problems.[8]

While there is still 'mainstream medical model' treatment approaches to mental illness I hope that my paper has addressed some of the key issues faced by Aboriginal people in Australia in a bid to strive towards making significant modifications in order to provide more culturally sensitive and appropriate care to individual community members, their families and the community as a whole.

As mental health professionals we need to establish a mutually respectful collaborative working relationship with traditional healers in the community. In this way, I believe that we are offering the community a the "best of both worlds" approach to the prevention and management of mental disorders with the overall goal of providing culturally relevant services for the betterment of mental health at the individual, family and community levels.

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ResponseABILITY, www.responseability.org.au/site/index.cfrm?display=134939 , Commonwealth of Australia, 2009, p.1

8 ResponseABILITY, www.responseability.org.au/site/index.cfrm?display=134939, Commonwealth of Australia, 2009, p.1

Internet and Computer Resources With Angela Lewis

Sexting

Yep, you read it correctly—sexting is a combination of the words sex and texting. It refers to taking sexually explicit or nude photos (usually of oneself) and sending them to other mobile phones. Of course now with all the social networking sites like Facebook and Twitter, if someone receives such a photo they can every easily upload it for the world to see. There is even a site called sextingpics.com, where anyone can go to upload sexually explicit pictures, view them and comment them. And folks please be warned, if you visit this website some of the amateur pictures of couples and women are most definitely R-rated. The *Herald-Sun* newspaper reported earlier this year that primary age children were even sexting, and raised concerns related to the inadvertent distribution of child pornography by students. In WA, *The Sunday Times* (19/5/2010) reported that there have already been charges laid against 13 teenagers over distributing child pornography as a result of them sending and receiving sexually explicit photos of themselves and other students. Regardless of a person's age, once a nude or compromising pictures leaves the owner's mobile phone and hits cyberspace it can (and usually does) end up anywhere (like Facebook or Twitter for example;) becoming a life-long legacy that could impact future relationships and employment prospects.

Facebook Friends and Social Support

I read a very interesting article in the *New Scientist* ('Why Facebook friends are worth keeping' 14/7/2010) discussing the benefits of having expanded friend networks that reach far and above the number of friends a person could manage in a real-life context. While many folks can't see the point of having virtual friends who they may never meet face to face; this article quotes a study which argues that these so called "loose ties" serve the function of providing a form of social support which is considered beneficial—even if the support and affirmation comes from friendship ties that could be considered weak. I will paste a link to the full article on both my Facebook and blog pages (www.angelalewis.wordpress.com) for anyone that wants to explore this further.

Getting Ready for Windows 7

Microsoft is ended support for Windows XP with SP2 (Service Pack 2) on July 13, 2010. Now support is discontinued for this edition, there won't be any additional security updates coming through—making your system more vulnerable to malicious viruses that can easily destroy a PC.
For those not ready to upgrade, Microsoft has made a service pack for Windows XP available that will buy users a bit more time with this operating system, but its believed support for that will end April 8th, 2014. See the Microsoft website for more details.

So, when you are ready to upgrade to Windows 7 these are recommended hardware requirements—however do your own homework and ensure that you discuss your requirements with your retailer:

- 1 Gigahertz (GHz) or faster 32-bit (x86) or 64-bit (x64) processor
- 1 Gigabyte (GB) RAM (32-bit) or 2 GB RAM (64-bit)
- 16 GB available hard disk space (32-bit) or 20 GB (64-bit).

Another Way to Select Text

Do you having trouble when you try to highlight or select text? Say when you put your cursor at the point where you want to start highlighting (selecting) the text and drag it across? Sometimes you end up with too much, sometimes too little; sometimes you end up all over the place!

You might want to try selecting with the keyboard: put your cursor where you want to start selecting, then hold down the Shift key. With your other hand use the cursor up / down arrow keys on your keyboard to select. If you tap the arrow it goes slowly, if you hold down an arrow then it selects quickly.

Tip! If you need to long a long distance, the press the Page Up and Page Down keys instead of the up/down cursor arrows.

Making New Folders in Windows

Use Windows Explorer to place yourself in the location where you'd like to create a new folder—this might be in the Windows Explorer or the desktop. Next right click your mouse and select **New Folder**, otherwise with the keyboard, hold down the Ctrl and Shift keys and then press N on the keyboard. Job done!

Hoarding is explicitly mentioned in the American Psychiatric *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition as a symptom of obsessive-compulsive disorder (OCD). http://www.compulsive-hoarding.org/ provides a comprehensive resource of up-to-date information about compulsive hoarding, its diagnosis, research and treatment.

Animal hoarding is a well-known though not well-understood phenomenon. This site is dedicated to researching animal hoarding and has links on its characteristics as well as treatment, prevention and identification: http://www.animalhoarding.com/.

Recent research on **Narcissistic Personality Disorder** can be found at www.mentalhealth.com or by going directly to this link: http://www.mentalhealth.com/dis-rs/Research%20On%20Narcissistic%20Personality%20Disorder.pdf

Please note that all Internet addresses were correct at the time of submission to the ACA and that neither Angela Lewis nor the ACA gain any financial benefit from the publication of these site addresses. Readers are advised that websites addresses in this newsletter are provided for information and learning purposes, and to ensure our member base is kept aware of current issues related to technology. AngelaLewis@optusnet.com.au.

While many folks can't see the point of having virtual friends who they may never meet face to face; this article quotes a study which argues that these so called "loose ties" serve the function of providing a form of social support which is considered beneficial - even if the support and affirmation comes from friendship ties that could be considered weak.

Register of ACA Approved Supervisors

NEW SOUTH WALES					
Martin Hunter-Jones	Avalon Beach	02 9973 4997	MA, A d. Ed Ba Psych, Philos	$100	Face to Face, Phone, Group
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Thomas Kempley	Central Coast	0402 265 535	MA Counselling, Supervisor Training	$55 ind, $75 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)
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
Brigitte Madeiski	Penrith	02 4727 7499	Dip Prof, Couns. Dip Womens Dev, Dip PSC, Superv. Trg (AIPC)	Neg.	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
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Donald Marmara	Sydney	02 9413 9794	Somatic Psych. Cert. Dev. Psych	$120	Face to Face, Phone, Group
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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
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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
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
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
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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
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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
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Alison Lee	Maroochydore	0410 457 208	Masters Gestalt Therapy	$100	Face to Face, Phone, Group
Lyn Baird	Maroochydore	07 5451 0555 or 0422 223 072	GD Counsell, Dip Psych, SOP Supervision, Ma Soc.Sc (Pastoral Counselling), RN, Dip CCFT, Cert IV TAA	$77	Face to Face, Group
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Heidi Edwards	Gympie	07 5483 7688 or 0466 267 509	B.Bsc; CMACA; MCCA; Prof.Supv.(AIPC); Fac MHFA	$99	Face to Face & Phone
Stacey Lloyd	Aspley	0417 644 650 or 07 3420 4127	MA (Couns), BA (Psych), Dip.Bus (Mgnt), Cert IV Trng & Asst	$100	Face to Face. Phone, Group
Virginia Roesner	Kawungan	07 4128 2202	M.Edu;B.Sci (Psychology); CMACA; Prof Supr (AIPC)	$88	Face to Face
Valerie Holden	Peregian Springs	0403 292 885	M Couns, B Couns, Prof Supervisor Trg	$80	Face to Face, Group
Brenda Purse	Shelly Beach	07 5493 2333 or 0402 069 827	M Couns, B. Couns Prof Supervisor Trg	$90	Face to Face, Group

Name	Base Suburb	Phone	Qualifications	PP Hourly Rate	Medium
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
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
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
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
Michael Woolsey	Seaford	03 9786 8006 or 0419 545 260	Registered ACA Supervisor, Bach Social Welfare, Dip Prof Couns, Cert IV Assessment & Training	$70	Phone, Face to Face
Suzanne Vidler	Braybrook	0411 576 573	Clinical Supervision training (LA Trobe Uni), Grad Dip, Psy, MA Cous., BA B.Sc;	$100	Phone, Face to Face, Group
SOUTH AUSTRALIA					
Moira Joyce	West Croydon	0432 764 151 or 08 7225 4319	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
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Deidre Nye	Canning Vale	08 6253 8190 or 0409 901 351	Supervisor Training; Trainer in NLP; TLT®; Hypnosis NLP Supervision Dip Prof Couns	$80	Face to Face, Phone, Group
John Dallimore	Fremantle	0437 087 119	COA Of Supervision (CCC) B. Couns B. Appl. Psych, Supervisor Training	$90	Face to Face, Phone, Group
TASMANIA					
David Hayden	Howrah	0417 581 699	Dip Prof Counselling, Supervisor Trg (AIPC)	$80	Face to Face, Phone, Group
Michael Beaumont-Connop	Newstead	0429 905 386	Master of Social Work, Gra.Dip. Social. Sci. Bachelor of Arts MNZAC	$100	Face to Face, Phone
NORTHERN TERRITORY					
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Rian Rombouts	Millner	08 8981 8030 or 0439 768 648	Dip Mental Health, Dip Clin Hypno, Supervisor Trg	$88	Face to Face, Phone
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					
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

Book Reviews

The Busting Away Depression Programme

By Lyndall Briggs & Gary Green

The Busting Away Depression Programme By Lyndall Briggs & Gary Green

Hypnotherapy is one of those areas that many counsellors, and indeed members of the public, feel strongly about and those feelings tend towards either pole rather than a middle ground. For myself, I am a firm believer in the maxim, 'If it works for you then go for it'.

With this in mind the first thing to be said for this programme is that many people have indeed found that 'It works for them'. I think the reason for this success is its synergistic methodology that relies on a combination of approaches and not just one alone. Thus many of their 'Tips for Busting Away Depression" (the acronym of 'BAD' seems rather paradoxical as one feels that that should be a good thing) would be perfectly at home in a CBT therapy session, sections on Diet quite at home in a naturopathy consult, and then of course there are the hypnotherapy and meditation components of the enclosed CD.

All in all this leads to a certain 'balance' in their approach that would make it not only effective but also appealing to many members of the general public.

The CD and accompanying guidebook are well produced and presented and as a therapist I can see a use for it in my practice.

CD + Guidebook
Price: $24.95
Where to buy: www.selfdevelopment.biz

Reviewed by Adrian Hellwig

New in 2010

Asia Pacific Journal of Counselling and Psychotherapy

Official Journal of the Asian Professional Counselling Association

www.apca-counselling.com

The ***Asia Pacific Journal of Counselling and Psychotherapy*** is a new peer-reviewed publication of the Asian Professional Counselling Association, Hong Kong. The Journal aims to provide a lively forum for academic and research papers with a focus on the best practice in the field of counselling and psychotherapy. It sets out to offer a keen resource for professionals, and to create dialogue between them in the Asia Pacific region and internationally. It hopes to provide information from experts contributing to a broader understanding of the practice of counselling and psychotherapy in the cultural context of the Asia Pacific regions. It is also intended that the Journal provide opportunity and encouragement to Bachelor, Masters and Doctoral students in counselling to publish their work. It will strive to publish original articles of quality and welcomes authors from Hong Kong, the Asia Pacific Region and internationally.

We are keen to publish original articles that reflect research projects, case studies, reflective studies, book reviews, commentaries and information about professional practice, letters and correspondence relating to the field. Articles must be submitted in English language. However, Chinese abstracts may be submitted for publication alongside English abstracts.

Forthcoming Papers

Current Development of Counseling and Psychological Services in Japan
D. T Yagi

The Counseling Profession: An important resource for enhancing human capital development
Pui-Tse Tse

Beyond Definition and Method: The next era for counselling and psychotherapy (from New Zealand)
R. Bowden

The Development of psychological intervention after disaster in China
L. Higgins, G. Xiang & Z. Song

"Accidents with the unknown" – Towards utilizing the hindrance of theory in counseling practice
B. Keeney

Calligraphy Therapy: A Complementary Approach to psychotherapy
H.S.R Kao

Counseling Psychology: The Fifth Estate of Hong Kong Mental Health
T. Seay

Invitation to submit

We plan to launch our first issue of this journal in March 2010. We write to invite you to contribute to this exciting new journal. We are looking for original articles, reflection papers or case studies which examine either traditional approaches to counselling or current approaches being used. These may be new contemporary approaches or an integration of traditional and newer approaches. Please visit our website for Instructions for Authors and journal policy.

Please email your submissions in Word document format to the Editor, Dr Ann Moir-Bussy, at **annmb@hksyu.edu**

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Mental Health
time to end the neglect

Dear Julia and Tony,

We call on both of you to show true **leadership** to bring to an end the decades of neglect of Australians with mental ill health. The community will no longer tolerate having only a one in three chance of getting access to mental health care.

Julia, we welcome your modest $277m over four years commitment to suicide prevention, but we are still waiting for a **meaningful** investment in modern mental health services. Your commitment to making mental health a second term priority will be an empty promise without large scale and sustained investment. You know what measures are needed – invest in them.

Tony, we commend your $1.5bn over four years commitment to youth mental health and early intervention services. This would transform the experience of young Australians with mental ill-health and relieve huge pressure on the mainstream health system. However, this investment must be stage one of a **long-term** reform plan and more needs to be done now for younger children and older adults.

We ask both of you to commit to end the unequal **access** to quality care for mental and physical health that is undermining families, communities and our national economy.

We ask both of you to **commit** to an annual independent mental health report card to ensure new investments deliver better services to all Australians.

This election we are relying on you both to do the **right** thing for Australia by ensuring all our communities have ready access to quality mental health care.

MENTAL HEALTH COUNCIL OF AUSTRALIA
ACA AUSTRALIAN COUNSELLING ASSOCIATION
UnitingCare Australia
AMA
Arts Access Australia
asca
brain&mind RESEARCH INSTITUTE
CATHOLIC HEALTH Australia
Catholic Social Services Australia
Eating Disorders FOUNDATION OF VICTORIA
lantern
Lifeline AUSTRALIA
melaleuca REFUGEE CENTRE
Mental Health Council OF TASMANIA
Mental Health Foundation Australia
mieact
NATIONAL MENTAL HEALTH CONSUMER & CARER FORUM
peer support australia
sane AUSTRALIA
THEMHS CONFERENCE
WAAMH
Orygen YOUTH Health Research Centre
mental health community coalition ACT

authorised by David Crosbie of 9 Napier Close Deakin, paid for by the Mental Health Council of Australia

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