COUNSELLING AUSTRALIA

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Submissions and letters may be addressed to:
The Editor
Australian Counselling Association
P.O Box 88
GRANGE QLD 4051
aca@theaca.com.au

See page 40 for peer-reviewed article submission guidelines.

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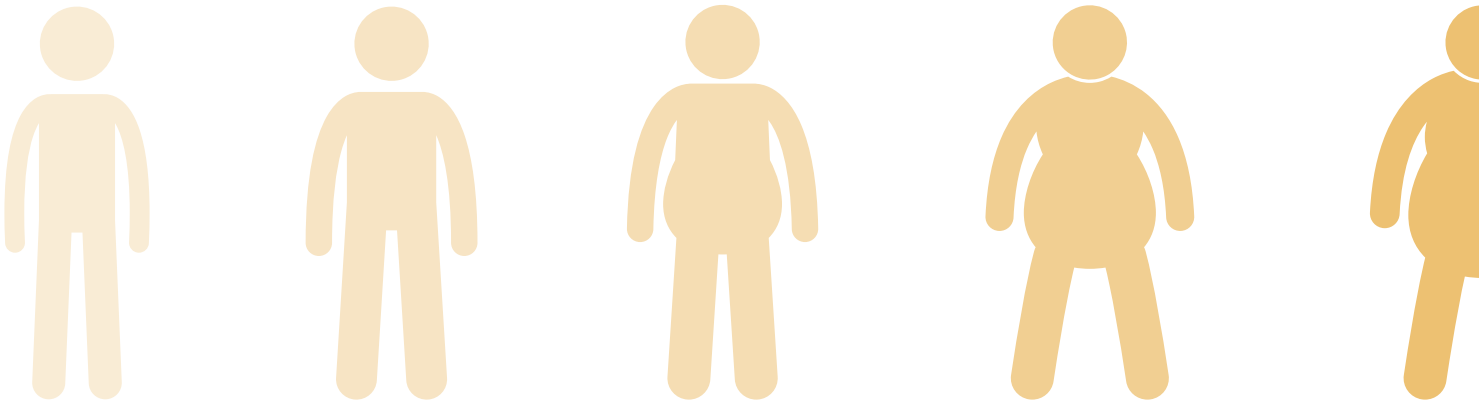
SUBMISSION ON OBESITY TO THE NATIONAL MENTAL HEALTH COMMISSION



ACA submission on obesity

This quarter's editorial has been replaced by the Australian Couselling Association's Submission on Obesity to the National Mental Health Commision.

Executive Summary

This submission to the National Mental Health Commission (NMHC) follows the recent discussions between the Australian Counselling Association (ACA) Chief Executive Officer and Ms Rebecca Hardin, Senior Adviser to the Federal Minister for Health on the weight issue in Australia. Ms Hardin recommended that we send this submission to the NMHC for action.

The Australian government is concerned with the obesity epidemic and its negative economic consequences, and is currently developing an updated food policy strategy. However, it does not wish to be seen as promoting a "nanny state" with over regulation. Therefore, the purpose of this Australian Counselling Association submission is to assist the government to combat this epidemic rather than add to the burden of over regulation.

The submission first overviews the issues underpinning the current obesity epidemic. It then highlights the research findings which demonstrate the correlation between emotional and psychological associations among individuals with weight issues. Examples are the food addictive component to the weight issue, inability among overweight/obese persons to make informed food choices, the need for a holistic approach towards weight management, and the need to integrate weight management counselling. Then the submission moves on to discuss the role and effectiveness of registered and trained Weight Management Counsellors within weight management programs. An example of such a program is the Healthy Weight Program (HWP), and the role of Weight Management Counsellors in this program is discussed. The submission concludes with two recommendations to address this current obesity epidemic.

Aims of the submission

The rates of overweight and obesity amongst adults have doubled over the past two decades with Australia now being ranked as one of the fattest developed nation.[1]

Therefore this submission aims to:

- increase awareness among leaders and government policy makers of the key association between mental health and weight issues;
- identify the current gaps in client access to appropriately trained and registered weight management counsellors in government funded weight management programs;
- increase awareness among leaders and policy makers of registered counsellors and their ability to deliver counselling components in weight management programs;
- increase awareness of the Healthy Weight Program (HWP), as an example of a weight management program where counselling is used, and
- provide practical recommendations for consideration.

The issue of overweight and obesity in Australia

The government of Australia is well aware of the current alarming overweight and obesity epidemic and of the associated financial costs to the government health and social services due to the epidemic and its adverse health outcomes.[2, 3,4,5,6,7] Statistical data published in 2009 by the Australian Bureau of Statistics projected that there would be 4.6 million obese people in year 2025. However this number has now reached 5.2 million persons in year 2014, far exceeding the projected number. This means that either the earlier projections were too low or that there is an obesity epidemic in Australia. This obesity epidemic can in turn lead to an epidemic of chronic diseases such as diabetes, cardiovascular diseases including hypertension and stroke, musculoskeletal diseases and certain forms of cancer. Its negative health consequences range from increased risk of premature death, to serious chronic conditions that reduce quality of life, and cost the Australian government health services billions of dollars for provision of physical and mental health services.

In the past, the government relied on traditional approaches, such as public health community nutrition campaigns and health education programs, through medical professionals such as General Practitioners (GPs) and dieticians to deliver the message of good nutrition and regular exercise to the community. However, in many instances, these messages were relatively ineffective for the following reasons.

- Most GPs do not have the time to counsel clients on overweight and obesity and refer such clients to dieticians who have long waiting lists and who are not trained in counselling techniques, unlike trained and registered weight management counsellors.
- Nutrition messages given by GPs/ dieticians are often counteracted by the powerful media which has been identified by consumers as an important source of nutrition information.[8] Thus, commonly advertised food messages are used by poorly informed consumers to make food decisions and promote the purchase of processed, canned and bottled foods containing high content of sugar, salt and preservatives.[9]
- Most obese clients are addicted to food and unless the addiction is managed with counselling, they will continue to be resistant to health advice and resistant towards changing their lifestyle and eating patterns.
- Most government-funded weight management programs are population based with public health messages to improve nutrition, reduce food intake and exercise more to increase energy utilisation. Very often the need for counselling is not mentioned and the client often drops out of the program as it does not have a holistic approach and a maintenance phase.

According to the Australian Health Ministry website, in an effort to better inform consumers and the food industry of types of foods available at supermarkets, the Health Star Rating (HRS) Advisory Committee of the Australian Health Ministry has recently developed a Health Star Rating style guide and calculator with New Zealand. This will be made available on the Australian Health Ministers' Advisory Council website. The purpose of this website is to educate consumers and the food industries, especially small businesses in the food industry. While it is an exciting new development, various potential anomalies have already been identified in relation to the HSR Calculator, where a star rating may be inconsistent with the Australian Dietary Guidelines, or when it is used to make comparisons within a food category or across comparable food categories, the star rating may mislead consumers.[10] Therefore educating consumers or clients through mass media or through websites can be a challenging task, and relying only on one type of intervention may not lead to expected outcomes. Most mass media campaigns have the effect of increasing awareness, but do not educate clients/ consumers. The best way of encouraging clients to select appropriate healthy food choices is by individual counselling by registered weight management counsellors to whom overweight and obese clients are referred through General Practitioners.

The association between mental health and weight issues

There is increasing evidence that there is a strong association between the weight issue and mental health.[11, 12, 13, 14] Poor diet and exercise habits are commonly driven by emotion. Research reviews of body image and dieting programs by the Australian Counselling Association (ACA) have found the following.

- Body image dissatisfaction and extreme dieting is associated with depression in both adolescents and adults. Through its effects on eating behaviour and reduced physical activity, body dissatisfaction is likely to contribute to binge eating and dieting and development of unhealthy weight gain;
- Longitudinal studies also indicate that body dissatisfaction predicts the later development of depression, anxiety and low self esteem.
- Hedonic hyperphagia, the scientific term for eating to excess for pleasure rather than to satisfy hunger, or recreational over eating can occur in a chronic form among various population groups and cultures.
- A review of 31 studies by Mann and Tomiyama found that dieting is a consistent predictor of future weight gain as dieters regain more weight than they lost on their diets and these studies demonstrate that dieting is counterproductive.[14]
- Health authorities believe that the accumulation of unhealthy messages, communicated to children and adults through food advertising in the media, is a leading cause of unhealthy consumption.[15,16,17, 18]

In addition, psychological disorders are found to be linked to obesity, including:[19]

- depression, often associated with smoking and drinking, dopaminergic deficits, an increase in cortisol levels, low grades of inflammation and abnormal levels of leptin and adiponectin; and
- both sexual and physical abuse, which have been associated with increased body mass index and waist circumference in adults, possibly as a result of an increase in levels of the stress hormone cortisol.

Discussion on the role of counselling interventions in delivery of weight management programs

A Cochrane Review by Shaw *et al*[21] provides an update on the effectiveness of psychological interventions in the management of individuals who are overweight or obese.

This review concluded that psychological interventions in combination with changes to diet and physical activity, is optimal in producing weight loss. This review was based on studies conducted in outpatient community settings, including hospital clinics, medical centres and primary care settings. The effective psychological treatments included stimulus control, reinforcement, self monitoring and goal setting. The studies varied in intensity, with a median duration of 12 weeks. Increased intensity, through longer duration, more frequent contact or more

behavioural strategies was associated with increased effectiveness.

Another study by Sacks *et al* in 2009 compared weight loss diets with different compositions of fat, protein and carbohydrates (carbs) and found no real evidence to reflect that high carb, low carb, high protein, low protein or low GI diets are any better than each other. After two years the large majority who had lost weight had put it back on again. These same studies showed that participants who attended counselling as part of the diet program lost more weight and the more counselling they attended the more weight they lost.[22]

Therefore there is a rational need to utilise weight management counselling as part of the diet and exercise program to increase the effectiveness of the program.

The ACA registered Weight Management Counsellors engage in a holistic approach by using a variety of interventions over an 8 week period to ensure an effective program outcome. They include:

- Psycho-education (including marketing strategies)
- Information on nutrition
- Addressing behavioural issues, habits, emotional triggers and personal issues
- Introducing physical activities and routines
- Life skills
- Support/counselling
- Meditation
- Self reflection/journalling
- Networking with other disciplines, e.g; dietetic, sports psychologists, available on Medicare
- Encouraging mid-week contact through SMS, etc
- Encouraging active participation in physical activities such as group walks and other group activities.

Therefore the ACA registered counsellor who has a strong applied focus, including mandatory training in evidence-based therapies such as Cognitive Behaviour Therapy (CBT) and Solution Focused Therapy, and special training in weight control management, is in a unique position to facilitate and counsel high risk clients on weight management.

It is to be noted that counsellors have delivered services to the Australian public for several decades. Prior to the introduction of the Better Access Initiative (BAI) in 2006, General Practitioners in Australia readily referred patients to counsellors. An earlier submission by ACA has discussed this issue in detail and has been separately submitted to the National Mental Health commission for consideration in April 2014[24].

Weight Management Counsellors in the Healthy Weight Program (HWP)

The Healthy Weight Program (HWP) is an example of a modulised psycho-social and dietary program designed specifically for delivery by Weight Management Counsellors and was released by ACA to its registered counsellors in October 2013. The HWP represents an opportunity for registered counsellors to participate in weight management training and deliver an effective niche product within the $832 million weight loss industry.

As you are no doubt aware, poor diet and exercise habits are commonly driven by emotion. The HWP employs a unique and powerful approach in that it simultaneously addresses the core emotional issues that result in both poor eating and exercise habits. The program is delivered over an eight week period under the guidance of a professional counsellor trained in weight management. Over the eight weeks the client applies, and is educated about, better dietary and exercise habits, whilst also dealing with their emotional barriers. The HWP aims to achieve desired outcomes based on clear understanding of targeted health behaviours, and the environmental context in which they occur.

The maintenance program in the HWP is of critical importance to its outcomes. As with all similar types of programs, the post program time is the time where clients tend to relapse back to their old eating patterns. To ensure this does not occur, the counsellor encourages the client to commit to a maintenance program. The maintenance component of the program is delivered through:

- Group meetings and activities
- Skype contact
- Webinars
- SMS
- Further counselling
- A combination of the above.

Table 1 attempts to compare the range of fees and costs charged by different ancillary health practices in private settings.

In summary, the use of weight management trained counsellors through this program would be very cost effective with a potential savings of over $4,000 per client as each counsellor would cost only $ 14,400 per client for 8 weeks while a psychologist would cost approximately $ 18,800. When compared to the huge costs for treatment of chronic conditions resulting from obesity mentioned in various economic reports, these costs seem miniscule indeed.

Recommendations

Public health initiatives such as diet and exercise by themselves cannot control obesity and there continues to be a significant rise in the rates of obesity. This is because most of these initiatives fail to recognisze underlying factors, such as:

- emotional issues;
- psychological issues;
- food addictions and
- mental illnesses.

Therefore, it is recommended that the National Mental Health Commission take urgent steps to mitigate this current obesity epidemic by supporting the inclusion of counsellors trained in weight control management by granting them provider numbers combined with Medicare rebates to overweight and obese clients who need to readily access registered weight management counsellors through this program.

We request that the Mental Health Review Commission consider two recommendations.

Recommendation 1

That the Mental Health Review Committee recommend to the Commonwealth Department of Health that Government provide Medicare rebates at $65.00 per session for 8 sessions per client to consult ACA Weight Management Counsellors. This should extend over a maximum 10 week period, with three follow up sessions with the client after six months to make sure they are still following the HWP, and to reinforce motivation.

Recommendation 2

That the rebates for HWP (as per option 1) be implemented as a pilot program for three states (Queensland, South Australia and NSW) as they have suffered the largest increases in obesity. The pilot project should be implemented for a study period of 3 years. A detailed project proposal, budget and work plan could be developed if requested.

To ensure implementation of recommendations 1 or 2 or both, high risk clients would first need to be identified as being eligible for the program via a mental health plan prepared by their General Practitioner(GP). The GPs should be informed by the National Mental Health Commission that ACA Weight Management Counsellors are included

TABLE 1 Summary of approximate fees to consult various health practitioners in Australia.

Fees $	Registered Counsellor	Dietician	Private Nutritionist	Private Naturopathist	Clinical Psychologist	Counselling Psychologist	Consultant Psychiatrist	Psychologist
1hour consultation	$85	$75 to $120	$120 to $180	$200	$225.50	$225.50	$312.20	$120 to $150
8 sessions of 1hr	$680	$ 600 to $960	$960 to $1440	$1600	$1804	$1804	$2497.60	$960 to $1200
10 clients per week	$850	$750 to $1200	$1200 to $1800	$2000	$2255	$2255	$3122	$1200 to $1500
Total costs for 8weeks	$6800	$6000 to $9600	$9600 to $14400	$16000	$18040	$18040	$24976	$9600 to $12000

Notes: The data in this table is taken from various sources such as Medicare. All providers listed, except the counsellors, receive Medicare rebates for their clients through Medicare.
Counsellor refers to a registered counsellor with Australian Counselling Association, trained in weight management.
Dietician refers to an Accredited Practising Dietician (APD) who is accredited by the Dieticians' Association of Australia. An APD is eligible for a Medicare, Department of Veterans' Affairs or private health fund rebate on services.
Nutritionist refers to members of the Nutrition Society of Australia. Only nutritionists who are Accredited Practising Dieticians are registered with Medicare.
Clinical psychologist and Psychologist refers to data for psychologists and clinical psychologists taken from Australian Psychological Society APS 2014-2015 Schedule of recommended fees and item numbers for psychological services, 1 July 2014 to 30 June 2015.

as being eligible for Medicare Provider rebates and that high risk children and adults should be referred to ACA registered counsellors. Such registration would confirm that the counsellors have completed an ACA authorised course of training leading to registration as Weight Management Counsellors under the Healthy Weight Program and competent to deliver the program.

Conclusion

The ACA looks forward to National Mental Health Commission support to enable the trained and registered ACA Weight Management Counsellors to expand the Healthy Weight Program to high risk clients who need counselling assistance to overcome their weight issues and associated psychological disorders.

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ONLINE AND IT RESOURCES

with Angela Lewis

What is Office 365?

Office 365 is the same Office you already know and use every day, but gives you access to Word, Excel, PowerPoint and Outlook through the internet, using a method known as cloud computing.

Because Office 365 is powered by the cloud, you can utilise your applications and files from virtually anywhere. The cloud is an industry term for remote or off-site hosting, which occurs over the internet. You use it by connecting via the internet, setting up an account and paying for the service. There are no actual installation discs.

Office 365 can run offline, but you must connect to the internet every 30 days to maintain your subscription and you will be prompted when it is time to reconnect.

It is worth noting that Office 365 files are compatible with Office 2010 and 2013 and while Office 2007 will work, you will lose some functionality.

At the time of writing, Office 365 Personal, which is compatible with PCs or Macs, plus one iPad or Windows tablet costs A$89 for a one year subscription, and this includes all updates.

Go to www.microsoftstore.com and type Office 365 in the search box for more information and to verify current prices.

The Find keyboard shortcut

Holding down the Ctrl key and then pressing the letter F (Ctrl & F), opens the Find facility in any program, including ones such as your Internet Explorer and Adobe Acrobat. You use Find when you want to locate text on a page or document easily.

When you type a word in this box it immediately locates and highlights each instance of that word or string or words.

The Windows 7 taskbar

The Windows taskbar is the bar across the bottom of the window and you can easily pin (attach) your favourite programs to the taskbar. For example, I like to have Outlook, Word, Excel and PowerPoint (amongst other things), as seen below.

The reason for doing this is so that you can quickly access a program by clicking on its icon directly from the taskbar, rather than having to use the Start Menu.

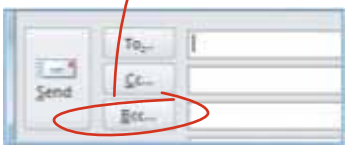
To pin a program to the taskbar right-click on the program or shortcut to the program and in the menu that pops out, choose *select the pin to taskbar* option. Alternatively you can also drag the required icon to the taskbar.

If you want to remove a pinned program, right-click on the taskbar icon and click *unpin this program from the taskbar*. Alternatively you can also drag the icon off of the taskbar and then click *Unpin this program from the taskbar*.

Protect email addresses in Outlook

Have you ever received an email (most commonly a joke), in which you can see every other recipient's email address – and even those on the previous forwards? This leaves email addresses open to misuse and may even violate someone's privacy.

Another option is to send a message to multiple people without revealing other recipients' identities, and you do this by utilising the Bcc (blind carbon copy) field in Outlook.



When you send an email by adding someone's name to the Bcc line, a copy of the message is sent to that person, but his or her name is not visible to any of the other recipients, ideal when sending that hilarious joke to the hundred nearest and dearest in your Outlook address book. However, this option should be used with caution in a business environment, as most companies prefer transparency and would not encourage the use of the Bcc.

Jargon

Legacy media
Media that is considered "old", such as radio, television and especially newspapers.

VLog
A video log, much like a blog but utilising a site such as YouTube to record your online diary.

Belfie
A selfie (photo of yourself) but instead of your face, you take a photo of your bottom, hence the 'B'.

Bikini bridge
Most often seen as a hashtag on Twitter, like so: #bikinibridge. It refers to photos girls or women take of themselves wearing a bikini and laying down so their hip bones stick out to make a 'bridge'.

Thinstagram
Also used as a hashtag, and denotes any photo of someone (usually female) who is very thin. It is a popular term in the Anorexic community.

Quick save

While working on a document or other file in every Microsoft program, holding down the Ctrl key and then pressing S (Ctrl & S), quickly and easily saves that file.

This shortcut key is super easy, so there is no excuse for not using it frequently during the course of working on a document.

Open a second instance of a program

To open a second instance of a program that is already open, press and hold the shift key and then click the required program icon on the taskbar. For example, if I have Microsoft Word open and I want to open a second instance of Word to contain a completely different document I would simply hold down the shift key and click the Word icon on the taskbar. Be careful doing this – if you have too many programs open (even of the same one), you may slow your computer down.

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 are provided for information and learning purposes, and to ensure our member base is kept aware of current issues related to technology. More IT hints are available at www.angelalewis.com.au.

NEWS AND RESEARCH FROM AROUND THE WORLD

US court enforces California ban on anti-gay therapy

The US Supreme Court has cleared the way for enforcement of a first-of-its-kind California law that bars psychological counselling aimed at turning gay minors straight.

The justices turned aside a legal challenge brought by supporters of so-called conversion or reparative therapy.

Without comment, they let stand an August 2013 appeals court ruling that said the ban covered professional activities that are within the state's authority to regulate and doesn't violate the free speech rights of licensed counsellors and patients seeking treatment.

The 9th US Circuit Court of Appeals ruled last year that California lawmakers properly showed that therapies designed to change sexual orientation for those under the age of 18 were outside the scientific mainstream and have been disavowed by most major medical groups as unproven and potentially dangerous.

"The Supreme Court has cemented shut any possible opening to allow further psychological child abuse in California," said state senator Ted Lieu, the law's sponsor.

"The court's refusal to accept the appeal of extreme ideological therapists who practice the quackery of gay conversion therapy is a victory for child welfare, science and basic humane principles."

The law says professional therapists and counsellors who use treatments designed to eliminate or reduce same-sex attractions in their patients would be engaging in unprofessional conduct and subject to discipline by state licensing boards. It does not cover the actions of pastors and lay counsellors who are unlicensed but provide such therapy through church programs.

Liberty Counsel, a Christian legal aid group, had challenged the law, as did other supporters of the therapy. They argue that lawmakers have no scientific proof the therapy does harm.

"I am deeply saddened for the families we represent and for the thousands of children that our professional clients counsel," Liberty Counsel chairman Mat Staver said in a statement. "The minors we represent do not want to act on same-sex attractions, nor do they want to engage in such behaviour."

New Jersey last year became the second US state to ban gay conversion therapy with children and teenagers, and Liberty Counsel also has been fighting that law, which took effect after it was signed by Governor Chris Christie.

The group's litigation counsel, Daniel Schmid, said the Supreme Court's refusal to consider a challenge to California's law, as opposed to issuing a ruling on the merits, has no bearing on Liberty Counsel's case in New Jersey, which is scheduled to be heard by the 3rd US Circuit Court of Appeals on July 9.

"We hope to get a good ruling out of the 3rd, which will hopefully get us back up to the Supremes," he said.

California's law was supposed to take effect last year, but it has been on hold while a pair of lawsuits seeking to overturn it made their way to the Supreme Court.

Now that the high court has declined to take the case, the state will be able to start enforcing the law after the 9th Circuit lifts an injunction it put into place during the litigation, an action that is expected to come within days, according to Christopher Stoll, a senior staff attorney at the National Centre for Lesbian Rights.

Another eight states and the District of Columbia have pending legislation modelled after the California and New Jersey laws, while lawmakers in five other states have refused to pass similar bans.

Meanwhile, the Texas Republican Party this month endorsed reparative therapy, adopting policy language recognising "the legitimacy and efficacy of counselling, which offers reparative therapy and treatment for those patients seeking healing and wholeness from their homosexual lifestyle."

www.theaustralian.com.au

Online psychotherapy gains fans and raises privacy concerns

Lauren Kay has never met her therapist in person. The 24-year-old entrepreneur found it difficult to take time off work for appointments.

So she started seeing a psychotherapist online.

"It's definitely been different," she says. Kay, who lives in New York, found her counsellor through an online therapy service called Pretty Padded Room. When it's time for an appointment, all she has to do is log in to the website, click a link and start video chatting.

The format works well for her. "It felt like Skyping with a friend," she says. "And when I was at my parents' house the other day, I got to show my therapist my cat."

Now, she says, she prefers these video sessions to traditional therapy. And she's not alone in that thinking. More and more people — especially Millennials — are trying web therapy.

And mental health-care providers are increasingly taking their services online. Aside from Pretty Padded Room, there's The Angry Therapist, Breakthrough, Virtual Therapy Connect and plenty of others.

There's a real demand for this sort of therapy, says Bea Arthur, a licensed mental health counsellor and the founder of Pretty Padded Room, which is based in New York. "Our target market is women in their 20s and 30s," she says.

People from all over the world can sign up. "We have clients in Belgium, Saudi Arabia, Korea," Arthur says. "It's been amazing."

Those seeking help can choose from nine licensed family therapists and clinical social workers. It costs US$45 for a 30-minute session, or less if you sign up for a monthly plan. The company doesn't accept insurance, but Arthur says some clients have gotten their insurance providers to reimburse them for sessions.

Some studies suggest that therapy online can be as effective as it is face to face. "We have a lot of promising data suggesting that technology can be a very good means of providing treatment," says Lynn Bufka, a clinical psychologist who helps develop health-care policy for the American Psychological Association.

"I don't think we have all the answers yet," Bufka says. There are cases where therapy online may not work, she notes. Therapists usually don't treat people with severe issues online, especially if they are contemplating suicide. That's because in case of a crisis, it's much harder for online therapists to track down their patients and get them help.

Privacy is another a concern. Instead of Skype, many online therapy companies choose to use teleconferencing software with extra security. Arthur at Pretty Padded Room says her company takes measures to protect her clients' records.

But it can be hard for people to know exactly how secure the website they're using really is, Bufka says.

And then there's the issue of licensing. Family therapists, mental health counsellors and clinical social workers are licensed to practice by individual state boards. But it's unclear whether a practitioner who lives in one state can or should treat someone who lives elsewhere.

"We'd like to see a little more mobility and flexibility with that, because certainly for licensed psychologists the standards are pretty similar across state lines," Bufka says. Perhaps, she adds, therapists could get a special certification that would allow them to practice in multiple states or countries.

The APA released a guideline for online therapy last year. It encourages online practitioners to take care protecting clients' data, and to familiarise themselves with state and international laws. But it doesn't resolve these issues.

Right now, some therapists try to dodge the licensing issue by calling themselves life coaches, which doesn't require state licensing. The problem with that, Bufka says, is anyone can call himself or herself a coach. Those seeking therapy online should ask potential therapists about their training, she says.

Policymakers are going to have to sort these legal ambiguities out sooner rather than later, says Arthur of Pretty Padded Room. "Ultimately it's about reaching people," she says. "We have to meet clients where they are. And if they're at home and they're not feeling so hot, why would you deny them [treatment]?"

Therapists have to keep up with the times, says John Kim, founder of The Angry Therapist. "It's kind of like bookstores and Blockbuster. Everything is shifting online. The same thing will happen with mental health."

In addition to therapy from a group of licensed therapists and life coaches that Kim trains, those who sign up on his website get daily motivational emails and access to group sessions via Google Hangouts. The service grew out of Kim's personal blog.

He's a licensed marriage and family therapist in California, and he sees clients both online and in person. But, he says, some of his clients actually feel more comfortable chatting on Skype than they do talking in person.

It helps that communication technology is getting better and better, Kim says. "When the internet was on dial-up and stuff, it was really hard to do something like this. But now you can literally see a teardrop."

Maanvi Singh

www.npr.org

NEWS AND RESEARCH FROM AROUND THE WORLD

A blood test for suicide? Alterations to a single gene could predict risk of suicide attempt

Johns Hopkins researchers say they have discovered a chemical alteration in a single human gene linked to stress reactions that, if confirmed in larger studies, could give doctors a simple blood test to reliably predict a person's risk of attempting suicide.

The discovery, described online in *The American Journal of Psychiatry*, suggests that changes in a gene involved in the function of the brain's response to stress hormones plays a significant role in turning what might otherwise be an unremarkable reaction to the strain of everyday life into suicidal thoughts and behaviours.

"Suicide is a major preventable public health problem, but we have been stymied in our prevention efforts because we have no consistent way to predict those who are at increased risk of killing themselves," says study leader Zachary Kaminsky, Ph.D., an assistant professor of psychiatry and behavioral sciences at the Johns Hopkins University School of Medicine. "With a test like ours, we may be able to stem suicide rates by identifying those people and intervening early enough to head off a catastrophe."

For his series of experiments, Kaminsky and his colleagues focused on a genetic mutation in a gene known as SKA2. By looking at brain samples from mentally ill and healthy people, the researchers found that in samples from people who had died by suicide, levels of SKA2 were significantly reduced.

Within this common mutation, they then found in some subjects an epigenetic modification that altered the way the SKA2 gene functioned without changing the gene's underlying DNA sequence. The modification added chemicals called methyl groups to the gene. Higher levels of methylation were then found in the same study subjects who had killed themselves. The higher levels of methylation among suicide decedents were then replicated in two independent brain cohorts.

In another part of the study, the researchers tested three different sets of blood samples, the largest one involving 325 participants in the Johns Hopkins Center for Prevention Research Study found similar methylation increases at SKA2 in individuals with suicidal thoughts or attempts. They then designed a model analysis that predicted which of the participants were experiencing suicidal thoughts or had attempted suicide with 80 per cent certainty. Those with more severe risk of suicide were predicted with 90 per cent accuracy. In the youngest data set, they were able to identify with 96 per cent accuracy whether or not a participant had attempted suicide, based on blood test results.

The SKA2 gene is expressed in the prefrontal cortex of the brain, which is involved in inhibiting negative thoughts and controlling impulsive behaviour. SKA2 is specifically responsible for chaperoning stress hormone receptors into cells' nuclei so they can do their job. If there isn't enough SKA2, or it is altered in some way, the stress hormone receptor is unable to suppress the release of cortisol throughout the brain. Previous research has shown that such cortisol release is abnormal in people who attempt or die by suicide.

Kaminsky says a test based on these findings might best be used to predict future suicide attempts in those who are ill, to restrict lethal means or methods among those a risk, or to make decisions regarding the intensity of intervention approaches.

He says that it might make sense for use in the military to test whether members have the gene mutation that makes them more vulnerable. Those at risk could be more closely monitored when they returned home after deployment. A test could also be useful in a psychiatric emergency room, he says, as part of a suicide risk assessment when doctors try to assess level of suicide risk.

The test could be used in all sorts of safety assessment decisions like the need for hospitalisation and closeness of monitoring. Kaminsky says another possible use that needs more study could be to inform treatment decisions, such as whether or not to give certain medications that have been linked with suicidal thoughts.

"We have found a gene that we think could be really important for consistently identifying a range of behaviours from suicidal thoughts to attempts to completions," Kaminsky says. "We need to study this in a larger sample but we believe that we might be able to monitor the blood to identify those at risk of suicide."

Along with Kaminsky, other Johns Hopkins researchers involved in the study include Jerry Guintivano; Tori Brown; Alison Newcomer, M.Sc.; Marcus Jones; Olivia Cox; Brion Maher, Ph.D.; William Eaton, Ph.D.; Jennifer Payne, M.D.; and Holly Wilcox, Ph.D.

The research was supported in part by the National Institutes of Health's National Institute of Mental Health (1R21MH094771-01), the Center for Mental Health Initiatives, The James Wah Award for Mood Disorders, and The Solomon R. and Rebecca D. Baker Foundation.

www.healthcanal.com

Antidepressant drugs do not improve well-being in children and adolescents

In an article published in *Psychotherapy and Psychosomatics* the effects of antidepressant drugs on well-being in children and adolescents are analysed.

Recent meta-analyses of the efficacy of second-generation antidepressants for youth have concluded that such drugs possess a statistically significant advantage over placebo in terms of clinician-rated depressive symptoms. However, no meta-analysis has included measures of quality of life, global mental health, self-esteem, or autonomy.

Further, prior meta-analyses have not included self-reports of depressive symptoms. Studies were selected through searching Medline, PsycINFO, and the Cochrane Central Register for Controlled Trials databases as well as GlaxoSmithKline's online trial registry, including self-reports of depressive symptoms and pooled measures of quality of life, global mental health, self-esteem, and autonomous functioning as a proxy for overall well-being.

Result showed a nonsignificant difference between second-generation antidepressants and placebo in terms of self-reported depressive symptoms. Further, pooled across measures of quality of life, global mental health, self-esteem, and autonomy, antidepressants yielded no significant advantage over placebo.

Even though limited by a small number of trials, this analysis suggests that antidepressants offer little to no benefit in improving overall well-being among depressed children and adolescents.

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This course provides a guide to best methods of response to suicide risk in clients while also providing an overview of potential risk factors.

Working with Subpersonalities

This course offers you information about subpersonalities: the theory behind the construct, the core understandings, and several exercises to guide your clients' work with them.

WORKSHOP VIDEOS

Crisis Counseling: The ABC Model

Dr. Kristi Kanel (California State University) reviews the history of crisis counselling, provides a background of crisis theory and explores 2 case studies: the first client is a rape survivor, and the second is a war veteran.

Crisis Stabilization for Children: Disaster Mental Health

Dr. Jennifer Baggerly (University of South Florida) worked with children in Louisiana following Hurricane Katrina and with children in Sri Lanka after the tsunami. This live demonstration video presents the guiding principles for responding to children after a disaster.

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Presented in an authentic and flowing style, this video includes five role plays where counselling professionals apply five different therapeutic approaches with clients.

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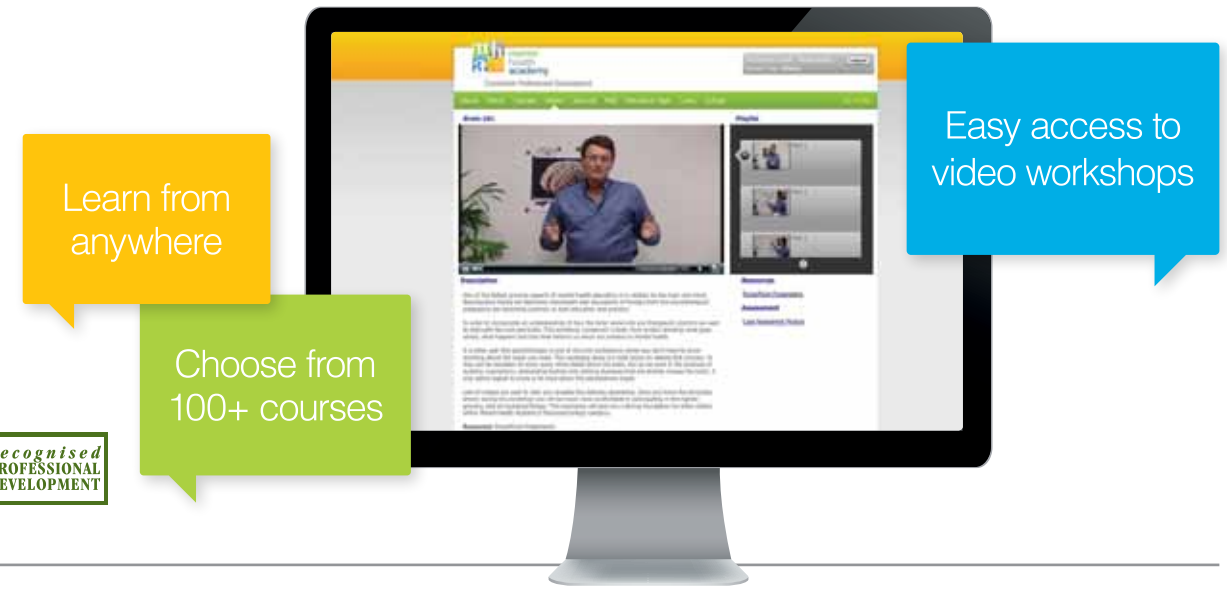

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Will is a central concept in the psychology of Psychosynthesis founder, Roberto Assagioli, who described will as operative on personal, transpersonal, and universal levels. This course is particularly oriented to those in the helping professions who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

Overview of the Principal Personality Tests

This course aims to give you an overview of the most common personality test types used today, the applications of their usage, and a sample of the types of questions they ask. The discussion of each test includes a short section outlining some of the major criticisms or limitations of the test.

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WORKSHOP VIDEOS (Continued.)

Play Therapy: Basics for Beginning Students

This video is the place to begin instruction in play therapy - it is upbeat and entertaining with great visuals, but also includes the critical basics for students with many live demonstrations. The presenter uses puppets to help communicate the rationale, principles, and basic skills of play therapy. Each skill is demonstrated through video clips of play therapy sessions with culturally diverse children.

Brief Counseling: The Basic Skills

In this video John Littrell (Colorado State University) shows how to teach brief counselling from a microskills framework. You will learn how to search out positives and solutions early in the session; how to structure a five-stage brief interview; how to ask questions that make a difference; and how to manage difficult clients.

Attachment and the Therapeutic Relationship

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

Using Undercover Teams to Re-story Bullying

This workshop uses real-life stories to describe how the school counsellor uses the Undercover Team Approach in a strategic way to disrupt a story of bullying relations in a secondary school classroom and rewrite an alternative story of support for the victim.

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SOUTH AUSTRALIAN PROFESSIONAL COUNSELLING ASSOCIATION 2014 ANNUAL CONFERENCE

Demystifying relationships: the *not* so obvious

by Helen Fuller, SAPCA President, 2014.

The South Australian Professional Counselling Association Annual Conference was held on Saturday 19 July 2014, at the scenic Skylight Room of Rydges, South Park, Adelaide. Thirty delegates attended.

The topic for the day, *Demystifying relationships: the not so obvious*, was chosen to provide counsellors with some insight into less "mainstream" issues in relationships. Our focus was temporarily deterred by the unexpected withdrawal of our first speaker, owing to family matters overseas, just one week prior to the conference. Nevertheless, we were most appreciative of Dr Alex Ryan, who stepped in with only five days notice.

As we commenced, I informed attendees of developments in the SA Wellness Project and the relationship with SAPCA for this year, and for the projected 5th Australian Positive Psychology Conference for 2016, in which we have been invited to participate. I also related that I participated as a speaker in the State Bereavement Forum, which again demonstrates the increased community awareness of SAPCA.

It was a great pleasure to have the CEO of ACA, Philip Armstrong, address our conference. We are always appreciative of Philip's work on our behalf and were happy to hear updates for future directions.

Following the Welcome and Opening Address, Rosie Coppin spoke on "Exploring workplace bullying". From her broad experience, coupled with her doctorate research, Rosie gave a deeply informative account of various ways of bullying along with strategies to employ against it. The discussion during the group activity indicated clearly the depth of personal experience within our group.

The second speaker was Naomi Hutchings, a practising sexologist, who spoke about "Sexual issues in relationships". Naomi, also a PhD candidate, is passionate about helping others in achieving better sexual health. As might be expected, the activities and the conversation provided lively delegate involvement!

Following our lunch break, Carol Moore, our Vice President, reintroduced the notion that many counsellors practise alone and thus SAPCA has provided a source of collegial support from specifically trained, and voluntary, counsellors to debrief for 15 minutes, as the need arises. It was noted that a debrief session is different from professional supervision. An updated list of current volunteers was distributed to delegates.

We also acknowledged the enormous effort from Dylan Przedworski, webmaster, who has continually upgraded the SAPCA website. Dylan has created a simple method of membership application and renewal as well as for conference registrations.

Our final speaker, Dr Alex Ryan, as previously mentioned, filled in for us at extremely short notice. Alex presented "Innovative strategies and approaches for relationship counsellors", based on his practical experience as well as information gained from the publishing of four books. There were immeasurable strategies and procedures offered in this presentation.

Each session evoked much internalising as our counsellors reflected on personal experiences and those of our clients. Interpersonal relationships are always difficult as it is hard to determine a "right or a wrong". We gained definite strategies throughout the day and had some fun along the way.

My thanks are extended to Rachael Cassell, who ably acted as master of ceremonies, and to the Board members who all contributed hugely to the success of the conference. I would also like to acknowledge the tireless effort from Carol Moore for the debriefing bookmarks, the use of her personal equipment and for her willingness to always "go the extra mile" when inevitable changes occur.

Efficacy of gambling treatment program on incarcerated offenders in Western Australia prisons

PEER REVIEWED ARTICLE

Abstract

Problem gambling counselling for incarcerated offenders is neglected in Australia. The present program is a pioneer program for prisoners in Western Australian. After attending the program, participants have shown a remarkable change in their attitude and beliefs towards gambling. Statistical analysis has shown that there is a significant difference between the pre-test and post-test scores of the Gambling Attitudes and Beliefs Survey (GABS). The result has shown that program is successful in changing the participants. Therefore, this project has provided a pilot study of how a therapeutic program can reduce their gambling problem and so to break their cycle of gambling, debt, crime and to reduce their risk of recidivism.

Introduction

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

Prevalence of problem gambling in Australia

It is estimated that up to 2.1% of Australian adults had a gambling problem (Productivity Commission 1999). In Western Australia, it is estimated that the prevalence of problem gambling of adult population is 0.7% (Productivity Commission 1999). According to Productivity Commission Gambling Inquiry Report (2010), it is estimated that there were 115,000 Australians categorised as 'problem gamblers' and 280,000 people categorised as at 'moderate risk' of gambling. For each problem gambler, it is estimated that a further seven individuals are directly affected. Problem gamblers also experience serious impacts including suicide, occupational loss and family breakdown (Gambling Research Australia 2010). The social cost of problem gambling is estimated to be at least $4.7 billion a year in Australia (Productivity Commission 2010).

Link between problem gambling and crime

In addition to the social cost of problem gambling upon the community, it is speculated that there is a strong link between problem gambling and crime. A survey found that gambling was the most common motivation for fraud and that the average loss was $1.1 million per incident in Australia (Productivity Commission 2010). In a study of Victoria State, the cumulative cost of the gambling-related crimes to victims was substantial. It was estimated that the overall value of 100 cases of gambling-related crimes totalled $37,278,441.00 (Victorian Responsible Gambling Foundation 2013). It is important to note that a criminal offence often affects multiple victims. This phenomenon is referred to as the 'multiplier effect'. Therefore, the monetary value estimated above is an underestimation of the financial impact of

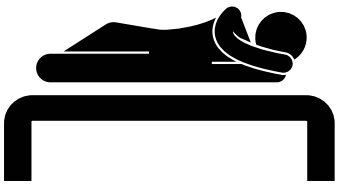
gambling-related crime. Most commonly victimised were businesses unrelated to the offender and the offender's employer. Gambling-related crimes committed against an employer were largely crimes of opportunity, with many offenders exploiting their access to cash, and control over accounts and auditing processes to defraud employers or clients. In addition, much of the criminal behaviour, including drug offences, has been directed at financially funding their gambling (Victorian Responsible Gambling Foundation 2013).

However, there was lack of assessment over gambling addiction on offenders. It had little official statistics to validate the relationship between problem gambling and crime. Researchers thus faced the difficulty to justify gambling in contribution to crime. Without an official statistics to support, there is lack of research in exploring the relationship between gambling and crime (Crofts 2003).

Prevalence of problem gamblers among Australia's prison populations

Despite the lack of official statistics, there were a number of surveys indicating the relationship between gambling and crime in Australia (Jones 1989, Lahn, 2000, Lahn & Grabosky 2003, Lahn 2005, Sakurai & Smith 2003). In New South Wales prisons, a study reported that 35% of women and 49% of men were assessed having 'some problem' to a 'probable pathological problem' with gambling. Moreover, 20% of women and 34% of men stated that gambling had contributed to their current imprisonment (Baron & Dickerson, 1999). Australian studies have estimated rates of problem gambling among offenders to lie between 17% and 30% (Lahn & Grabosky 2003). A study in Australian Capital Territory prisons has estimated that 33% of prisoners had gambling problem. That prevalence is 18 times higher than in general population (Lahn 2005). These Australian studies have suggested that the rate of problem gambling among offenders is greater than among the general population. Regarding the prevalence of problem gambling among prison populations in Western Australia, a study has reported that the prevalence rate of problem gambling among prisoners is 22% in Western Australian in which half of them reported that they had tried to quit gambling and more than a third believed that they were less likely to reoffend if they could control their gambling (Jones 1989, O'Connor & Jones 1998).

In another study, researchers have also reported that problems gamblers reported high levels of involvement in criminal behaviour. Severe problem gamblers are significantly more likely to commit income-producing crimes, such as theft, burglary, break-in, fraud, forgery and drug dealing (Sakurai & Smith 2003). The most serious current offences recorded for problem gamblers were property crime (37.1%) and violent crimes (28.6%) (Lahn & Grabosky 2003). Other studies of offenders have reported property crime and fraud as the main offences committed by problem gamblers. In this study, gamblers particularly resorted to crime when they have desperately embarked on the 'chasing' of previous losses. As debts mount, the need for a 'big win' becomes dominant. Problem gamblers are more likely to commit income producing crime to finance their gambling and to pay their debts (Lahn, 2000, Lahn 2005, Sakurai & Smith 2003). These surveys have suggested that gambling played a contributory role in crime.



As gambling had directly contributed to the offences of these prisoners, there is a strong need of running a gambling treatment program at prisons. In a survey, 25% of female gamblers and 32% of male gamblers in prison felt they would like help with their gambling problem (Baron & Dickerson, 1999).

Gambling treatment program in prison in Australia

Over the last decade, state and territory governments have put in place a range of regulations and other measures intended to reduce harm to gamblers (Productivity Commission 2010). However, there is still a gap in the prison and justice system as those prisoners with gambling addictions go unnoticed. Unlike drug and alcohol issues, addicted gambling is a hidden problem and also a stigma for people. In Australia, all states assess offenders for risk and need, such as domestic violence, drug and alcoholic addiction. However, no assessment is done for gambling addiction (Lahn & Grabosky 2003). Perrone et al., (2013) reported that in Australia there is a lack of awareness in the criminal justice system of problem gambling as an issue, and inadequate screening for problem gamblers in offender populations. Problem gamblers may not be aware or may be in denial that gambling behaviour exists. One of the reasons prisoners are not picked up on their gambling problem because there is no screening done on them. Without treatment, incarcerated offenders might not be able to break the cycle of gambling addiction, debt and crime. They are more likely of re-offending.

If offenders can be screened at the assessment unit of the Magistrate, cases of gambling addiction would be greater than currently identified. Identifying offenders with gambling problem is the first step in breaking the cycle of gambling-related crime. Despite the need of the problem gambling therapeutic program for the incarcerated offenders in Australia, there is a lack of such kind of programs available in prisons. In Australia, although all states provide rehabilitation programs for offenders, such as Pathway, Life Skill, Cog Skill, Choice Change and Consequence Program, anger management program, domestic violence program, drug and alcohol program, Narcotic Anonymous and Alcoholic Anoynmous, there are no specific program for gambling problems except in Victoria and New South Wales (Nixon et al 2006). In 2007, a problem gambling program for Vietnamese women was developed and implemented in acknowledgement of the relationship between problem gambling and Vietnamese women's offending (Department of Justice Victoria 2008). In NSW, a gambling awareness program and Gamblers Anonymous programs are offered to inmates with related problems at Cessnock Correctional Complex.

Despite a few gambling programs available in some Australia prisons, no research has been done to assess the effect of those programs on prisoners in Australia. Moreover, there was little research done on the gambling treatment program on prisoners internationally. Only one study has reported the impact on the attitudes towards gambling among the prisoners after attending a gambling treatment program in Canada (Nixon et al 2006). The study has provided valuable information on comparing the results between Canadian and Australian prisoners.

Gambling treatment program in Western Australia

The gambling treatment program was run by Mission Australia between July 2013 and June 2014 in Western Australia. This program was the first gambling treatment

program provided for incarcerated offenders with gambling problems at prisons.

The thrust of this program has applied motivational interviewing technique (Miller & Rollnick 2002) and "harm-reduction" approach. The program aimed at lowering the risk of prisoner to develop problems associated with their gambling, specifically the chances of resorting to crime and consequently to obviate the need for crime to pay gambling-related debts or to finance their gambling. Our program aims at supporting incarcerated offenders to gain a better understanding of their gambling habit in their life. It hopes that participants will increase their knowledge of their gambling and identify the triggers to their gambling situations. Most important, this program will equip them with new skills of coping with their gambling habit.

Despite there have been a few similar gambling treatment programs available in New South Wales and Victoria, there is still no research done on examining the effect of gambling treatment program on incarcerated offenders with gambling problem in Australia. The purpose of this paper is to examine the efficacy of the gambling treatment program on the prisoners in Western Australia. It is hypothesised that after attending the program, there will be a change in the attitudes and beliefs towards gambling among the prisoners whom have gambling problem. It has been noted that the longer gambling has been at problem levels, the more likely that crime will be associated with the gambling. Therefore, in order to help the prisoners to break their vicious cycle of gambling and re-offending, Mission Australia has designed this INSIGHT Gambling Treatment Program for prisoners before their release. The word "INSIGHT" is come from the first letter of a statement "Integrating New Skills In Gambling Habit for successful Transition back into community".

It has been noted that the longer gambling has been at problem levels, the more likely that crime will be associated with the gambling.

Design

The gambling treatment program is the first gambling counselling program running in Western Australia prisons. It is a structured program providing for incarcerated offenders in a series of group sessions. The program comprised six sessions with each session lasts for one and a half hour. The program is scheduled once a week in each prison. We have run the program in total eight prisons in Western Australia metropolitan area. The program ran in the daytime and weekdays. The facilitators in this project are experienced counsellors with qualifications of Master degree in counselling, financial counselling and also a problem gambling certified therapist

with experience working with problem gamblers before.

During this program, participants have gone through the same topics including personal history of gambling, view of their gambling problem, mistaken beliefs towards gambling, vicious cycle of gambling problem, stages of change, impact of gambling on their life, trigger situations to their gambling, coping strategies, budgeting skills and ways to restructure their life. The main dynamic of the program is the sharing and discussion among the participants with the assist of the facilitators in the group. In addition, participants have been given a handbook and being asked to do some exercise during the program. Facilitators have encouraged participants to share their personal experience and beliefs in relating to each topic. It could facilitate the participants to drill in their personal experience and to gain a better understanding of their gambling experience. This program can help the participants to build up their insight of their problem from which they can change their attitudes and beliefs towards gambling. At the end of the program, they are awarded a certificate of completion the program.

Participants

There was no screening for selection of their participation in this program. Prisoners can join the program voluntary. Promotion of the program was done through putting flyers in prisons' notice board, newsletter, and information session for the prisoners. Moreover, the program was also on the list of the Client Management System (CMS) in which prisoners can choose the programs to join. Prisoners would be excluded from program should they pose a potential threat to the safety of the counsellor or other participants. Different prisoner security classifications also meant that in some instances prisoners are unable to participate in the program (Victorian Responsible Gambling Foundation 2013). There have been a few prisoners being excluded from this program because of the above reason.

Despite the program is originally designed in group session, certain situation has influenced the running of the program. As some prisoners have been transferred from one prison to another prison, they would drop off the group and needed to be follow up individually. If some prisoners are transferred to prison in rural area, they will drop off from the whole program and not able to finish it. There were a number of prisoners dropping off this program because of this reason.

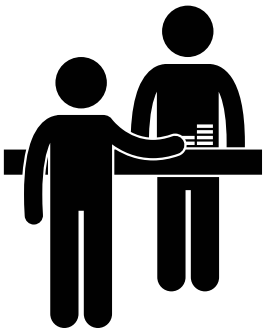
Measure

Three instruments are used in this program. They are EIGHT Gambling Screen (Sullivan 1999 & Gamblers Rehabilitation Fund 2009), Gambling Attitudes and Beliefs Survey (Breen & Zuckerman 1999) and Inventory of Gambling Situations (Turner, Zangeneh & Littman-Sharp 2006, Littman-Sharp et al 2009).

Procedures

At the first session of the program, all participants were asked to sign a consent form to express their voluntary participation in the program. They were allowed to withdraw from the program anytime if they wished.

After introducing the structure of the program and rules in the group, participants were given a handbook and



asked to do a few exercises including a self-completed test of the EIGHT Gambling Screen and how do they look at their gambling problem. Then, they were asked to do a pre-test to assess their attitudes and beliefs towards gambling at the beginning of the program.

Despite there may be argument that the prisoners are already incarcerated and gambling is forbidden inside prison, it has reported by prisoners that gambling does exist inside prisons. Gambling within correctional institutions is believed to be a common activity (Williams 2013). Their wager ranged from card games to betting on sports and on fighting among prisoners. The prisoners used their toiletries, snacks, soft drink and what they earned from their work inside prison to gamble. Prison psychologist has also reported that some prisoner's family is asked to pay to other prisoner's family in the community for the loss prisoner has made within the prison. Therefore, it is assumed that incarcerated offenders would maintain the same attitude and beliefs towards gambling inside prison. Imprisonment cannot stop their gambling habit but may reduce their frequency and amount spent on gambling only.

Traditional problem gambling screenings are lengthy and complicated. In the history of problem gambling research, the South Oaks Gambling Screen (SOGS) is the dominant measurement tool (Lesieur & Blume 1987, 1993). Since this program is voluntary participation, it does not want any initial screening deterring away the participants as they are sensitivity to be labelled or any stigma upon them. It is the reason to adopt a self-completed EIGHT Gambling Screen (Sullivan 1999 & Gamblers Rehabilitation Fund 2009). The EIGHT Gambling Screen comprises eight questions to assess problem gambling, with four or more 'yes' answers indicating that gambling may be an issue in their life. It is designed to be brief and can be self-completed in approximately one minute in order to provide prompt assessment and feedback. Because problem gambling is assumed as a persistent and recurrent problematic behaviour (DSM-IV), the EIGHT Gambling Screen questions ask whether problem gambling issues have ever occurred, rather than within a set recent period or commonly called 'current' screens. This approach is to avoid incorrectly finding that the person is not a problem gambler because the gambling is temporarily absent at the time of screening (Abacus Counselling Training & Supervision Ltd. 2006). This situation particular applies to incarcerated offenders in prisons in which gambling is supposed being prohibited. If test only assesses their current behaviour, it will yield a "false positive" result of a non-gambler to all prisoners and does not give any indication of gambling which has ever been a problem to them before their imprisonment. Moreover, a self-completed test also makes the participants feel more comfortable to confess their gambling problem by themselves rather than being pointed out having a gambling problem by the counsellor. The main purpose of the program is not to identify which prisoner has different level of gambling problem but to encourage them to gain awareness of their gambling issue only. A study has reported that the EIGHT Gambling Screen correlated positively with the SOGS (74%) and correctly recognised 93% of pathological gamblers identified by the SOGS Screen (Abacus Counselling Training & Supervision Ltd. 2006). In another study compared the EIGHT Gambling Screen scores with SOGS scores of inmates in a New

Zealand medium security prison, the EIGHT Gambling Screen identified 91% of inmates whom have been diagnosed of problem gambling disorder, while SOGS identified 82% of these problem gambling disorder inmates (Abacus Counselling Training & Supervision Ltd. 2006). The EIGHT Gambling Screen is currently being utilised by the South Australian Government Department of Human Services, the South Australian Break Even Program in Conjunction with Department of Correctional Services, the Victorian Commission for Gambling Regulation and New Zealand Corrections as an assessment screen for sentenced offenders with gambling problems (Abacus Counselling Training & Supervision Ltd. 2006). Therefore, the Eight Gambling Screen is selected for this program.

After arousing the awareness of their gambling problems, participants were invited to share their view of gambling. Then, they were asked to do a pre-test of their attitudes and beliefs towards gambling by completing the Gambling Attitudes and Beliefs Survey (Breen & Zuckerman 1999). They were informed that the test was to assess their current attitudes and beliefs towards gambling. Participants were also informed that they were going to do this test again at the end of the program as a post-test to assess any change of their attitudes and beliefs towards gambling. The Gambling Attitudes and Beliefs Survey (GABS) has 35 questions and answers in a four points scale of Strongly Agree, Agree, Disagree and Strongly Disagree. GABS is designed to assess a latent affinity for gambling and a measure of attitudes and beliefs about gambling in persons who gamble on some regular basis. Non-gamblers will not comprehend many of the GABS items. Higher GABS scores indicate that gambling is felt to be exciting and socially meaningful, and that luck and strategies are important. GABS has proved to be a significant predictor of gambling participation and has demonstrated validity to assess gambling affinity across disparate ranges of gambling-problem severity (Breen & Zuckerman 1999, Strong et al 2004).

GABS can be used to help identify, explore and dispute core dysfunctional beliefs which contribute to long-term gambling (Breen & Zuckerman 1999). After doing the pre-test of the GABS, all participants were aroused of their interest in sharing of their gambling experience. This exercise has facilitated the participants to explore their gambling experience and to review their mistaken thinking towards gambling. After discussing their gambling life experience in the second session, facilitators summarised their gambling experience by using Mitchell Brown's The Problem Gambling Cycle. A new Gambling-Related Crime Model is also introduced to explain their pathway to jail. Participants are asked to check which stage they are in that cycle.

In the third session, they were asked to do an Inventory of Gambling Situations test (IGS). The IGS was designed by the Centre for Addiction and Mental Health (CAMH) and widely used in Canada and United States. IGS is a 63-item self-report questionnaire. The IGS can convert its results into an individualised Client Profile that details the situations in which client has gambled excessively (Littman-Sharp et al 2009). The Client Profile can show clients to identify their own area of vulnerability and recognise those types of situations that are most likely to trigger their problem gambling behaviour. The subscales of the IGS include Negative Emotions, Conflict with Others, Urges and Temptations, Testing Personal Control, Pleasant Emotions, Social Pressure, Need for Excitement, Worried about Debts, Winning and Chasing, and Confidence in Skill. Identifying situations in which individuals gamble may be important for developing or improving treatments (Petry, Rash & Blanco 2010). IGS therefore helps counsellor to design an individualised treatment plan for people with gambling problems. In this session, facilitators can encourage participants to think of the warning signs for their gambling habit. In corresponding to their trigger situations to their gambling behaviour, participants are asked to brainstorm some coping strategies for their risky situations to their gambling habit.

GABS [the Gambling Attitudes and Beliefs Survey] can be used to help identify, explore and dispute core dysfunctional beliefs which contribute to long-term gambling.

In the fourth session, participants were asked to review the impact of gambling on their life and family. Then, facilitator introduced the Transtheoretical Model (TTM; Prochaska & DiClemente, 1982, 1983; Prochaska, DiClemente, & Norcross, 1992). One of the key constructs of the TTM is the Stages of Change. The Stages of Change are: Pre-contemplation, Contemplation, Preparation, Action and Maintenance. Then participants were asked which stage they considered they were during the class.

In the fifth session, participants were encouraged to discuss the myths of gambling, to share their mistaken beliefs towards gambling, to brainstorm the pros and cons of gambling and not gambling. The focus of this session is to strengthen their correct attitudes and beliefs towards gambling.

In the last session, facilitator debriefed the topics being discussed in the last five sessions. Then, participants were asked to write down their long-term and short-term goals, and to sign a self-promised contract for the changes they chosen. Finally, all participants were asked to do the post-test of GABS again. The post-test result is to compare with the pre-test result to see any change of their attitudes and beliefs towards gambling. After they have done the final evaluation, participants are awarded a certificate of completing the course.

Results

In order to provide a quantitative analysis, this study has used SPSS software to conduct the data analysis. Paired t tests were done to test the participants' changes in their attitudes and beliefs towards gambling.

During the program, our project has received total 96 referrals for this program. Their age ranged from 19 years old to 57 years old, with an average age of 33.36 and median age of 34. Among the referrals, 88 referrals were male and 8 referrals were female. There were total 66 participants, 59 males (89.3%) and 7 females (10.7%) who have finished the programs and have completed both the pre-test and post-test of GABS. Among the participants who have completed the program, 42 (63.6%) were of European Caucasian, 8 (12.1%) were Indigenous Australian, 2 (3%) were Middle East, 1 (1.5%) African, 1 (1.5%) Jews and 12 (18.3%) Asians. Their ethnicities include Caucasian Australian, Indigenous Australian, British, Irish, Scottish, Romanian, Italian, Zimbabwe, Vietnamese, Hong Kong Chinese, Iraqi, Indian and Jewish. Among the participants, 18 reported taking drugs while gambling

and 15 reported consuming alcohol while gambling. Therefore, participants with co-morbid problems are common. There were a few factors disrupting some prisoners not being able to complete the program. These factors included prisoners' early release, being transferred to regional prison, being hospitalised, voluntary withdrawal due to pre-occupied by other training course or lost interest in the program.

In this study, we did not attempt to label or classify participants in different level of gamblers, such as non-problem gambler, moderate-risk gambler or problem gambler. We only intend to arouse their awareness of gambling influence on their life. Therefore, participants were asked to do a self-reported assessment. In the EIGHT Gambling Screen, all participants answered "yes" to four or more questions, it indicated that gambling has influence in their well-being and they were probably problem gambler. All participants admitted that they have gambling problem. Therefore, all participants were assumed to have gambling problems.

Pair t test were used to calculate their difference of their pre-test and post-test scores in Gambling Attitudes and Beliefs Surveys. Statistical results are t = 11.1153, df = 65, standard error of difference = 2.146. Statistical analysis showed that there is a significant difference between the pre-test and post-test scores ($p < 0.001$). (Table 1)

Statistical analysis has shown that the EIGHT Gambling Screen result was positive correlated with the result of the Gambling Attitudes and Beliefs Survey. The Correlation coefficient between the EIGHT Gambling Screen and the pre-test of GABS was R = 0.2224, p <= 0.07277 (t = 1.825, DF = 64). However, result has shown no correlation between their years of gambling and the scores of EIGHT Gambling Screen. There is also no correlation between their age and the scores of EIGHT Gambling Screen, nor a correlation between their age and their scores of GABS.

Table 1

Group	Pre-test	Post-test
Mean	96.17	72.32
SD	15.43	16.60
SEM	1.90	2.04
N	66	66

t = 11.1153
df = 65
standard error of difference = 2.146
P > 0.0001

The t test difference is statistically significant.

Confidence interval:
The mean of Pre test minus Post test equals 23.85
95% confidence interval of this difference:
From 19.56 to 28.13

Discussion

Despite prisoners are already incarcerated and gambling is supposed to be forbidden inside prison, statistical analysis has shown that the EIGHT Gambling Screen result was positive correlated with the result of the Gambling Attitudes and Beliefs Survey. Both the EIGHT Gambling Screen and the Gambling Attitude and Beliefs Survey results have supported that the participants have a persistent and recurrent problematic gambling behaviour.

In the past, outcome of gambling treatment program only relied on the evaluation done by the participants. Only recently some studies have made efforts to

develop, implement and evaluate problem gambling services within the correctional setting (Brown et al. 2002). In the absence of formal evaluations to measure the effectiveness of problem gambling treatment program for offenders, prisoners were asked to comment on the usefulness of problem gambling service using a four-point scale ranging from 'no use' to 'very useful' (Victorian Responsible Gambling Foundation 2013). However, there is no statistical analysis on those programs. Moreover, there is question on the efficacy of the gambling treatment program on prisoners as there is no evaluation to show the long-term effect after their release in the community.

In this present study, the efficacy of the Gambling Treatment Program is measured by the participant's response to the Gambling Attitudes and Beliefs Survey (GABS). The rationale of this design is that people are all creatures of habit. Our behaviour is the result of the interaction between what we believe and how we feel. If we want to change behaviour, it is necessary to change the underlying beliefs and feelings related to that behaviour (Bundy 2004). Therefore, participants were assessed their latent affinity for gambling by using the GABS. It is hypothesised that if clients have shown decrease in scores of the GABS after attending the Gambling Psychotherapeutic Program, their latent affinity for gambling also reduce. Lower GABS score indicates that gambling is felt to be less exciting and meaningful to them. In fact, GABS has proved to be a significant predictor of gambling participation (Breen & Zuckerman 1999, Strong et al 2004). In this study, prisoners have reported that they have either reduced or even restrained their participation in gambling inside prison since they attended the program. As prison life is routine, boring and lack of stimulation, gambling is one of the major entertainments for prisoners. One research has found that more than half of those who gambled problematically before incarceration continue to do so while incarcerated (Turner et al 2006, 2013). It is an undeniable fact that gambling does exist within prisons. The statistical analysis of the GABS of this study has showed that the t test result reaches a statistical significant ($p<0.0001$). It can assume that our gambling treatment program is successful in changing the participants' attitude and beliefs towards gambling. Their change of attitudes and beliefs are indication of their initial step in controlling their gambling behaviour. Therefore, this program has shown a positive result on prisoners in changing their attitudes and beliefs towards gambling.

Moreover, feedback, empathy and mutual support atmosphere were provided during the group dynamic. They enjoyed the mutual support atmosphere and they were committed to share their experience in the group. Group dynamic resembled a partnership and companionship which further facilitated the therapeutic relationship in the group session.

Besides the attitudes and beliefs towards gambling, there are other factors that influence their behavioural change. Factors include motivation to change that behaviour, the value underlying the behaviour, the perceived cost and benefits of changing, the barriers to changing, beliefs and confidence in our ability to perform the behaviour change, and the support and reinforcement of others (Bundy 2004). Motivation is a state of readiness or eagerness to change (Miller & Rollnick 1991). During the program, facilitators have applied the motivational interviewing technique to help participants

identify and change their gambling behaviour. Participants were encouraged to understand their thought process and to identify their emotional reactions related to their gambling problem. In exploring the impacts of gambling on their life, mistaken beliefs, ambivalence and barriers towards their gambling change were removed and choice of life was discussed. Finally, participants were encouraged to set their goals.

The efficacy of the program on prisoners can be explained by the Transtheoretical Model and Motivational interviewing technique (Miller & Rollnick 2002). Motivational interview takes its theoretical basic from the Transtheoretical Model or Stages of Change Model (Prochaska & DiClemente 1982). At the end of the program, participants were asked to rate their own stages of change. Most of them reckoned they were already either in the preparation or the action stage. Of course, a long-term followed up survey of the prisoners' participation in gambling after their release to the community will be good. However, their maintenance also depends of a long-term support by other service such as counselling or mutual support group service in the community.

The other challenge is the credence of the length of this kind of gambling therapy program on participants. Problem gambling is a serious and prevalent problem for incarcerated offenders. Gambling treatment program should be given for prisoners with related problem before and after their release (Allen Consulting Group 2011). In-prison treatment should focus on preparing offenders to gain an insight of the impact of gambling on their life and contribution to their imprisonment. While post-prison programs should include provision of social and treatment support networks appropriate for the released offenders. However, providing problem gambling programs to offenders in the community involves a number of challenges. These include offenders may present with a variety of anti-social and other offending-related problematic behaviour. Offenders may be challenging in one-on-one counselling and difficult to integrate into group-based support activities in the community program. Thus, referral of offenders with complex needs to existing community-based problem gambling programs is unlikely to work effectively. While community-based agencies can provide support to address financial and relationship problem experienced by problem gamblers, the delivery of an effective program to offenders will also require the involvement of the Community Corrective Services and Gambling therapist with specific experience working with offenders. It is recommended that the Community Corrective Service and service provider agencies should jointly develop protocols for case management and information exchange for cases involving offenders with gambling problem, giving equal priority to clinical and compliance management outcomes (Allen Consulting Group 2011). It would be advantageous to link these prisoners into problem gambling services before release, or alternatively upon their transition back into the community (Victorian Responsible Gambling Foundation 2013). Thus, gambling treatment program should carry the same weight as drug and alcoholic program for offenders in the justice system.

Problem gambling help-seeking behaviour was relatively low among defendants, with just over a third reporting engagement in gambling-related help service.

However, problem gambling help-seeking behaviour was relatively low among the defendants, with just over a third (39.2%) reporting engagement in gambling-related help service. In addition to the gambling treatment services, only 11 defendants (8.8%) had engaged in either the Crown or Australian Hotels Association self-exclusion programs (Victorian Responsible Gambling Foundation 2013). Sakuari and Smith (2003) suggested the courts to look favourably upon offenders who have demonstrated rehabilitative efforts in relation to gambling issues, such as abstinence (periodic or permanent), attendance at counselling or participation in self-exclusion programs. "While acknowledge rehabilitation as an important aspect of sentencing in the case of gambling-related crime, the judiciary was almost unanimously silent on the issue of mandated treatment" (p.72 Victorian Responsible Gambling Foundation 2013). Therefore, it should reconsider that gambling treatment program can be mandatory for those offenders who have committed gambling-related crime to reduce their chance of recidivism.

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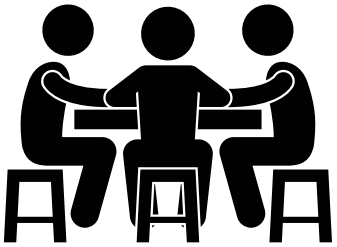

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Bernard W. S. Fan, Master Degree in Counselling, Diploma in Financial Counselling, Certificate in Gambling Counseling and Graduate Diploma in Child Psychotherapy. Is currently a Gambling Educator/Counsellor in WA.

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Group supervision – does it count?

by Kate Caffrey, Julie Scott and Geraldine Touhey

Trainee counsellors Kath Caffrey, Julie Scott and Geraldine Touhey experienced group supervision as a challenging space where they learned perhaps most from each other.

'I remember a discussion with my training provider when I had started my first placement. We were discussing supervision hours and whether or not I could include the group supervision I received:

"It doesn't count."

"What do you mean it doesn't count? BACP [British Association for Counselling & Psychotherapy] guidelines say…"

"That doesn't matter, for the purposes of this course, group supervision does not count."'

So, what is the point of group supervision? Does it count?

For the record, group supervision does 'count' in terms of contributing towards the BACP recommended number of hours of supervision needed per month. How much it contributes depends on how many people there are in the group.1

But, looking beyond the clock, in this article we are going to try to answer the question 'Does it count?' by explaining what group supervision meant to us, as members of a supervision group on a training placement, and how it informed our practice. And, having asked others about their experiences of it too, we hope to show that it has real value.

'For two years, once a fortnight, we were stuck together for an hour and a half. Although we had talked about supervision during training and induction, group supervision barely warranted a mention. I remember that first session, in a small dark room, nervous and uncomfortable, and, as the supervisor waltzed in, I wondered how on earth I was going to cope without making a total idiot of myself. What I did not know then was how much I would come to value these sessions, how much I would learn, and how much I would miss them when they were over.'

It's true that not everyone has a positive experience of group supervision, so what was it about our experience that was so beneficial? After much discussion, we have pinpointed some key areas as examples of things that we valued from our sessions:

- education
- challenge
- acceptance
- trust
- empathy
- congruence
- confidentiality
- group dynamics
- growth
- humour
- the role of the supervisor.

We are aware that we are all unique and will have different experiences; there may be some things we have not considered here. But we hope that this reflection will be useful to trainees and experienced counsellors alike.

Education

Group supervision provided us with an enormous opportunity to learn. We were exposed vicariously to a variety of different clients, counselling styles and intervention techniques. We learned a lot from just having the opportunity to sit with other counsellors (trainee or otherwise) and hear their experiences of client work. By sharing experiences and hearing other people's points of view, we were able to discuss issues that arose – ethical dilemmas, areas of theory, different perspectives.

We learned how to do supervision, how to prioritise which clients to bring. Part of this was being challenged about whether or not supervision was 'problem management', as often we would just bring the bad stuff. We learned to appreciate that there was also space to acknowledge what had gone well. As time went on we acquired the skill of presenting clients through feelings rather than just their story.

Time management was an issue – why did we leave certain things to the end of our time when they were so much more important than those we had discussed earlier? Also, there was the need to work together in sharing out the allotted time. Who gave their time away, why might that happen, and how could we stand up for our own time? By the end, there was always flexibility and group members would often willingly give time away for the greater good.

We experienced a generous exchange of knowledge. There was raised awareness of differing communication styles and how to become a more effective communicator and listener.

Challenge

The challenge to be really honest was there from the start. We were constantly asked by our supervisor how we felt, to the point of blushing and feeling some fear about getting it wrong, or making some sort of theoretical mistake. We had to own up to being bored by clients, and had to dig really deep to find what we were feeling. It was scary moving away from the safety of theory.

Then came the challenge of expressing what we thought of the others' practice. The chance to think about what we would have done in their situation allowed us to experience another client and extend our knowledge. We learned to respect challenge, to go with it as deeply as was needed. 'There were times, when the supervisor was challenging something that another group member said, when I wanted to shrink into my chair and become invisible. I could see the struggle and pain they were going through and wanted them to be OK, willing them to get the point and reach the right conclusions. I wanted to tell the supervisor to stop and give them a break, and it took a long time before I felt comfortable and safe enough to be able to do that.'

Acceptance

It took time to establish rapport, to get to know the others in the group, but it was vital that we felt comfortable for the group to work. We had to learn to accept that we were different but equal, that all our contributions had value. One member started group supervision before they had even seen any clients, and had to listen to the rest of us as we described our experiences, and deal with envy, feelings of inferiority and fear about failing: 'Even then it was the group that gave me the strength and the kick and the acceptance needed to do the live training session, which meant I could finally see clients. It always felt like a safe place in which to fail. The faith and support were deeply strengthening.'

Our initial nerves soon eased: 'At first I was afraid that whatever I said would be wrong and the others would judge me as useless, but the supervisor asked me for my opinion and would not accept no for an answer. And the more I contributed, the more confident I felt. Even when I was not in agreement with the others, my contribution was valued and discussed and, as time passed, we grew more comfortable with each other, enough to say what we felt had been good and also what not so good… We were also not shy of complimenting good practice and would definitely challenge anyone who did not accept our praise – and we learned to say "thank you" instead of blushing and deflecting!'

We began to grow as counsellors, finding our own feet and becoming more confident: 'I learned to put my trust in relative strangers, to give and receive support (and leave behind the stubborn feeling that I can do it all on my own). I was able to value weakness and vulnerability, and have an appreciation of what others openly shared (I would have hidden from this in the past because it tied into my insecurities).'

"I learned to put my trust in relative strangers, to give and receive support (and leave behind the stubborn feeling that I can do it all on my own). I was able to value weakness and vulnerability, and have an appreciation of what others openly shared..."

Trust

We were able to establish trust early on. It was clear that none of us were there to achieve at anyone else's cost and we were all willing the others to succeed. This allowed us to be supportive, aware of others' feelings yet unafraid to challenge fellow group members. We have spoken to other people who have had less happy experiences of their group members: not accepting other people's point of view, not accepting constructive criticism, being obstructive, not contributing or contributing too much or switching off when it was not their turn. We were lucky that these things never happened to us.

For us the trust that we shared allowed us to grow in ways we had not anticipated: 'The establishment of trust within the group allowed us to approach areas I would have found difficult or impossible to do elsewhere, and which have gone on to form a very significant part of my personal development as a person and a counsellor.'

Empathy

'We were always aware of each other, knew when one of us was feeling pressured or had been particularly challenged by a session… We tried to walk in the other's shoes in client terms – how would I have dealt with that situation/client? I had admiration and respect for the way someone handled things I would have found difficult.'

As counsellors, empathy should come naturally – it is only polite that this courtesy is extended to our fellow group members. The experience we had of group supervision was a counselling experience and the core conditions remained present with us in our group.

'When something particularly painful or poignant was discussed and one of us had been left raw and tearful, we closed ranks and gave each other the support, warmth and care that were needed. We felt safe. And afterwards we would go for coffee or a beer and get ourselves back on track with a laugh or a hug, and kept each other going.'

Congruence

Our group provided a safe space to develop congruence – this most tricky of skills. It was important that we were congruent with each other. It would have felt like a betrayal if we had kept things to ourselves that were important: '… being able to share judgments, unpopular feelings, shameful admissions. It was a huge help in dealing with clients – it served the purpose of clearing out any judgement by getting it out into the open.'

We talked to someone from a different supervision group who had a very different experience: '… and he went on to say that he started work with a new client by telling them all about himself and what he had been through so they knew that they were working with someone just like them, and I'm sitting there thinking, "Oh my god, that is so wrong, there are strict boundaries about self-disclosure and when it can be useful." My ethical alarm bells were ringing like mad, but the supervisor said nothing, did not challenge him or ask our

opinions, and I knew that if I said anything he would go off on one and say that it was all my stuff, and I was afraid to challenge him.'

If congruence is about finding the right way to tell the truth, then group supervision is a good forum for learning how to do this well!

Confidentiality

At first glance there is no problem establishing rules for confidentiality within the group setting. As counselling professionals, we have all been trained in the need for and importance of confidentiality in supervision to protect the client and the fact that this is a moral and ethical obligation.

'Confidentiality is a central tenet of counselling and psychotherapy, and, by extension, of supervision.'

In the first session, when we were discussing what we hoped to achieve and gain from group supervision, boundaries were outlined, including the need for confidentiality: 'What we discuss stays in the room (within usual legal requirements).'

The problem arises, however, when group members become friends and meet outside the supervision environment – how hard is it to maintain the boundaries? Certainly we were always careful to protect client confidentiality, and actual cases were never discussed outside the room, but other issues occasionally arose, sometimes over coffee at a later date. Once we all came out of the supervision a little shell-shocked as the supervisor had been particularly hard on us, and I remember asking, 'What was all that about – was it just me?' and discovered that the others had felt the same. I spoke to the supervisor individually but he brought it back to us in the next session. He felt that we had missed a learning opportunity, and that it felt like we had been talking about him 'behind his back', and had broken his confidentiality. If we had asked about it in the session it would have been more congruent and allowed for a debate. With hindsight I understand that. However, it shows that, even in a group where everyone gets on, there is a question of power balance and how this can affect the performance and development of the group members.

Group dynamics

In theory, group supervision is about a group of like-minded people coming together for a shared purpose, which should enhance their performance, growth and understanding. It is usual for groups to go through stages of development: from formation, through establishment of roles and needs, to a common sense of values and performance once the members are at ease with each other. Problems arise where there is unresolved conflict or individuals in the group do not share the overall aim of group development and are more focused on their own needs. This can impact negatively on all members, and shows the need for clear boundaries, honesty, congruence, and a strong but fair-minded facilitator.

"Although the others had criticised my actions, as I left I realised that I would not do things differently. I was more aware of the person I was and the counsellor I wanted to be. I had listened to what they had to say, and respected their points of view, but my sense of self was stronger."

Growth

As group members we were aware how we had grown and developed as the two years came to an end. We learned how 'to be' and had the confidence to take this into the counselling room and into our professional lives in general. Having spoken to other people in the group, we realised that, for most of them too, even if at times their experience had not been comfortable, this had been a chance to learn and develop as a counsellor. One explained: 'Although the others had criticised my actions, as I left I realised that I would not do things differently. I was more aware of the person I was and the counsellor I wanted to be. I had listened to what they had to say, and respected their points of view, but my sense of self was stronger.'

Humour

It was important that we were able to laugh, to lighten the mood without shirking the seriousness of the subject matter. Humour brought us closer together. Use of humour added a dimension of familiarity, comfort and safety that seemed to allow other conditions to flourish beneath it. It was never used with malice.

The role of the supervisor

Sally Despenser, who wrote the BACP Information Sheet on supervision, advises:'At one end of the spectrum, the supervisor, acting as leader, will take responsibility for apportioning the time between the therapists, then concentrating on the work of individuals in turn. At the other end of the range, the therapists will allocate supervision time between themselves, using the supervisor as a technical resource.'

We thought a lot about this aspect of group supervision. The supervisor has a key role in the success of the session and their contribution can make or break the group. Although part of a supervisor's training is in group supervision, there seem to be many different views on what is required of them. From a supervisee's perspective it seemed to us that a good supervisor has a variety of obligations. They have to be able to:

- negotiate different characters
- challenge perceptions
- enable free discussion
- bring out the best in all participants.

An important part of their role is to point out areas of good practice and what

could be done differently, and encourage ethical good practice. It is also important that they encourage group members to share responsibility for the sessions, such as timing, input, ideas, challenge and making sure the discussions do not get too cosy or comfortable.

They must be unafraid to make group members step outside of their comfort zone (eg role play). It is also helpful if they inspire the group members to begin to supervise each other and gain confidence in their ability to do so.

By contrast, a poor supervisor does not challenge poor practice or domineering group members or encourage free debate. Poor supervision does not include all group members and promote growth. It is detrimental if the supervisor does not involve him or herself in the process or encourage group members to share responsibility for the process. Again we were lucky: our supervisor was experienced, ethically-minded and (although it pains us to admit it) quite funny. At the start he took on quite a facilitative role but, as our group grew more accustomed to each other, he was able to let us take on more responsibility and be more active in the organisation of the sessions.

Conclusion

Counselling is by nature isolating and can be rather lonely. There are few opportunities to work with other counsellors and share knowledge. Group supervision has the potential to inform and enhance counsellors, and offers a unique chance to share other people's experiences of counselling. Ideally the group members will be engaged and supportive, and the potential for growth is limitless. But, even where the members do not work so well together, there is the potential to learn and improve selfawareness. The supervisor has a key role.

Group supervision should be encouraged, but its participants should be taught how to make the most of it.

'I have learned to listen and the value of other people's opinions. I have learned to make sure that I use the time wisely and not allow others to dominate, and conversely, to make sure that other group members are included and allowed their space. I have learned that no one has all the right answers all of the time, and that to think that you have is to be unethical. There is a need for openness and responsibility. I have learned that it is important to speak your mind, even when you are afraid, and value the consequences of doing so, good or bad. I have learned that good support is a vital part of practitioner self-care.'

We were very lucky. We had a great experience and have made true friends, and our learning has been exponential. Our supervisor knew how to manage us while allowing us to take responsibility and challenging us, sometimes relentlessly but always with kindness, respect and humour. Through group supervision we have become better counsellors, more self-aware, open to the value of other views and aware of all the potential for learning.

Finally, to answer the question, 'What is the point of group supervision?', the point would seem that it provides an opportunity to enhance professional practice, widen perspective and make the most of an undervalued resource – other counsellors!

Kath Caffrey MBACP (Accred) qualified in 2011 and is currently working as a high school counsellor in Cheshire, and in private practice in Southport.

Julie Scott qualified in 2011 and is currently working as a therapist and trainer for Flintshire Mind.

Geraldine Touhey is currently employed by NHS England, supporting emotional health and wellbeing, and also works as a stress management coach in a private practice.

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PEER REVIEWED ARTICLE

Being 'more than' a counsellor: personal development as professional development

by Veronica Sandall

Recognising that other aspects of my life touch on my counselling and consciously interweaving those skills and practices into my work.

Just as the 'doing' in counseling is important so too is the 'being' and 'becoming' (EYLF 2009)

This is about taking responsibility of 'who it is' I bring to the therapeutic relationship. I owe a lot to influences beyond the theories and interventions in what I do, to 'be' in the counsellor role, espoused by the ethical principles (ACA 2013) particularly in relation to personal and professional development. Being mindful of the discourse concerning personal development emphasis on training objectives and client needs rather than on personal growth per se (Irving & Williams 1999) I aim to acknowledge those processes and activities I engage in my 'other' life which impact and contribute to a personal development supporting who I am and what I bring as counsellor.

To hold true to my philosophy on 'being' a counsellor I continue to explore my own depths and heights in order that I am able to hold, witness and empathise; asking myself, "Am I committed to becoming that person I am expecting of the other?" at every point of my professional and personal development. And I see that there are indeed many ways I explore and deepen my personal experiences with awareness of the impact on the other.

One particular activity that has supported this is being part of a group of artists that uses awareness and exploration to enhance our own creativity.

What interests me is the collaborative nature of our exploration and the level of trust, respect and support that has developed. We come from different disciplines e.g. movement, spoken word, sculpture, image or sound, and are developing our ability to empower

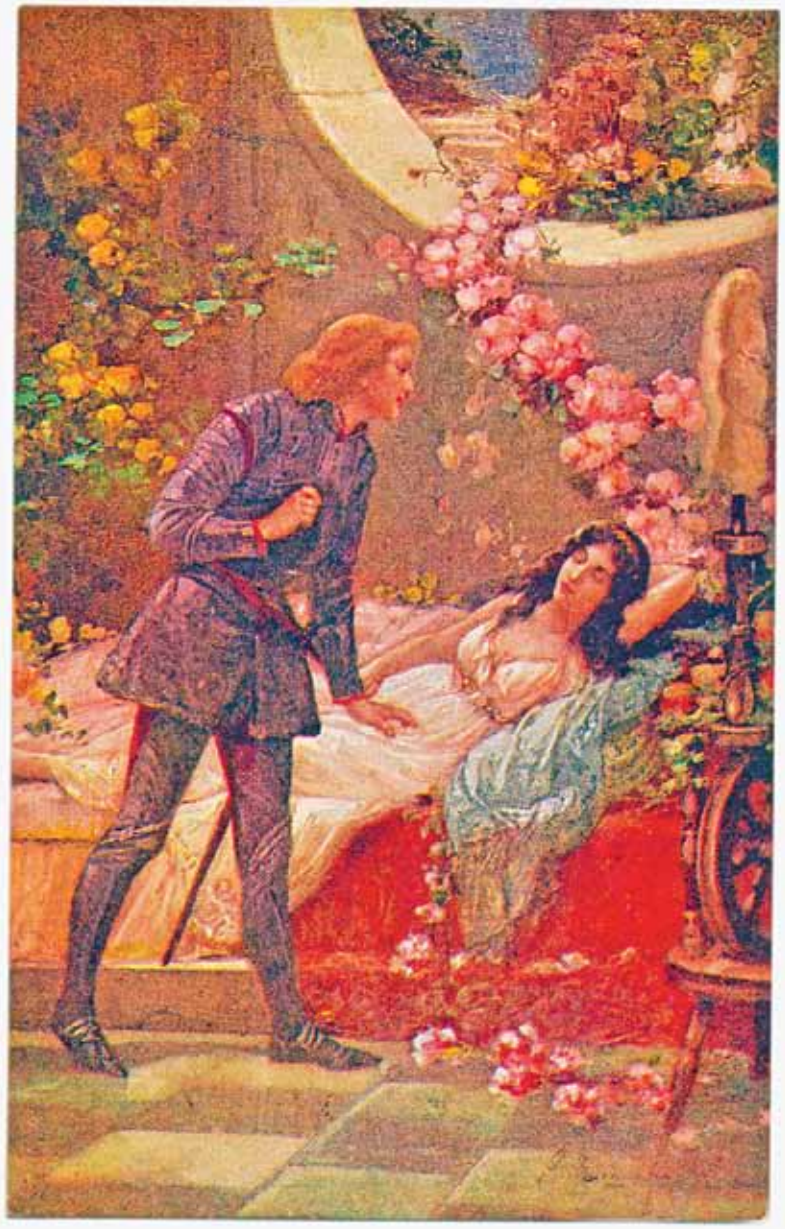
others to contribute based simply on being human. In response there is from each of us, a 'willingness to become a process' and a connection to the 'core conditions' of unconditional positive regard, empathy and congruence (Rogers 1961). I aim to work towards this process with my clients giving value to the contributions they bring from their culture/perspective.

There are many parallels to counselling theories and models in our artistic collaboration work: Jungian archetypes, Transactional Analysis scripts, Existentialism, Systems theory, and Gestalt phenomenological underpinning in particular.

I introduced a storytelling device to the other artists to explore relational aspects for a dance piece I was hoping to create. From exploring certain roles I hoped to create a contact improvisation piece based on our interaction with others in our 'default' setting way of relating. This sort of device would work in a group counselling session perhaps for families or as I have successfully used in a school and youth group session, culminating not in a performance arts piece but perhaps simply in a 'contained' role play experience.

What interests me is the collaborative nature of our exploration and the level of trust, respect and support that has developed.

Almost any traditional tale has excellent parallels to life today no matter how far back in history they 'began'. This helps me to keep in mind the existential issues that clients bring; amongst the glitter, romance and heroism there is realism, and the human condition is portrayed through its characters.



I chose Sleeping Beauty. It has a number of characters and inanimate objects such as the spindle and forest, which play an important part in the unfolding story. Family is a major theme for me and is mirrored in other socially organised groups such as this Creativity Network. Exploration of roles and being present in my body and feeling self gives us much to share - the imagery and subtleties of the story shine through in the reflection discussions that followed.

Alongside family I witnessed issues of responsibility, jealousy, exile, naivety, the part nature plays in our lives and the wished for child play out in mine and other artists movements and choice of positioning. Others discussed images of the cursed gift, inevitable fate, female patience and passivity and the heroic quest.

Form is something which interests me, possibly from my experiences with family and other 'imposed' social systems. Positional awareness and sense of space and boundaries is something I have taken into the counselling room. Either directly when working with stones, shells or miniature models whereby the client chooses objects to represent. Or even indirectly when I am setting up the environment and client counsellor contract.

Improvisation needs a heightened degree of awareness, meaning you exist moment to moment. You are not a doer, responding to the past, memory, or thinking. The situation, you and all are involved in it. I can deepen this level of awareness through mindfulness or meditation techniques, which I practice either in the group or alone before we start. We can share simple meditation or mindfulness exercises with much success within the counselling session where a client shows an interest. In particular I recall one client who was experiencing panic attacks (male 23) who was able to bring his awareness to sensations in his body in order to feel more grounded and connected to the point of pre-empting and

avoiding the attacks. This touched on both transpersonal/physiological aspects. These were aspects previously unexplored in our counsellor-client relationship. (Clarkson 1992)

Letting go of the 'need to know' in dance improvisation work is part of the process which is parallel to my 'story' as a counsellor and one which I admit can be challenging, particularly when one's client is seeking answers and comes eliciting a child to parent ego state. I do have a good grounding in directing/choreography to know where the sticky points may be and how to navigate us out of them should it be necessary. Likewise in my counselling I know I can rely on a good theoretical underpinning and practical tools to draw upon whist enabling the client autonomy in letting their story unfold.

In terms of my own unfolding story I find the work I do in the Creative Network group supports my personal development in a way that can only be beneficial. To know myself better, hone my skills of observation of what might be my own unresolved issues, and help me guide others through their material are all key competencies for counsellors to develop.

Each time we came together I looked to which role/character I was drawn to and found myself being aware of something new. Sometimes I wanted to be the Queen to change her character and hence re write the script. Had she been less naïve she might have protected the princess more and then I tell myself that she did the best she could, as do most mothers. Sometimes I related to the forest of thorns: silent, assertive, strong, knowing, deciding the moment when all could wake. I still work with the internalised 'you have to work hard to earn anything' (TA injunctions/drivers/scripts) and so am aware of the challenge for me to take on the princess or prince role, characters seemingly privileged with an easy access to the 'Happy Ever After'. I am mindful also of the needs of the 'offenders' who are typically seen as the wicked fairy and perhaps the spindle. It draws me to look at the underlying cause and not just the presenting issue. This is of paramount importance in my work with young people referred with an initial referral of behaviour concerns.

My own supervisor skilfully gave time for and encouraged the discussion of the experiences and hobbies I was involved in and would engage in professional dialogue drawing in parallels with my client base of the time. Hence adhering to the multiple 'eyes' of the Hawkins and Shohet integrative process model. I too endeavour to build the supervisor-supervisee relationship to gain a holistic picture of my own supervisees 'being' in order to assist in their 'becoming'. By encouraging counsellors to think about the bigger picture so that what might be seen to begin as a 'restorative' aspect of the supervision relationship actually becomes the supervisee's natural channel for the 'formative'. (Inskipp and Proctor 1993).

So in looking to professional development logs it seems there is a place for the recording of reflection and subsequent self-awareness of activities not directly related to mainstream training practices. If documented within a framework of stated objectives or outcomes these might bring together the personal and the professional and ensure one's being is acknowledged. A more holistic look such as this in developing one's professional practice rather than going against the current push for evidence-based practice, target setting and accountability may actually support more congruent engagement with real and relevant experiences, bringing professional development logs to life.

This would be a good question to ponder next; how to create a robust system to acknowledge and record such activities alongside the mainstream.

Veronica Sandall, ACA Member, Masters Counselling and Psychotherapy, Post Graduate Certificate in Supervision, Masters Level BACP accredited Advanced Diploma in Integrative Counselling.

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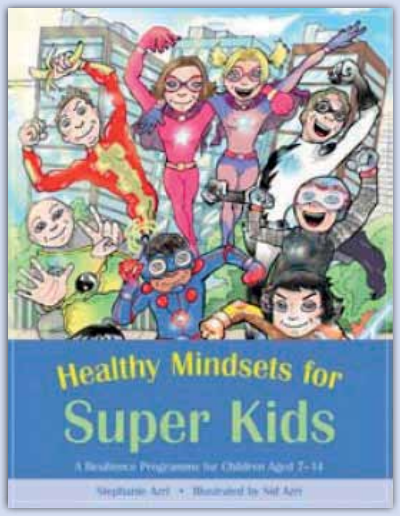

Healthy mindsets for super kids: A resilience programme for children aged 7-14

Stephanie Azri
Price: AU$33.95
Publisher: Jessica Kingsley Publishers
Where to buy: All major online bookstores

A ten-session programme designed to boost resilience in children, focusing on key themes from anxiety to anger management.

It's an ideal resource for those working with and helping children and features fun characters to engage the children.

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TASMANIA				
Michael Beaumont-Connop	**Newstead**	0429 905 386	$60	FTF/PH/WEB

ACA SUPERVISOR COLLEGE LIST		MEDIUM KEY: FTF: face to face | PH: Phone | GRP: Group | WEB: Skype		
Name	Suburb	Contact number	Per person hourly rate	Medium
David Richard Hayden	**Howrah North**	0417 581 699	Upon Enquiry	FTF
VICTORIA				
Patricia Dawson-Davis	**Mooroolbark**	0424 515 124	Indiv $80 Pr Hr, Grp $60 1 1/2 To 2 Hrs	FTF/GRP/PH/WEB
Sandra Brown	**Frankston, Mount Eliza**	03 9787 5494 And 0414 545 218	$90	FTF/GRP/PH/WEB
Joanne Ablett	**Phillip Island**	0417 078 792	$100	FTF/GRP/PH/WEB
Graeme John Riley	**Gladstone Park**	03 9338 6271 Or 0423 194 985	$85	FTF/WEB
Barbara Matheson	**Melbourne**	03 9703 2920	Upon Enquiry	FTF
Suzanne Vidler	**Newport**	0411 576 573	$110	FTF/PH
Jenni Harris	**Kew**	0406 943 526	Small Grp Only: $90 Per 3 Hr Session	FTF
Rosslyn Wilson	**Knoxfield**	03 9763 0772 Or 03 9763 0033	Indiv $70 Pr Hr, Grp $40 Pr Hr	FTF/GRP/PH/WEB
Melissa Harte	**Pakenham, South Yarra**	0407 427 172	$132 To $143	FTF
Michael Woolsey	**Seaford, Frankston**	0419 545 260 Or 03 9786 8006	Upon Enquiry	FTF
Judith Ayre	**Bentleigh**	0417 105 444	Upon Enquiry	FTF
Molly Carlile	**Inverloch**	0419 579 960	Upon Enquiry	FTF
Claire Sargent	**Canterbury**	0409 438 514	Upon Enquiry	FTF
Sheryl Brosnan	**Carlton North/Melbourne**	03 8319 0975 Or 0419 884 793	Upon Enquiry	FTF/GRP/PH/WEB
Keren Ludski	**Malvern**	03 9500 8381 0418 897 894	Upon Enquiry	FTF/PH/WEB
Cas Willow	**Newport Or Traralgon**	03 9327 2293 Or 0428 655 270	$130	FTF/PH/WEB
Zohar Berchik	**South Yarra**	0425 851 188	Upon Enquiry	FTF
Gabby Skelsey	**Elsternwick**	03 9018 9356	Upon Enquiry	FTF/PH/WEB
Kenneth Scott	**Bunyip**	0407 814 447	Upon Enquiry	FTF
John Dunn	**Colac/Mt Gambier**	03 5232 2918	Upon Enquiry	FTF
Jennifer Reynolds	**Lower Templestowe**	0425 714 677	Upon Enquiry	FTF
Anna Atkin	**Cheltenham**	0403 174 390	Upon Enquiry	FTF
Anna Atkin	**Berwick**	0432 331 361	Upon Enquiry	FTF
Paul Huxford	**Yarraville**	0432 046 515	Upon Enquiry	FTF
Tim Connelly	**Healesville**	0418 336 522	Upon Enquiry	FTF
Roselyn Crooks	**Brookfield**	0406 500 410	$60	FTF
Joan Wray	**Mobile Service**	0418 574 098	Upon Enquiry	FTF
Sara Edwards	**Dingley**	0407 774 663	Upon Enquiry	FTF
Lisa Derham	**Camberwell**	0402 759 286	Upon Enquiry	FTF/WEB
Nyrelle Bade	**Geelong**	0402 423 532	Upon Enquiry	FTF
Peter Mauger	**Bairnsdale**	0412 141 340	Upon Enquiry	FTF
Beverley Kuster	**Narre Warren**	0409 938 397	Upon Enquiry	FTF
Helen Wayland	**St Kilda**	0412 443 899	Upon Enquiry	FTF
Vicki Gekas	**Eden Park**	0403 004 710	Upon Enquiry	FTF
Keith Hulstaert	**Belgrave**	0409 546 549	Upon Enquiry	FTF
Theodore Dimopoulos	**Altona**	0421 256 214	Upon Enquiry	FTF
Marie Bajada	**Ballarat**	0409 954 703	Upon Enquiry	FTF
Graham Hocking	**Park Orchards**	0419 572 023	Upon Enquiry	FTF
Lindy Chaleyer	**Brighton East**	438013414	Upon Enquiry	FTF
Sandra Bowden	**Lysterfield**	0438 291 874	Upon Enquiry	FTF
Batul Gulani	**Melbourne**	0412 977 553	Upon Enquiry	FTF

ACA SUPERVISOR COLLEGE LIST		MEDIUM KEY: FTF: face to face | PH: Phone | GRP: Group | WEB: Skype		
Name	Suburb	Contact number	Per person hourly rate	Medium
Lynne Rolfe	**Berwick**	03 9768 9902	Upon Enquiry	FTF
Paul Montalto	**Thornbury**	0115 315 431	Upon Enquiry	FTF
Kaye Jones	**Camberwell**	0417 387 500	Upon Enquiry	FTF
Linda Davis	**Gippsland Leongathal**	0432 448 503	Upon Enquiry	FTF
Danielle Aitken	**Kilcunda**	0409 332 052	Ind $80 Grp $45	FTF/GRP/PH
Kathleen Brennan	**Narre Warren**	0417 038 983	Upon Enquiry	FTF
Debra Darbyshire	**Berwick**	0437 735 807	Upon Enquiry	FTF
Patricia Reilly	**Mount Martha/Gardenvale**	0401 963 099	Upon Enquiry	FTF
Hans Schmid	**Knoxfield**	03 9763 8561	$70	FTF/PH
Robert Mcinnes	**Glen Waverley**	0408 579 312	Upon Enquiry	FTF
Cheryl Taylor	**Port Melbourne**	0421 281 050	Upon Enquiry	FTF
WESTERN AUSTRALIA				
Lillian Wolfinger	**Yokine**	08 9345 0387 Or 0401 555 140	$60.00	FTF/PH
Amanda Lambros	**Victoria Park**	0423 151 743	Upon Enquiry	FTF
Carolyn Midwood	**Duncraig**	08 9448 3210	Indiv $110 Pr Hr, Grp $44	FTF/GRP/PH/WEB
Salome Mazikana-Mbenjele	**South Headland**	08 9138 3000 Or 08 9172 2212	Upon Enquiry	FTF
Eva Lenz	**South Fremantle**	0409 405 585	Upon Enquiry	FTF
Sharon Blake	**Fremantle**	424951670	Upon Enquiry	FTF
Deidree Brereton	**Canning Vale**	0409 901 351	Upon Enquiry	FTF
Carol Moore	**Old Reynella**	08 8297 5111 Or 0419 859 844	Indiv $99 Pr Hr, Grp $35	FTF/GRP/PH
Patricia Sherwood	**Boyanup**	08 97261505	Upon Enquiry	FTF
INTERNATIONAL				
Dina Chamberlain	**Hong Kong**	85260289303	Upon Enquiry	FTF
Fiona Man Yan Chang	**Hong Kong**	852 91984363	Upon Enquiry	FTF
Polina Cheng	**Hong Kong**	852 9760 8132	Upon Enquiry	FTF
Eugnice Yiu Sum Chiu	**Hong Kong**	852 2116 3733	Upon Enquiry	FTF
Wing Wah Hui	**Hong Kong**	+852 60285833	Upon Enquiry	FTF
Cary Hung	**Hong Kong**	85221761451	Upon Enquiry	FTF
Giovanni Ka Wong Lam	**Hong Kong**	+852 9200 0075	Upon Enquiry	FTF
Frank King Wai Leung	**Hong Kong**	+852 3762 2255	Upon Enquiry	FTF
Yat Chor Wun	**Hong Kong**	852 264 35347	Upon Enquiry	FTF
Jeffrey Gim Tee Po	**Singapore**	65-96199153	$100.00	FTF/PH/GRP/WEB
Robert Tai Lee Lieh	**Singapore**	65-96318622	$95	FTF/PH
Deborah Cameron	**Singapore**	+65 91868952	100	FTF/GRP/PH/WEB
Ellis Lee	**Singapore**	N/A	Upon Enquiry	FTF
Indumathi Balasubramanian	**Singapore**	N/A	Upon Enquiry	FTF
Prem Kumar Shanmugam	**Singapore**	N/A	Upon Enquiry	FTF
Eugene Chong	**Singapore**	+65 6397 1547	Upon Enquiry	FTF
Gan Su Keng	**Singapore**	+65 6289 6679	Upon Enquiry	FTF
Nadia Rahimtoola	**Singapore**	+65 9647 1864	Upon Enquiry	FTF
David Kan Kum Fatt	**Singapore**	+65 9770 3568	Upon Enquiry	FTF
Cecilia Lee Ching Hoon	**Singapore**	+65 9029 6543	Upon Enquiry	FTF
Emilia Yee	**Singapore**	+65 9183 5007	Upon Enquiry	FTF
Ruby Murty	**Malaysia**	60166809499	Upon Enquiry	FTF

SUBMISSION GUIDELINES

WANT TO BE PUBLISHED?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

Why submit to *Counselling Australia*? To get publishing points on the board!

Being published is part of most career advancements for professional counsellors and psychotherapists, particularly those who wish to advance in academia.

All peer reviewed articles are eligible for OPD points and publishers can claim on their CVs to have been formally published. *Counselling Australia,* a peer reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285), is now calling for articles and papers for publication.

Counselling Australia is designed to inform and discuss relevant industry issues for practicing counsellors, students and members of the Australian Counselling Association. It has an editorial board of experienced practitioners, trainers and specialists. Articles are invited to be peer reviewed and refereed or assessed for appropriateness by the editor for publishing. Non-editorial staff may assess articles if the subject is of a nature as to require a specialist's opinion.

The quarterly journal is published every March, June, September and December.

Editorial policy

Counselling Australia is committed to valuing the different theories and practices of counsellors. We hope to encourage readers to submit articles and papers to encourage discussion and debate within the industry. Through their contributions, we hope to give contributors an opportunity to be published, to foster Australian content and to provide information to readers that will help them to improve their own professional development and practice. We wish to promote to readers the Australian Counselling Association and its commitment to raising the professional profile and status of counsellors in Australia.

Previously published articles

Articles that have been previously published can be submitted as long as permission for reprint accompanies the article.

Articles for peer review (refereed)

- Articles are to be submitted in MS Word format via email.
- Articles are to be single-spaced and with minimal formatting.
- Articles must be submitted with a covering page requesting a peer review.
- Attach a separate page noting your name experience, qualifications and contact details.
- The body of the paper must not identify the author.
- Articles are to contain between 1500 and 5000 words in length.
- Two assessors, who will advise the editor on the appropriateness of the article for publication, will read refereed articles.
- Articles may be returned for rewording or clarification and correcting prior to being accepted.

Conditions

- References are required to support argument and should be listed alphabetically.
- Case studies must have a signed agreement by the client attached to the article for permission for publication.
- Clients must not be identifiable in the article.
- The author must seek permission to quote from, or reproduce, copyright material from other sources and acknowledge this in the article.
- All articles are subject to our editing process and all authors will be advised of any necessary changes and sent a copy prior to the proofing of the journal for publication.
- Authors are to notify the editor if their article has been published prior to submission to *Counselling Australia*.
- Only original articles that have not been published elsewhere will be peer reviewed.
- *Counselling Australia* accepts no responsibility for the content of articles, manuscripts, photographs, artwork, or illustrations for unsolicited articles.

Deadline

Deadline for articles and reviewed articles is the 7th of February, May, August and November. The sooner articles and papers are submitted, the more likely they are to be published in the next cycle.

AIPC

Gain Entry Into An ACA Professional College

With An ACA Accredited Specialty Vocational Graduate Diploma

At the 2011 ACA Annual General Meeting ACA publicly launched its Professional Colleges. ACA Professional College membership is available to members that have specialist training, skills and experience in specialty areas of practice. The benchmark training standard for most Colleges (all except Hypnotherapy) is an ACA Accredited Vocational Graduate Diploma in the area of specialty practice.

Currently the Professional Colleges include: Addictions (Alcohol And Other Drugs), Grief And Loss, Family Therapy, Supervision and Counselling Hypnotherapy.

The Professional Colleges will serve to establish national standards for specialty areas of practice within Australia – something that has been substantially missing for some time.

Get Direct Entry Into A Professional College

AIPC currently delivers a Vocational Graduate Diploma of Counselling with a choice of 3 specialty areas that provide you with direct entry to a Professional College upon graduation. The specialties cover the following fields: 1. Addictions 2. Family Therapy 3. Grief & Loss

Flexible And Cost Effective

Each of the VGD's can be undertaken externally at your own pace. Here's how a graduate qualification can advance your career:

- Demonstrate your specialty expertise through ACA College Membership.
- Develop a deeper understanding of your area of interest and achieve more optimal outcomes with your clients.
- A graduate qualification will assist you move up the corporate ladder from practitioner to manager/ supervisor.
- Make the shift from being a generalist practitioner to a specialist.
- Formalise years of specialist experience with a respected qualification.
- Maximise job opportunities in your preferred specialty area.
- Gain greater professional recognition from your peers.
- Increase client referrals from allied health professionals.

PLUS, you'll **save over $6,000.00** (67% discount to market).
A Graduate Diploma at a university costs between $10,000 and $38,000. BUT, you don't have to pay these exorbitant amounts

Learn more and secure your place here now: www.aipc.edu.au/vgd

Alternatively, call your nearest Institute branch on the FreeCall numbers shown below:

Sydney	1800 677 697	Brisbane	1800 353 643	Reg QLD	1800 359 565
Melbourne	1800 622 489	Adelaide	1800 246 324	Gold Coast	1800 625 329
Perth	1800 246 381	Reg NSW	1800 625 329	NT/Tasmania	1800 353 643

ACCEPTANCE & COMMITMENT THERAPY WORKSHOPS 2014

LIMITED SPACES PER EVENT

Designed for **psychologists, counsellors, social workers, occupational therapists & other mental health professionals**

WHAT IS ACCEPTANCE & COMMITMENT THERAPY?

Acceptance and Commitment Therapy (ACT) is a growing discipline within psychology utilising mindfulness-based strategies while encouraging value-driven action and acceptance. ACT therapy offers a simple and effective approach to facilitating mindfulness practice, enhancing acceptance and connecting with values, helping clients live a richer and more meaningful life.

ACT has been widely researched and holds empirical support for effective use with a wide range of psychological conditions such as depression, anxiety, trauma, post-traumatic stress disorder, chronic pain and personality disorders and can be used when working with individuals, couples and groups.

INTRODUCTORY WORKSHOP

The two-day introductory workshop is for psychologists, counsellors, social workers, occupational therapists and other mental health professionals who want to learn about, or may be lacking in confidence when using ACT. This workshop has been developed to support clinicians to understand the core principles within the ACT framework and to begin integrating ACT processes such as mindfulness, values clarification and cognitive defusion into their practice.

This is an experiential workshop where you will be given an opportunity to participate in the 6 core processes of ACT and in turn understand the fundamental attributes to delivering ACT. This practical hands-on training will give you a broad understanding of ACT and the confidence to begin using the core processes with clients.

ADVANCED WORKSHOP

The two-day advanced workshop is for clinicians with a basic understanding of ACT looking to flexibly apply the 6 core processes of the therapy model in different scenarios of everyday practice.

In this advanced workshop you will learn practical tools to getting unstuck as a clinician when dealing with challenging clients and situations. This workshop will provide you with an opportunity to see live ACT role plays ranging from introducing ACT for the first time to a client and obtaining client consent through to working within complex client presentations and how to balance values, mindfulness and committed action. You will learn troubleshooting strategies and most importantly how to deal with tough situations when clients get stuck and no longer respond to the basic ACT approach.

If you are looking for advanced applications of ACT over a wide range of psychopathology including depression, anxiety, trauma and personality disorders, this workshop is for you.

WHAT ELSE YOU WILL GET

Prior to both the introductory and advanced training you will receive short pre-workshop readings and resources. Although not necessary, these resources will help you in understanding the history and development of ACT.

On completion of the workshops you will also receive questions and answers to test your knowledge which comply with industry active CPD requirements.

PRESENTED BY

Nesh Nikolic (BA Psych, Grad Dip App Psych, M Clin Psych, MAPS, MACCP) is a Clinical Psychologist and ACT trainer with over 8,000 hours of one-on-one therapy experience.

Nesh has practiced ACT within a number of therapeutic contexts including individual therapy, couples counselling and family therapy. He has also worked with the Canberra Raiders and other athletes on increasing sporting performance using ACT.

Nesh runs a busy private psychology practice and has applied ACT to a wide range of mental health difficulties including depression, anxiety, trauma, personality disorders, eating disorders and pain management.

INTRODUCTORY WORKSHOPS

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MELBOURNE

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PERTH

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MELBOURNE

SYDNEY

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