COUNSELLING AUSTRALIA

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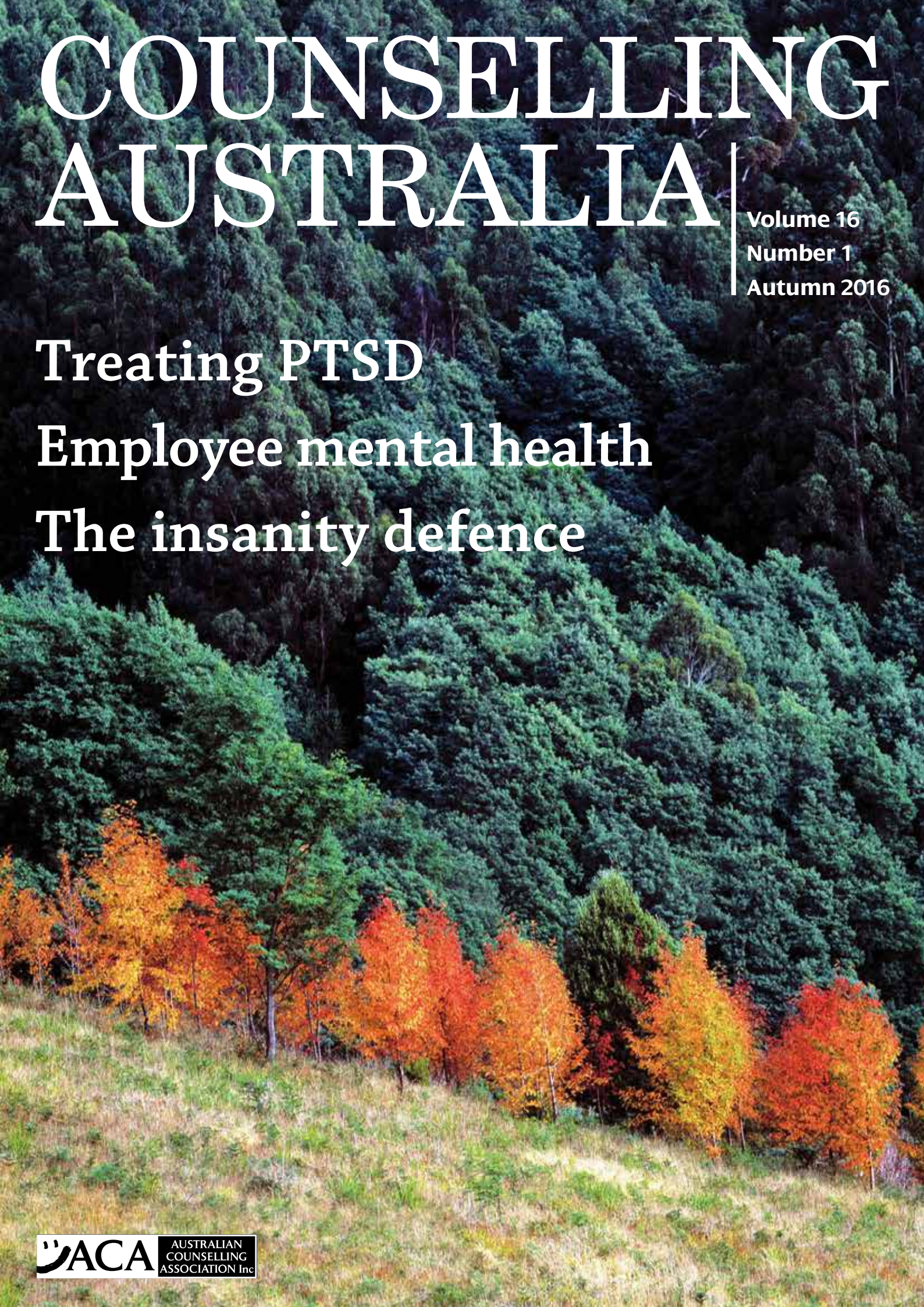
Treating PTSD

Employee mental health

The insanity defence



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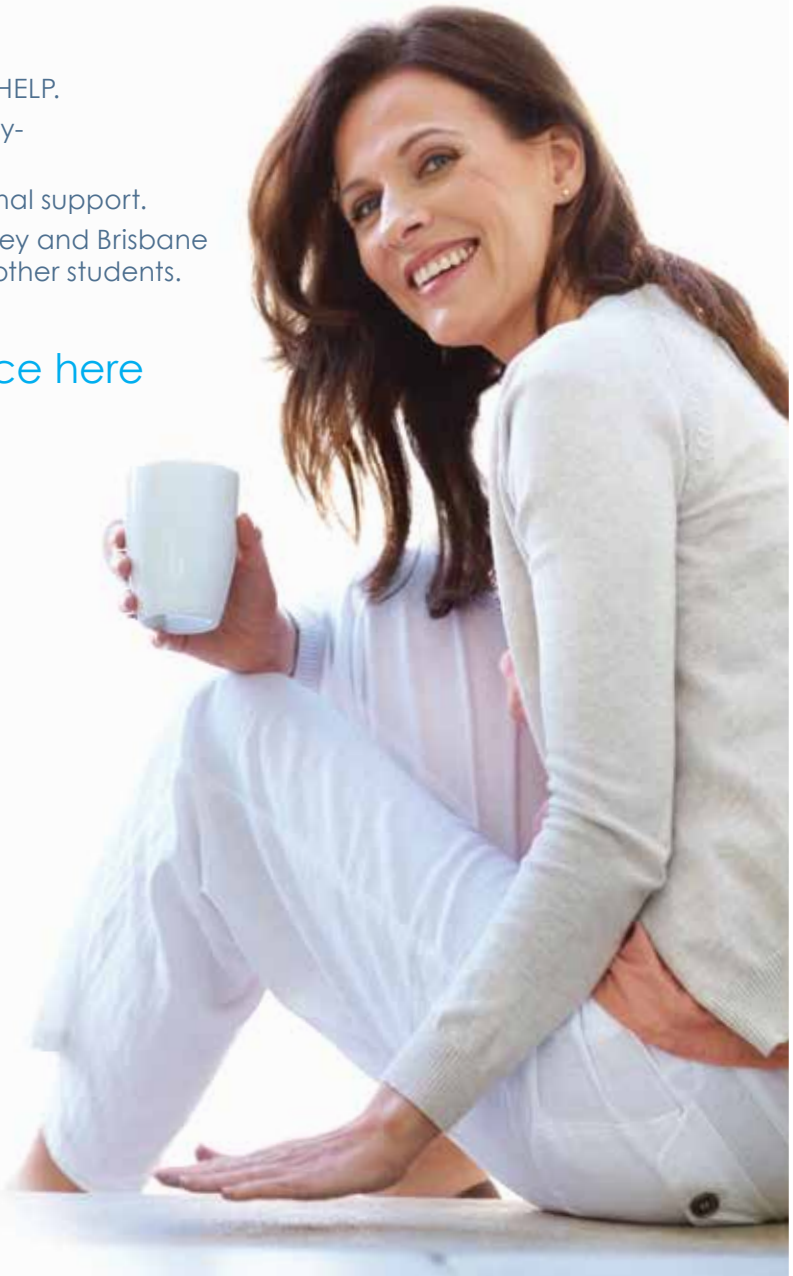

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What's in a Title?

By Philip Armstrong FACA

One of the more controversial and emotional discussions that I have been involved with recently is the correct use of academic titles/qualifications for counsellors/psychotherapists. Australian Counselling Association Inc (ACA) current policy on this issue is quite clear at this time, only counselling qualifications can be used by counsellors that are relevant to their practice, including PhDs. A holder of a PhD that is not relevant to counselling cannot at this time refer to themselves as "Doctor" in their marketing material or in any other situation where they are presenting as a counsellor. Pretty much if you are wearing your counsellor hat and your PhD or Doctorate is not in counselling, counselling psychology or similar then you cannot refer to yourself as Doctor or use the post nominal PhD. This policy is consistent with similar peak bodies and international peak bodies such as the American Counseling Association.

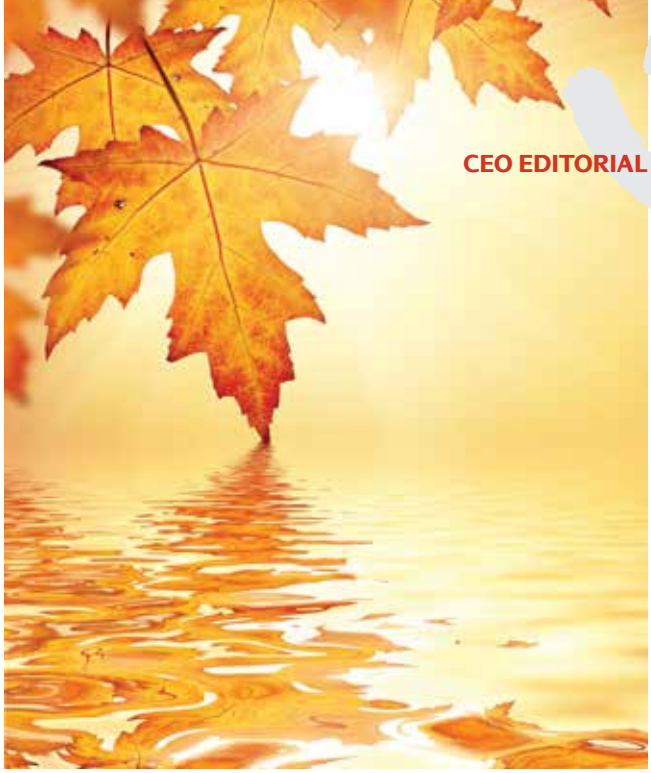
The argument for being allowed to use the title of Doctor regardless of what the PhD was in follows that the title is earned with the completion of a PhD or Doctorate degree. Therefore the title is conferred with the qualification and can be used in any or all situations determined by the holder. The confirmation of the title does not come with restrictions. The holder of the title will have learnt knowledge and skills through the process of undertaking the PhD which are likely to have a positive impact on their counselling skills in one way or another. This is a pretty emotional argument that works on the single focused basis that the work undertaken earns the recipient a title that can be used globally for all situations in both a professional and social setting. This argument may allay the need for the recipient of the PhD/Doctorate to be recognised as having completed what is a significant piece of work however, it is narcissistic in its construct. It does not take into account what that may actually mean to others, particularly those not familiar with what is involved in the undertaking of a PhD or Doctorate. What responsibility does the recipient take for the consequences of the use of their title?

In an academic setting such as a University where the large majority of lecturers hold a PhD the title Doctor has little meaning in regards to standing, it is expected as a pre-requisite that lecturers either have a PhD or are undertaking one. The nature of a person's PhD is generally obvious by the faculty they work in and the subjects they lecture on. It is all very transparent and all are familiar with the process. It is in the mainstream of commercial and professional practice where the title and its meaning become hazy and ambiguous. Transparency becomes optional and egos can take over. In Australia there is no title protection for the term "Doctor" or "PhD" nor is there a legal definition that a PhD or Doctorate qualification must meet to ensure everyone is reading from the same page. In essence the misuse or intentional exploitation through misrepresentation of the title for one's own personal gain is a moral and ethical issue as opposed to a legal one. This needs to be addressed by peak bodies such as ACA through a registration process that is designed to help the public identify a PhD qualified counsellor. To help with transparency peak bodies need to outline any restrictions within their Code of Conduct which should also be spelt out in detail in the organisations policy document. This to help members of the public not familiar with higher degrees.

According to the Australian Bureau of Statistics in 2015, within the Australian workforce only 29% of working males and 24% of working females hold a bachelor degree or higher academic qualification. This equates to approximately just over a quarter of working Australians have actively studied and been exposed to the higher education sector. Around 73% of working Australians must then depend on the transparency of a holder of a graduate qualification to honestly and accurately translate the area of specialisation in which the qualification was completed. The level at which the qualification was undertaken is outlined by the Australian Qualifications Frame work (AQF). The AQF set the level that a qualification needs to be delivered at.

The AQF website http://www.aqf.edu.au informs us that: "A*QF levels and the AQF levels criteria are an indication of the relative complexity and/or depth of achievement and the autonomy required to demonstrate that achievement. AQF level 1 has the lowest complexity and AQF level 10 has the highest complexity.*" A bachelor degree being level 7, with a Masters at level 9 and PhD/Doctorate being level 10. It is expected that each level has a pre-requisite that must be met before one can move onto the next level. It would be expected that before anyone could undertake a PhD they would have already completed a bachelor's degree followed by a Master's degree or have completed a body of work determined to be equivalent. Each of these qualifications would usually be within the same area of expertise, in the case of a counsellor each of the degrees would have been in counselling, psychology, mental health or similar.

This would all seem logical. So it could be safely assumed anyone working as a counsellor with a PhD would have completed a logical sequence of work in counselling going from AQF level 7 to 10. Yes, actually no, if you take the original argument put forward being anyone with a PhD can call themselves "Doctor" regardless. Therefore the question begs asking is it ethical for someone with a PhD in Naturopathy who also holds a Diploma in counselling (AQF level 5) as their highest counselling qualification to then refer to themselves as Doctor and state they hold a PhD when offering counselling services. Is this really a case of misrepresentation, an intentional attempt to paint themselves



as being more qualified than they really are with the intention of attracting more clients or work.

What about "best practice" or consumer protection, how is the consumer who has no idea about how higher education works supposed to be protected from this type of practice. It is not unreasonable to think that people searching the web for a service may be influenced to use one service as opposed to another if one is delivered by a professional stating they are a "Doctor" and another isn't. Yes it is the consumer's responsibility to check the bona fides of anyone they seek services from however if they are not conversant with the education system there is only so much they can do.

There is also the reality of when was the last time you asked your GP, Dentist, Chiropractor or any other professional to see their bona fides. Yes there are usually impressive certificates in frames hanging on the walls or pasted onto websites but as to whether these are legitimate or relevant to the service being offered is another question. Many qualifications state the level completed be it Master's degree or PhD but actually don't clarify what the specific area of expertise was. It must also be taken into consideration we are working with some of the most vulnerable people in the country, to expect many of them to have the energy, knowledge or focus required to undertake investigative work of the expected qualifications and registration requirements is entirely unreasonable. This client group needs protecting whilst having confidence that the professional is accountable to them through a Code of Conduct and have gone through a meticulous registration process.

It is the job of the professional peak body to instil confidence in government, employers, consumers, other professions and the general public that its registered members are at all times accountable to a Code of Conduct that works on a principle of transparency, honesty and integrity. Allowing members to introduce themselves as Dr xxxxx to a prospective client seeking out a counsellor when in actual fact the highest qualification in counselling they have may be a Diploma/Bachelor/Masters degree in counselling would not be ethical. It is misleading as the prospective client is going to rationally assume the term Doctor or use of the post nominal PhD refers to the therapists counselling qualifications.

What if ACA allowed members whose PhD was not in counselling to use the title under the condition that the member was to clarify in the first meeting with the client that their PhD is not in counselling. I would wonder what the initial purpose of using the title is if disclosure is after the fact considering the title is actually irrelevant to the service being offered. Would this not be simply an exercise to impress the client as the title is redundant to the client's needs? Is this then more about the counsellor and their professional need for status and recognition or ego as opposed to being in the client's best interest? How does referring to yourself as Doctor, to then have to explain to a prospective client your PhD is actually in another discipline or nonaligned field to counselling, in your clients best interest? How would a client react if they were to find out that their counsellor who goes by the name of Dr xxxxx was in actual fact a Dentist and the highest qualification they had in counselling was a Diploma. Why would you want to put a client in this position in the first instance?

There is very little if anything put forward by those who support an open use of the title Doctor and the post nominal PhD that moves from self-interest to being in the best interest of the client and profession. ACA policy is clear on this issue and consistent with other peak bodies working within the mental health arena.

The AQF website http://www.aqf.edu.au informs us that:

"AQF levels and the AQF levels criteria are an indication of the relative complexity and/or depth of achievement and the autonomy required to demonstrate that achievement. AQF level 1 has the lowest complexity and AQF level 10 has the highest complexity."

Technology Update

With Dr. Angela Lewis

PHOTO: 123RF.COM

To start 2016, I have a mix of interesting things to look at, including using Instagram (or Insty as the kids like to call it ☺), the burgeoning market of online extra marital affair websites and some links to information on Orthorexia Nervosa.

Instagram

Instagram is a popular photo-sharing app for Smartphone's. Compared with other social networks, Instagram is relatively simple and quite basic as it is focused on sharing your photos while viewing photos of friends, celebrities or anyone else you choose to follow. Like me, you might be wondering why you need a separate photo app when you can just post your pictures on an existing Facebook or Twitter account, but for those you choose to use it, the focus is the simplicity of posting a photo and then directing it also be posted on Twitter and Facebook or any other social network they are using without having to type much text aside from inserting a few hashtags (#). People who use this app are generally interested in looking for more followers, comments or interaction from the Instagram community - for example they may be trying to get publicity or attention for something they are selling or promoting or simply enjoy public adoration for the selfies they post of themselves in every conceivable light.

In order to achieve this, they hash tag their photos, so that when other users browse for categories, they will come up in search categories.

For example, if you tag a photo you post of your sleeping cat with the hashtag #kitty. #cutekitten or #kitten, users browsing through the #kitten tag in an Instagram search should see your photo. If another user likes the photo they click a heart icon under it.

Like most other social networking sites, you must be at least 13 years old to create an account on Instagram and while users you may occasionally encounter some inappropriate content on this app, it does have strict rules banning nudity and other types of offensive posts.

If you want to install it on your smartphone, just go to the App Store icon and search for Instagram, follow the prompts to download it and start posting pictures, searching for photos and following others. If you'd like to know more before you start using it, I suggest doing a Google search on Instagram as there are many simple tutorials (including on YouTube), available for free.

Facebook friend

Most of us are probably now using Facebook in some shape or form as people young and old have embraced it as a way to keep in touch and share their lives. However there are times when you may receive a friend request from someone who you don't consider a friend as such (for example a work colleague), and therefore don't feel comfortable giving them access to all aspects of your private life, photos or

activities. This can be further complicated if you feel that refusing the friend request may also not be the right thing either as you do not wish to cause hurt or offence.

I have a simple suggestion: accept the friend request and then go straight to your friend list in Facebook and to the right of each person's name you will see a button marked 'Friend'. Click that button and change it to **Acquaintance**. This means when you next post anything to Facebook you can click the Friends button and select **Friends except Acquaintances**, which means that anyone marked as an Acquaintance will not see that particular post. Note that it stays on this choice until you change it again. You can create Custom Lists of friends in the same way.

Accessing extra mrital affairs online

We have heard quite a lot about the website Ashley Madison (the website set up for married people looking for an affair or relationship etc outside of their marriage) on the news in the last few months; however there are a number more still going strong online, with a sample few below.

- *www.maritalaffair.com*
  This UK site promises discretion and even gives some pointers for how to get the most effective results out of your affair.
- *https://en.gleeden.com*
  Bills itself as the first extra marital affair site run by women.
- *www.findnewpassion.com*
- *www.marrriedsecrets.com*
  According to this site: "Married secrets can help you find discreet married affairs that you take as far as you want, whether just a little flirting, a passionate encounter, romantic married affairs, married dating or affectionate companionship".
- *www.victoriamilan.com.au*
  An Australian site which is simple and to the point.
- *www.hushaffair.com*
  The motto here is "your desires are our secrets".
- *www.illicitencounters.com*
  Evidently the largest site of this kind in the UK.

For more tips, hints and reference material on technology and social media, visit me anytime at www.angelalewis.com.au or follow me on Twitter @AngeLewisMelb.

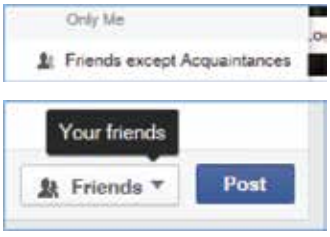


PHOTO: 123RF.COM

Spotlight on Orthorexia Nervosa

Orthorexia Nervosa is a medical condition in which the sufferer systematically avoids specific foods that they believe to be harmful. They are fixated on how pure or clean their bodies are and can be obsessed with regular fasting, dieting and cleansing themselves. Unlike Anorexia Nervosa suffers who are focussed on the quantity of food they consume, Orthorexia suffers have an obsession with eating foods which they consider healthy and this condition is said to be characterised by an extreme or even excessive preoccupation with avoiding foods they perceive to be unhealthy. The term Orthorexia derives from the Greek (*ortho*: right or correct), and orexis: appetite; literally translating to "correct appetite", but in practice is taken to mean "correct diet". At the time of writing, Orthorexia Nervosa is not considered to be an eating disorder according to the American Psychiatric Association. The leading authority on this condition is Dr. Stephen Bratman, who first coined the term in 1996. He claims that in rare cases this fixation can become so extreme that it may lead to severe malnutrition. He argues that even in less severe cases, the attempt to follow a diet that cannot provide adequate nourishment is said to lower self-esteem, as the sufferers blame themselves rather than their diets for a constant hunger and the resulting cravings for forbidden foods. Below are two good links to help you learn more about this condition. Dr Bratman's website: *www.orthorexia.com* and *www.nationaleatingdisorders.org/orthorexia-nervosa.*

PEER REVIEWED ARTICLE

Adult Posttraumatic Stress Disorder

By Vicky Dawes

Experiencing a PTE is common. In fact some 50-75% of people report experiencing at least one PTE in their lives (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013; Ogle, Rubin, Berntsen, & Siegler, 2013). It is normal and common to experience psychological distress following exposure to a traumatic event. Most people find their distress settles in the days and weeks following the event and do not go on to develop an Acute Stress Disorder (ASD[1]) or Posttraumatic Stress Disorder (PTSD) (Greenberg, Brooks, & Dunn, 2015).

> However, in a minority, symptoms persist, developing into depression, anxiety, Acute Stress Disorder (ASD) or Posttraumatic Stress Disorder (PTSD) (Greenberg et al., 2015)

PTSD is characterised by the development of a range of typical symptoms following exposure to a traumatic event and the diagnosis can have significant and far-reaching implications for the affected individual and those around them (Greenberg et al., 2015). However, there are evidence-based interventions that can aid recovery. This review will present the full DSM-5 diagnostic criteria for PTSD, prevalence figures, typical clinical presentations and how PTSD can impact the client, along with an overview of the assessment process and a review of treatment options.

DSM-5 Diagnostic Criteria

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

- Directly experiencing the traumatic event(s).
- Witnessing, in person, the event(s) as it occurred to others.
- Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
- Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse).
  - **Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
   - **Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
   - **Note:** In children, there may be frightening dreams without recognizable content.

PHOTO: 123RF.COM

3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
   • **Note:** In children, trauma-specific re-enactment may occur in play.
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
5. Markedly diminished interest or participation in significant activities.
6. Feelings of detachment or estrangement from others.

Posttraumatic Stress Disorder

Stressful life threatening events are part of normal human experience (RANZCP, 2013). All of the below can be described as a potentially traumatic event (PTE):

7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behaviour.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

• **With dissociative symptoms:** The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalisation:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealisation:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).
   • **Note:** To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behaviour during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

■ **With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Note: The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria in DSM-5."

(*Diagnostic and statistical manual of mental disorders: DSM-5*, 2013)

Prevalence

Lifetime prevalence[2] of PTSD is reported as between 5 and 10 per cent (ACPMH (Australian Centre for Posttraumatic

Mental Health), 2013; Ronald C Kessler, Berglund, et al., 2005). As an estimated 50-75% of people report exposure to at least one potentially traumatic event (PTE) in their lives, this equates to approximately 15-25% of those people exposed to PTEs also having had a diagnosis of PTSD (Breslau, 2001). However, it should be noted that approximately half of those who develop PTSD recover within the first 12 months regardless of treatment (R C Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). 12 month prevalence[3] reports are 4.4% - 6.4% in Australia and 3.5% in the United States (R C Kessler, Chiu, Demler, Merikangas, & Walters, 2005; Slade, Johnston, Oakley Browne, Andrews, & Whiteford, 2009). Exposure to certain traumatic events is more likely to result in the development of PTSD than others. Up to 50% of survivors of intentional acts of violence or prolonged/ repeated events go on to develop PTSD, for example survivors of rape or military combat, whereas around 10% of survivors of non-intentional trauma such as natural disasters or accidents go on to develop PTSD (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013; *Diagnostic and statistical manual of mental disorders: DSM-5*, 2013). Rates of PTSD are also higher in certain vocational groups where there is increased risk of traumatic exposure, for example, police, fire fighters and emergency medical personnel (Greenberg et al., 2015). PTSD can affect any person, of any age (*Diagnostic and statistical manual of mental disorders: DSM-5*, 2013). It is more prevalent in females than males, which is thought to be due in part to a greater risk of exposure to traumatic events such as rape (R C Kessler et al., 1995). Women also tend to experience PTSD for a longer duration (R C Kessler, Berglund, et al., 2005).

Typical presentation

There is no one typical presentation of PTSD and an affected individual may not report having experienced a traumatic event at all when they first present to a health professional (Liebschutz et al., 2007). The client with PTSD can present with a wide range of symptoms including "mood disorders, anger, relationship problems, poor sleep, sexual dysfunction or physical health complaints such as headaches, gastrointestinal problems, rheumatic pains and skin disorders" (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013). Appearance can be affected and the individual may appear dishevelled or have poor personal hygiene. Some individuals experience a predominance of fear-based re-experiencing and behavioural symptoms, or arousal and reactive-externalising symptoms, see Criteria B.

This can present as reporting distressing dreams or flashbacks where the person feels like they are re-experiencing the traumatic event and may last from a few seconds to hours or days. They may report sweating and rapid heartbeat at the time of the flashback. Increased arousal may present as poor concentration, irritability and anger, sleep problems and they may demonstrate a heightened startle response, for example jumping to loud noises such as the telephone ringing. Others may present with more prominent avoidance and negative symptoms, see Criteria C and D, such as reporting detachment and estrangement from others and feeling unable to experience love or joy and actively seeking to avoid memories of the traumatic event out of mind, sometimes going to extreme lengths to do this. They may also be prone to engaging in self destructive behaviours such as drug or alcohol use, see Criteria E. A combination of prominent symptoms is also possible.

(ACPMH (Australian Centre for Posttraumatic Mental Health), 2013; *Diagnostic and statistical manual of mental disorders: DSM-5*, 2013).

Impact of diagnosis

PTSD has been shown to be linked to significant impairment in physical health, relationships and employment and an increased risk of suicide (Kramer, Lindy, Green, Grace, & Leonard, 1994).

ONGOING EXPOSURE

It is important to consider the possibility that an individual with PTSD may still be at risk of exposure to traumatic events. For example in domestic violence situations or emergency services personnel (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013).

EMPLOYMENT

Individuals with PTSD can have difficulties maintaining and gaining employment (Savoca & Rosenheck, 2000). Smith, Schnurr, & Rosenheck (2005), found a positive correlation between PTSD symptom severity and probability of unemployment.

IMPACT ON FAMILY

Family members can be significantly affected by the affected individual's PTSD symptoms and can experience significant psychological distress (Monson, Taft, & Fredman, 2009). This can be as a direct result of the PTSD symptoms for example "irritability and anger, withdrawal from family involvement and emotional numbing" or indirectly as a result of the affected individual being unable to cope at work leading to financial difficulties. Clinical practice guidelines recommend that "wherever possible, family members should be included in education and treatment planning, and their own needs for care considered alongside the needs of the person with PTSD" (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013).

PHYSICAL HEALTH

Beristianos et al found that veterans over the age of 55 with a diagnosis of PTSD had a significantly greater risk for vascular disease including congestive heart failure, myocardial infarction and peripheral vascular disease (Beristianos, Yaffe, Cohen, & Byers, 2014).

PSYCHIATRIC/PSYCHOLOGICAL

Individuals with PTSD are 80% more likely to suffer from at least one other mental disorder, for example depression, anxiety, substance use disorders (R C Kessler, Lane, Shahly, & Stang, 2012). PTSD is also associated with an increased risk of suicide (Kramer et al., 1994).

SUBSTANCE USE DISORDERS

PTSD and substance use disorder co morbidity rates have been found to be as high as 25-59% (Brown, Recupero, & Stout, 1995; Najavits, Weiss, & Shaw, 1997; Stewart, Conrod, Samoluk, Pihl, & Dongier, 2000).

Assessment

SCREENING

The first stage in detecting PTSD in clients is screening. By virtue of avoidance being a characteristic feature of PTSD and the social stigma surrounding some traumatic experiences such as sexual assault, many people suffering from PTSD do not mention a traumatic event at all during initial presentations (Liebschutz et al., 2007). Practitioners, including counsellors, should have a low threshold for enquiring about traumatic experiences, particularly with clients who repeatedly present with non-specific health issues, and in populations at higher risk of PTSD such as refugees and asylum seekers, and high-risk occupations such as emergency

services and military personnel (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013).

There are several PTSD screening measures available, and any used should be age and culturally appropriate. One such example is the **Primary Care PTSD Screen (PC-PTSD)**, which asks:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
3. Were constantly on guard, watchful, or easily startled?
4. Felt numb or detached from others, activities, or your surroundings? (Prins et al., 2003)

DIAGNOSIS

Diagnosis of PTSD is made by unstructured clinical interview along with collateral histories; structured clinical interviews[4] and self report inventories. In order to meet the diagnostic criteria of the DSM-5, the individual needs to have a history of being exposed to a traumatic event and have experienced symptoms from each of the diagnostic criteria clusters, that is intrusion, avoidance, negative cognitions and mood, and alterations in arousal and reactivity (*Diagnostic and statistical manual of mental disorders: DSM-5*, 2013; Greenberg et al., 2015). These symptoms need to have been present for at least one month after the traumatic event, must significantly affect day to day functioning and must not be due to a medical condition or substance (i.e. alcohol or medication) (*Diagnostic and statistical manual of mental disorders: DSM-5*, 2013). It should be noted that a diagnosis of PTSD is not the only potential mental health consequence of exposure to trauma. Depression, substance abuse, complicated grief and adjustment and anxiety disorders can occur instead of, or co-exist with, PTSD (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013).

GENERAL ASSESSMENT CONSIDERATIONS

Initial assessment should include a comprehensive history including a trauma history including prior exposure to trauma in addition to the index event.

Note: A detailed history of the index trauma is not necessary in the initial sessions and indeed may be counter-therapeutic. (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013)

Attention should be paid to:

- Current and past psychosocial functioning, including prior mental health problems
- The presence and course of PTSD symptoms
- Co-morbid problems such as substance use
- Quality of life indicators such as health status, marital and family situation, occupational, legal and financial status
- Social support networks, resilience and pre-trauma coping strategies
- The potential for transgenerational effects of trauma such as in children of veterans or holocaust survivors
- Collateral history (with the client's permission)
- Assessment of risk of self-harm, harm to others and suicide
- Assessment and monitoring should be revisited multiple times throughout the treatment process

(ACPMH (Australian Centre for Posttraumatic Mental Health), 2013)

SPECIAL CONSIDERATION – SYMPTOM EXAGGERATION AND MALINGERING.

By virtue of its traumatic cause, PTSD is often the subject of legal action, for example following violent crime, sexual abuse or motor vehicle accidents. Where there is the potential for financial gain through compensation, benefit eligibility or other secondary gains such as in the occupational setting, the counsellor should be aware of the possibility of symptom exaggeration and malingering. Suspicions should be raised for a client reporting a high severity rating for every component of the DSM-5 Diagnostic Criteria. Care should be taken, however, to maintain an empathic approach (ACPMH, 2013).

Treatment of PTSD

There is a large range of psychological and pharmacological interventions available for the treatment of PTSD. For example: trauma-focussed cognitive behavioural therapy (TF-CBT), eye movement desensitisation and reprocessing (EMDR), brief psychodynamic psychotherapy, hypnosis, interpersonal therapy, narrative exposure therapy and emotion freedom techniques (EFT) (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013).

For many, there is insufficient evidence to make a strong practice recommendation, for others, the evidence available suggests that the treatment is ineffective or may in fact be detrimental. This review will focus on two psychological interventions for adults with PTSD with a strong evidence base: trauma-focussed cognitive behavioural therapy (TF-CBT) and eye movement desensitisation and reprocessing (EMDR). Interventions for children and adolescents and pharmacological interventions have been excluded from this review.

The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder recommend that

> "Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing" (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013).

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– This is a Grade A Recommendation[5].

It should be noted that regardless of treatment modality offered, the client should be provided with information prior to the start of treatment and there should be ongoing monitoring and management of side effects and suicide risk.

TRAUMA-FOCUSSED COGNITIVE BEHAVIOURAL THERAPY (TF-CBT)

This involves psychoeducation, anxiety management and relapse prevention along with the two core interventions of TF-CBT: Exposure therapy and cognitive restructuring.

- **Exposure therapy –** as used in the treatment of anxiety disorders helps the client confront the focus of their anxieties. In PTSD this involves graded exposure of confronting the memory of the trauma in a controlled and safe environment. It may also involve confronting the avoided locations, situations and activities. This is referred to as "in vivo" exposure. Through habituation, that is by keeping the individual in contact with the anxiety-provoking stimulus for long enough, the anxiety symptoms will abate (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013; Foa & Rothbaum, 1998).
- **Cognitive restructuring –** This is used to help the client identify biased or distorted thoughts and memories of the traumatic experience and then challenge and modify them. It also helps the individual to identify, challenge and modify distorted or maladaptive beliefs about themselves and the world around them (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013; Foa & Rothbaum, 1998).

EYE MOVEMENT DESENSITISATION AND REPROCESSING (EMDR)

EMDR was developed by Dr Francine Shapiro in 1989. EMDR asks the client to focus on thoughts, physical sensations, emotions and negative imagery surrounding the traumatic experience, whilst following the therapist's hand movements for 20-30 seconds or more, thus resulting in the individual making repeated back and forth eye movements. The therapy now consists of eight sessions of treatment incorporating components comparable to CBT such as cognitive therapy, imaginal templating where coping responses to anticipated stressors are rehearsed and in vivo exposure (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013). Its mechanism of action is unclear although several possible theories have been postulated. One such theory being that EMDR, by having the client focus on two tasks at once, causes a disruption of the memory image in the working memory. This then may enable the individual to obtain a psychological sense of distance from the traumatic experience. This may result in memory reprocessing producing psychophysiological changes such as decreased heart rate and skin conductance. The reprocessing and physiological chances may work together to reduce PTSD symptomatology (Gunter & Bodner, 2009). More research is required as to the mechanism of action. However, evidence from trials suggests that it is an effective method of treating PTSD.

The evidence for TF-CBT and EMDR for adults with PTSD

- "The most researched form of therapy for adults with PTSD is trauma-focussed therapy" (ACPMH, 2013). There are several variants on trauma-focussed therapy including: prolonged exposure, cognitive processing therapy, cognitive therapy, narrative exposure therapy and eye movement desensitisation and reprocessing. More trials have been conducted on cognitive-behavioural trauma-focussed therapy (TF-CBT) than any other trauma-focussed therapy.
- Multiple trials have shown that: "trauma-focussed therapy results in greater reduction in PTSD symptoms than supportive counselling" (See ACPMH, 2013 for details on studies).
- EMDR has been shown to be effective in reducing PTSD symptoms versus waitlist (6 studies) and nondirective counselling (9 studies). (See ACPMH (Australian Centre for Posttraumatic Mental Health), 2013).
- Six studies comparing EMDR to TF-CBT have found their results to be not statistically significant (Ironson, Freund, Strauss, & Williams, 2002; Johnson & Lubin, 2006; Power et al., 2002; Rothbaum, Astin, & Marsteller, 2005; Taylor et al., 2003; Vaughan et al., 1994 via ACPMH (Australian Centre for Posttraumatic Mental Health), 2013).
- Three trials have studied Internet delivered TF-CBT (Knaevelsrud,

C., & Maercker, 2007; Lange et al., 2003; Spence et al., 2011). Initial results show some benefit in internet-delivered TF-CBT reducing PTSD symptoms and it may be offered if the alternative is no intervention (Grade C) (ACPMH, 2013).

CLINICAL PRACTICE GUIDELINE NOTES:

- **Early psychological interventions for adults exposed to potentially traumatic events** such as psychological debriefing, should not be offered for all adults exposed to a potentially traumatic event (ACPMH, 2013). Limited research has shown no benefit to offering group debriefing sessions and it may be that those who receive debriefing are at increased risk of PTSD diagnosis (Van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002).
- **Interventions for Acute Stress Disorder and acute PTSD.** Practice guidelines offer Grade C level evidence suggesting that TF-CBT is beneficial in reducing subsequent PTSD symptoms in people who are presenting with ASD or acute PTSD symptoms within the first four weeks of trauma exposure (ACPMH, 2013).
- **Pharmacological interventions.** For adults with PTSD, TF-CBT or EMDR should be used as a first line treatment rather than pharmacotherapy (Grade B). When considered, selective serotonin reuptake inhibitors (SSRIs) are suggested first choice medication (Grade C) (ACPMH, 2013).

Note: The many and varied possibilities for potentially traumatic events, for example motor vehicle accidents, sexual assault and terrorism; and affected populations, for example Aboriginal and Torres Strait Islander peoples, military, refugees, children and older people, each bring with them their own particular challenges and requirements. Detailed information pertaining to specific situations and populations is beyond the scope of this review. Care should be taken to seek further information on a case-by-case basis as to how best adapt practice guidelines.

END NOTES

1. Acute Stress Disorder (ASD) is defined as the development of characteristic symptoms (similar to those of PTSD), lasting from 3 days to 1 month following exposure to a PTE. See DSM-5 for full diagnostic criteria (*Diagnostic and statistical manual of mental disorders: DSM-5*, 2013)
2. Lifetime prevalence – "percentage of the population who have had PTSD at some time in their lives"(ACPMH (Australian Centre for Posttraumatic Mental Health), 2013)
3. 12 month prevalence – "percentage of the population who have had PTSD in the past year" (ACPMH (Australian Centre for Posttraumatic Mental Health), 2013)
4. For example the PTSD Symptom Scale Interview PSS-I (Foa, Riggs, Dancu, & Rothbaum, 1993) Full manual available at: http://www.istss.org/assessing-trauma/posttraumatic-symptom-scale-interview-version.aspx
5. NHMRC grades of recommendation – a guide to indicate the strength of the recommendation in the clinical practice guideline (NHMRC, 2009)

Grade A – Body of evidence can be trusted to guide practice

Grade B – Body of evidence can be trusted to guide practice in most situations

Grade C – Body of evidence provides some support for recommendation(s) but care should be taken in its application

Grade D – Body of evidence is weak and recommendation(s) must be applied with caution

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Australians are spending more on mental health services and employers need to take notice

By Allan Fels

There are definite costs of mental illness in the workplace but the return on investment in a mentally healthy workplace can be a big boost to the bottom line.

New data released by the Australian Institute of Health and Welfare (AIHW) shows that Australians spent an estimated A$8 billion on mental health related services in 2013-14. The direct financial impact on Australian business is in the vicinity of $11 billion every year, largely due to absenteeism ($4.7 billion) and reduced productivity ($6.1 billion) from unwell workers still attempting to work.

All this shows that mental health is more than a social issue. It should also be right at the top when we are thinking about which factors influence productivity and prosperity.

At the launch of the government's response to the National Mental Health Commission in November last year, Prime Minister Malcolm Turnbull said:

"Mental illness gnaws away at participation, it gnaws away at productivity."

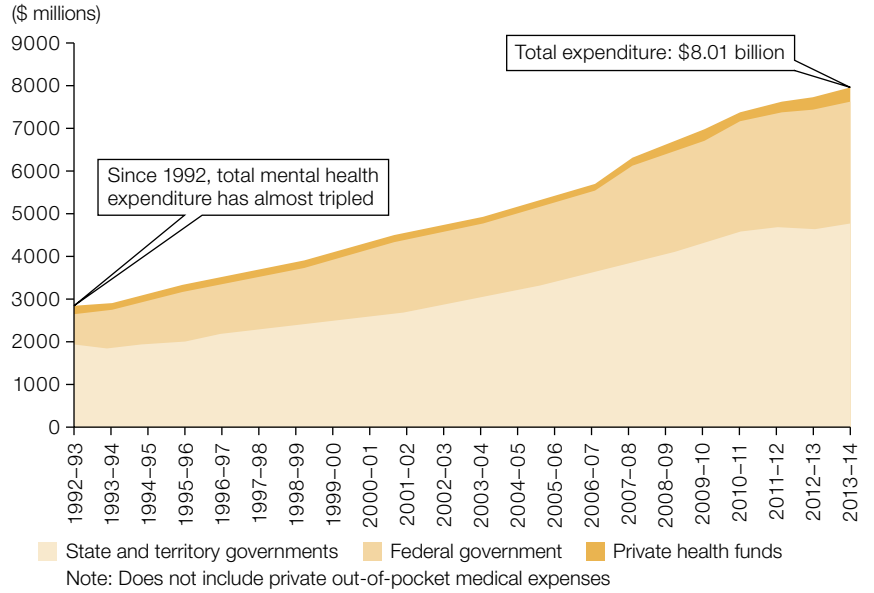
Federal and State Government spending on mental health services has steadily increased over time although what's not known is how much employees are spending out of their own pockets.

In recent years, the big implications mental ill-health has on economic productivity and production have become clearer. Of the 3.7 million Australians who have mental health problems in any year, some 3 million have a mild to moderate condition. Many of these are in paid work but they are not there as often as they should be, or contributing as much as they would like when they are there.

A 2014 report from Pricewaterhouse-Coopers (PwC) found mental health conditions result in around 12 million days of reduced productivity for business in this country each year. And, given one in six people in employment experience a mental health issue every year, those millions of days are being lost across the economy; in every sector and among organisations of all sizes. This is not just an issue for the big end of town.

A 2012 OECD report also sought to quantify the productivity losses caused by mental ill health. It found workers with a mental disorder are absent for work for health reasons more often than other workers (32% versus 19%), and they are away for longer (six days versus 4.8). The report also concluded that 74% of workers with a mental disorder reported reduced productivity while they were at work in the previous four weeks, compared to 26% of workers without a mental disorder.

Expenditure on mental health related services



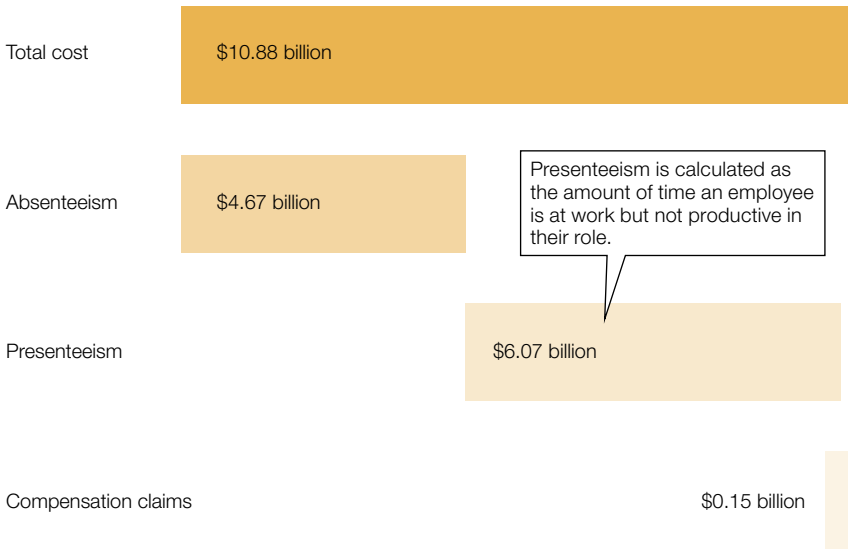
Note: Does not include private out-of-pocket medical expenses

SOURCE: AIHW, AUSTRALIAN GOVERNMENT

Alans Fels, Professorial Fellow, University of Melbourne

Federal and State Government spending on mental health services has steadily increased over time although what's not known is how much employees are spending out of their own pockets.

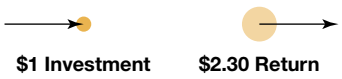
Productivity losses due to mental health (per year)



SOURCE: beyondblue, PwC

Return on investment for mental health workplace initiatives

On average, the return on investment (ROI) ratio for successful mental health initiatives in the workplace is 2.3 – $2.30 returned for every single dollar invested.



$1 Investment **$2.30 Return**

However, the ROI is different depending on the size and type of industry.

Small organisations have a high opportunity for return on investment. For instance, small companies in the mining industry receive a $15 return in productivity for every $1 successfully invested.

$1 Investment **$15 Return**

Small organisations in the utilities, information services, media and telecommunication industries all also have high ROIs.

Medium-sized organisations in the utilities, public administration and safety and waste service industries also see a significant positive ROI.

Large organisations, however, commonly have a lower ROI than smaller organisations and may need to invest at a team level.

SOURCE: beyondblue, PwC

IMAGE: 123RF.COM

So what can business do to reduce those losses? Plenty.

A few years ago the National Mental Health Commission joined with the business sector, the mental health sector and the government to form the Mentally Healthy Workplace Alliance. It commissioned a study that combed peer-reviewed literature to find what workplaces can do in relation to stress, mental strain, psychological health and wellbeing. That report, Creating Mentally Healthy Workplaces, concluded there were six key areas and strategies for business to explore.

Many of the report's recommendations are common sense measures. Things like smarter work design and positive work cultures, for example, were found to be key to preventing mental health problems. Similarly, promoting resilience and early intervention can help reduce the impact of mental ill health, and promote recovery.

In 2014, the Alliance teamed up with beyondblue to launch Heads Up, a national campaign for mentally healthy workplaces. The response of businesses that have signed up has been encouraging. They report lower turnover rates, less time off due to stress related injuries and find staff are managing their own mental health "up front".

All of this makes good business sense. In fact, the PwC research suggests the average return on every dollar invested in improving mental health yields a $2.30 return. It also compared the return on investments in mental health for small, medium and large organisations.

Across the country, our awareness of the importance of mental health is gradually improving. People are taking stock. A Heads Up survey of 1000 Australian workers found workers will leave jobs they judge to be mentally unhealthy.

So the evidence is in and smart employers are taking action. It makes sense on so many fronts. If we enable people to live contributing lives – to lead the type of fulfilled lives we all seek in

terms of relationships, family and jobs – we can lift national productivity and make our country a kinder, better place to live.

One word of caution however. Creating a mentally healthy workplace is not a set-and-forget type action. It takes ongoing care and attention. And, like all key areas of organisational culture, change has to come from the top.

DISCLOSURE STATEMENT

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PEER REVIEWED ARTICLE

Using Trauma-Focused Cognitive Behavioural Therapy to Treat Children with Posttraumatic Stress Disorder Symptoms: A Critical Review

By Tara Hamilton

Children exposed to a traumatic event can experience posttraumatic stress disorder (PTSD) symptoms (Stallard, 2006). The National Institute for Clinical Excellence (NICE) investigated children visiting the emergency department after a traumatic injury and found thirty percent displayed symptoms of PTSD (2005). PTSD in children is a serious condition and can be both chronic and encumbering (Dowd & McGuire, 2011). Moreover, the capacity of parents to manage their child's trauma is a key factor influencing the development and treatment outcome.

There are a large number of randomised controlled trials assessing psychological interventions for traumatised children and adolescents. Randomised trials of anxiety management training and eye movement desensitisation (EMDR) (Dowd & McGuire, 2011) have been documented, however the intervention that has attracted considerable interest and is perhaps the most widely disseminated is trauma-focused cognitive behavioural therapy or TF-CBT (Cary & McMillen, 2012; Cohen, Mannarino & Deblinger, 2006; Stallard, 2006).

PHOTO: 123RF.COM

The TF-CBT model was developed by Cohen, Mannarino and Deblinger (2006) and is designed to assist children, adolescents and their parents after experiencing trauma. Reviews of the child sexual abuse treatment outcome literature demonstrates that TF-CBT has the most rigorous empirical support in effectively treating children with PTSD. Consequently, TF-CBT is now being applied to children and parents suffering a variety of traumatic experiences including traumatic grief and exposure to domestic violence. TF-CBT addresses the needs of the child by incorporating trauma-sensitive interventions and cognitive behavioural aspects as well as components of attachment, neurobiology, family, empowerment and humanistic theories. TF-CBT is designed to target PTSD symptoms and reactions, depression and anxiety. In addition, it can help resolve behavioural problems, however not in children struggling with preexisting behavioural delays.

There are six principal values of TF-CBT that are essential for the intervention to work effectively (Cohen, Mannarino & Deblinger, 2006). The six values form the acronym '**C.R.A.F.T.S**':

- *Components-based treatment refers to building central skills that is provided in a way that best suits the individual child and family,*
- *Respect of the individual, family, religious, community and cultural values,*
- *Adaptable and flexible in applying the principal aspects of the treatment to the individual,*

- *Family involvement is a fundamental component of the individual's treatment including improving the relationship between parent and child,*
- *Therapeutic relationships assists in restoring trust, optimism and self-esteem in traumatised individuals and their parents, and*
- *Self-efficacy, a long-term goal, enables the individual to regulate their affect, behaviour and cognitions through providing life skills and enhancing individual strengths.*

Trauma-focussed CBT involves sequential 90-minute weekly sessions with the child and parent paced according to the clinician's expertise (Cary & McMillen, 2012). The intervention involves eight components that comprise the acronym, '**P.R.A.C.T.I.C.E**':

- *Psychoeducation* and parenting skills,\
- *Relaxation*,
- *Affect*-regulation,
- *Cognitive* coping,
- *Trauma* narrative development and processing,
- *In vivo* gradual exposure,
- *Conjoint* sessions and
- *Enhancing* long-term development.

Before the TF-CBT model was developed, earlier cognitive behavioural approaches were implemented to treat children of sexual abuse including structured parent counselling-child psychotherapy (SPC-CP), cognitive-behavioural therapy adapted for sexually abuse pre-school children (CBT-SAP) and sexual abuse-specific cognitive behavioural therapy (SAS-CBT) (Cary & McMillen, 2012). The earliest intervention (SPC-CP) by Cohen and Mannarino (1993) focused on exploring the impact of abuse on the family, developing a sense of self-efficacy in the abused individual and providing an understanding of how the abuse impacted on the individual's behaviours and relationships. In their subsequent interventions (CBT-SAP), the treatment was based around cognitive restructuring and included psychoeducation and family involvement (Cohen & Mannarino, 1996a, 1996b, 1997). In their later approach (SAS-CBT), the cognitive component remained a principal component with the addition of stress management (Cohen & Mannarino, 2008). In these earlier stages, although abuse was discussed, the intervention did not include structured formalised exposure. The later inclusion of gradual exposure techniques including in vivo was a result of Deblinger and Heflin's (1996) earlier work in their cognitive behavioural treatment manual. Deblinger also focused on the role of the parent (Cary & McMillen, 2012). In 1997, Cohen, and colleagues joined together to brand the TF-CBT version as it is known today and began treating traumatised youth.

The eight components of TF-CBT are implemented over 12 to 16 sessions (Grasso, Marquez, Joselow & Webb, 2011). The first three components focus on providing psycho-education about trauma, posttraumatic stress and treatment in addition to teaching skills including relaxation, emotion identification, regulation and cognitive coping strategies. Both child and parent also commence gradual exposure to the trauma. In subsequent sessions, the trauma is largely focused on the individual's personal experience. In the second phase of treatment, the child develops a trauma narrative that will expose them to the trauma to assist with emotional and cognitive processing. During this stage, the parent will meet separately with the therapist until the trauma narrative is completed. If the child feels comfortable, they will share their trauma narrative with the parent at a later session. In the final phase, safety skills and long-term development is focused on.

Using TF-CBT to treat traumatised children is one of two treatments recommended by The National Institute for Health and Care Excellence (NICE) (2005) and the only program recommended by the American Centre for Child Protection (Chadwick Centre for Children and Families, 2004). Moreover, it is the treatment rated the most efficacious by the Child Physical and Sexual Abuse:

Table 1. Studies Included in Review

Author	Title	Year of Publication
Cary & McMillen	The data behind the dissemination: A systematic review of trauma-focused cognitive behavioral therapy for use with children and youth.	2012
Cohen, Mannarino & Iyengar	Community treatment of posttraumatic stress disorder for children exposed to intimate partner violence.	2011
Cohen, Mannarino & Knudsen	Treating sexually abused children: 1 year follow-up of a randomized controlled trial.	2005
Cohen, Mannarino, Perel & Staron	A Pilot Randomized Controlled Trial of Combined Trauma-Focused CBT and Sertraline for Childhood PTSD Symptoms.	2007
Deblinger, Mannarino, Cohen, Runyon & Steer	Trauma-focused cognitive behavioral therapy for children: Impact of the trauma narrative and treatment length.	2011
Diehle, Opmeer, Boer, Mannarino & Lindauer	Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: what works in children with posttraumatic stress symptoms? A randomized controlled trial.	2014
Dowd & McGuire	Psychological treatment of PTSD in children: An evidence-based review.	2011
Leenarts, Diehle, Doreleijers, Jansma & Lindauer	Evidence-based treatments for children with trauma-related psychopathology as a result of childhood maltreatment: A systematic review.	2013
Mannarino, Cohen, Deblinger, Runyon & Steer	Trauma-Focused Cognitive-Behavioral Therapy for Children Sustained Impact of Treatment 6 and 12 Months Later.	2012
Nixon, Sterk & Pearce	A randomized trial of cognitive behavior therapy and cognitive therapy for children with posttraumatic stress disorder following single-incident trauma.	2012
O'Callaghan, McMullen, Shannon, Rafferty & Black	A randomized controlled trial of trauma-focused cognitive behavioral therapy for sexually exploited,	2013
Scheeringa, Weems, Cohen, Amaya-Jackson & Guthrie	Trauma-focused cognitive-behavioral therapy for posttraumatic stress disorder in three- through six year-old children: A randomized clinical trial.	2011
Smith, Yule, Perrin, Tranah, Dagleish & Clark	Cognitive-Behavioral Therapy for PTSD in Children and Adolescents: A Preliminary Randomized Controlled Trial.	2007

Guidelines for Treatment (Saunder, Berliner & Hanson, 2004). In a review by Dowd and McGuire , the efficacy of TF-CBT for treating PTSD in sexually abused children was demonstrated in five RCTs (2011).

Search strategy

For the following review, a hand search of electronic databases using PsycINFO, The Cochrane Library and Summon on the UQ library page were undertaken to source the highest levels of evidence (NHRMC, 2009). Thus, only randomised controlled trials, systematic reviews and meta-analyses that were published within the last ten years (2004-2014) were considered. References and cited material were also examined. The search used variations of the following terms: TF-CBT, PTSD, CBT, CHILD*, TREAT*, RCT and SYSTEMATIC REVIEW. The hand search yielded 13 studies including ten RCTs, and three systematic reviews. The studies included in this review can be found summarised in Table 1.

The studies were located from a variety of Journals including The Irish Journal of Psychology, Child Abuse and Neglect, Archives of Pediatrics and Adolescent Medicine, American Academy of Child and Adolescent Psychiatry Depression and Anxiety, European Child and Adolescent Psychiatry, Child Maltreatment, Journal of Abnormal Child Psychology, Journal of Child Psychology and Psychiatry, British Journal of Psychiatry and Children and Youth Services Review. The studies also included a wide diversity of ethnicities including Caucasian, African American, Asian British, Hispanic, Congolese and European. The age of youth reviewed ranged from three to nineteen. Only two RCTs that included very young children were located as there is insufficient research for TF-CBT treating this population.

Methodological limitations

All RCTs and reviews demonstrate that TF-CBT is effective in achieving and maintaining a reduction of PTSD symptoms in children and adolescents compared to either an alternative treatment or no treatment. However, there are a number of methodological limitations that need to be highlighted that could restrict its use in clinical practice.

First, all of the participants from the RCTs were selected from convenience samples including referrals from professionals (Cohen, Mannarino & Knudsen, 2005; Cohen, Mannarino, Perel & Staron, 2007; Deblinger, Mannarino, Cohen, Runyon & Steer, 2011; Nixon, Sterk & Pearce, 2012; O'Callaghan, McMullen, Shannon, Rafferty & Black, 2013) and specialist centers (Cohen, Mannarino & Iyengar, 2011; Diehle, Opmeer, Boer, Mannarino & Lindauer, 2014; Scheeringa, Wems, Cohen, Amaya-Jackson & Guthrie, 2011; Smith, Yule, Perrin, Tranah, Dagleish & Clark, 2007). The studies excluded participants if they were not fluent in their native language (Cohen et al., 2011; Cohen et al., 2007; Diehle et al., 2014; Nixon et al., 2012), the parent or child had a significant mental (e.g., psychosis) or medical illness (Cohen et al., 2011; Cohen et al., 2005; Cohen et al., 2007; Deblinger et al., 2011; Scheeringa et al., 2011), had a history or current substance abuse problems (Cohen et al., 2005), had a significant development disability (IQ <80) (Cohen et al., 2011; Cohen et al., 2005; Deblinger et al., 2011; Nixon et al., 2012; O'Callaghan et al., 2013; Scheeringa et al., 2011; Smith et al., 2007), were taking psychotropic medications (Smith et al., 2007), had a head injury as a result of the trauma (Nixon et al., 2012; Scheeringa et al., 2011; Smith et al., 2007), experienced sexual assault or chronic trauma (e.g., child abuse; Nixon et al., 2012), had severe emotional and behavioural problems (O'Callaghan et al., 2013), were experiencing ongoing trauma-related threat (Smith et al., 2007), or were at risk of suicidality (Diehle et al., 2014). Moreover, a few of the studies excluded participants if their primary carer did not consent or was unavailable to participate (Cohen et al., 2011; Cohen et al., 2005; Cohen et al., 2007).

As a result of the strict exclusionary criteria employed by many of the treatments, the groups were not a heterogeneous sample of traumatised children and adolescents who may be experiencing symptoms of PTSD. Furthermore, excluding participants reduces the external validity of the results (O'Callaghan et al., 2013). Thus, future studies should broaden the criteria to be maximally inclusive of individuals who have co-morbid conditions, emotional or behavioural problems, are experiencing ongoing trauma and threats or are foreign-speaking.

Second, very little is known concerning the effectiveness of TF-CBT for very young children with only a small number of controlled trials limited to victims of sexual abuse (Scheeringa et al., 2011; Stallard, 2006). This review located only two RCTs with very young children; one aged three to six who had experienced a life-threatening traumatic event (Scheeringa et al., 2011) and the other four to eleven who had experienced sexual abuse (Deblinger et al., 2011). In the first study, the group that received treatment improved significantly more than the wait-list group in reducing PTSD symptoms. The children were able to comprehend and complete the tasks 80 to 90 percent of the time, providing evidence for the efficacy of TF-CBT for young children. However, because an unusually high attrition rate occurred in this study, it is unknown whether TF-CBT was effective for treating trauma other than sexual abuse.

In the second study by Deblinger and colleagues, a few of the outcome measures could not be administered to some children due to cognitive and developmental limitations (2011). Moreover, the main PTSD outcome measure, Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL), may not have accurately measured treatment effects. Thus, due to the limited evidence of traumatic events other than sexual abuse and the lack of age-appropriate measures, the applicability of TF-CBT in this population remains tentative.

A third limitation was that the time since the traumatic event occurred for participants was either not mentioned (Cohen et al., 2007; Deblinger et al., 2011; Diehle et al., 2014; Nixon et al., 2012; Smith et al., 2007), appeared quite vague (e.g., 'within the last 6 months'; Cohen et al., 2005) or the children were experiencing multiple trauma during treatment (Cohen et al., 2011). Moreover, in one study, participants did not necessarily need to personally experience a trauma to be eligible for the treatment (O'Callaghan et al., 2013). Therefore, it is uncertain if any of the traumatic events had occurred as recent as in the last month or two and whether the children were experiencing acute or chronic PTSD symptoms. Consequently, due to the limited empirical evidence of recently traumatised children, the efficacy of early TF-CBT for children with acute and chronic PTSD symptoms is still largely undetermined.

Fourth, the majority of RCTs have largely concentrated on sexually abused children who are more likely to have experienced repeated traumas (Stallard, 2006). Many of the studies in this review have also focused on this group (Cohen et al., 2011; Cohen et al., 2005; Cohen

et al., 2007; Deblinger et al., 2011; O'Callaghan et al., 2013). Child abuse is purposeful and usually accompanied by violence or threats of violence (Stallard, 2006). Moreover, sexual abuse generally occurs in environments where parental conflict, parental mental illness and poor relationships exist. In comparison, children who have experienced one traumatic event such as a motor-vehicle accident are generally exposed to the trauma to a lesser degree and for a shorter length, with minimal disruption to family life than victims of sexual abuse. Thus, it is necessary to establish whether TF-CBT is suitable for treating traumas other than sexual abuse, or whether they require abuse-specific treatments.

Moreover, almost all of the studies in this review had insufficient numbers, limiting the statistical power to detect for clinical significance. The majority of the RCTs in this review had either high attrition rates (Cohen et al., 2011; Cohen et al., 2005; Diehle et al., 2014; Scheeringa et al., 2011) limiting the internal validity (Cohen et al., 2011) or limited sample or cell sizes (Cohen et al., 2007; Deblinger et al., 2011; Mannarino, Cohen, Deblinger, Runyon & Steer, 2012; Nixon et al., 2012; O'Callaghan et al., 2013; Scheeringa et al., 2011; Smith et al., 2007) limiting the external validity of the study (O'Callaghan et al., 2013). Smith and colleagues (2007), estimated that based on a natural recovery rate of 60 percent in the treatment group and 15 percent in the wait-list group, 14 children in each group would provide 80 percent power to detect a significant difference at $p < .05$ (Smith et al., 2007). Thus, larger sample sizes are essential to detect clinical significance between treatment groups.

Besides the two follow-up studies (Cohen et al., 2005; Mannarino et al., 2012), and three others that included a six-month follow-up, few studies have included follow-up assessments of 12 months or longer (Stallard, 2006). In the RCTs that did include long-term assessment, results showed that treatment gains were sustained. However, without longer-term data, conclusions cannot be made regarding the effects of TF-CBT after 12 months (Diehle et al., 2014).

Another limitation existed between several studies, with inconsistencies in the outcome measures used and those assessed (Stallard, 2006). Specifically, the assessment of very young children poses particular challenges in terms of their cognitive and developmental limitations (Deblinger et al., 2011; Mannarino et al., 2012; Scheeringa et al., 2007). As a result, some of the outcome measures could not be administered to all participants, limiting the statistical power of analyses (Deblinger et al., 2011). For example, the PTSD measure, Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime Version (K-SADS-PL), may not have been sensitive enough to detect subtle treatment effects (Deblinger et al., 2011; Mannarino et al., 2012). Thus, future research should address the lack of self-report measures for this population (Mannarino et al., 2012). Moreover, only using self-report measures (as found in O'Callaghan et al., 2013) limits the external validity of the study, as participants are prone to response bias (Stallard, 2006). a Future studies can employ triangulation such as including parent or teacher measures to improve the external validity.

In only three of the RCTS (O'Callaghan et al., 2013; Scheeringa et al., 2011; Smith et al., 2007), a wait-list condition was employed as the control group. Evidence suggests that natural remission of PTSD symptoms in children can occur and thus using a wait-list group acts as a good control (Nixon et al., 2012). Future studies could include an additional no-treatment control group to assess whether differences are more clinically significant than the other treatment control.

Finally, the majority of the studies did not assess the efficacy of parental involvement on the child's outcome to treatment. In fact, only one study examined how maternal adjustment affected the child's adjustment to treatment (Nixon et al., 2012). As family involvement in TF-CBT is one of the principal components, future studies could measure the parents' depressive and anxiety symptoms and examine how they relate to the child's adjustment to therapy (Cohen et al., 2006).

Clinical implications

The studies included in this review demonstrate several areas of research necessary to be undertaken to inform clinical practice. First, the large attrition rates (Cohen et al., 2011; Cohen et al., 2005; Diehle et al., 2014; Scheeringa et al., 2011) due to ongoing sexual behaviours (Cohen et al., 2005) and exposure to ongoing violence (Cohen et al., 2011) needs to be addressed. In these instances, factors that relate to attrition should be studied and procedures should be investigated for children and their families to remain in treatment.

Second, the findings of the study with children aged four to eleven who had experienced contact sexual abuse (Deblinger et al., 2011; Mannarino et al., 2012) may only be generalised to children who have experienced that type of trauma. The other study of very young children who had experienced a life-threatening traumatic event was limited by high attrition rates (Scheeringa et al., 2011). Scheeringa and colleagues suggested that attrition rates are much higher in very young children as their externalising behaviours are less severe and their internalising behaviours are less verbalized than older children, consequently their parents may be less motivated to continue treatment as the problem appears to be less prominent (2011). Thus, it still remains tentative whether TF-CBT is the most appropriate treatment for very young children with a range of traumas. Future studies are necessary in assessing the efficacy of TF-CBT for treating very young children (Mannarino et al., 2012).

Third, there is an absence of age-appropriate outcome measures for PTSD, depression and anxiety for very young children due to cognitive and developmental limitations (Deblinger et al., 2011). This again poses a problem for clinicians when working with this population. Thus, further research is required to develop self-report measures for this cohort.

Fourth, the majority of the studies included strict exclusionary criteria and thus did not allow for a heterogeneous sample of children. However, in a real-life settings, clinicians will be treating children with varying degrees of traumas, from culturally diverse backgrounds, different home settings including foster and residential care and varying levels of caregiver support (Diehle et al., 2014; Mannarino et al., 2012; O'Callaghan et al., 2013). Thus, the replication of TF-CBT in regular clinical practice is necessary to test

the generalisability of the findings (Smith et al., 2007).

Finally, the involvement of the family is a principal component of TF-CBT (Cohen et al., 2006). Nixon and colleagues (2012) emphasised the immense impact maternal depression and unhelpful thinking has on the child's progress in therapy. Thus, in clinical practice, maternal adjustment to TF-CBT should be assessed. Future research could consider holding a separate treatment targeted for maternal adjustment during the course of the child's treatment. Leenarts and colleagues' review also highlights the involvement of parents, however since research is contradictory on whether the parents involvement is required for therapy success, further investigation into the family involvement is necessitated (2013).

In conclusion, despite the methodological limitations and implications for clinical practice, TF-CBT has strong evidence supporting its efficacy in treating traumatised children and adolescents. Thus, based on the evidence provided in this review, TF-CBT should be the treatment of choice for traumatised children and adolescents. Based on the findings of this critical review, future research can work towards the following: recruitment of a more heterogeneous sample including recently traumatised children and children who have experienced a trauma other than sexual abuse; reducing attrition rates; conducting longitudinal studies; improving outcome measures for very young children; developing a tailored treatment or finding an alternative to effectively treat younger children; including a wait-list control and assessing parental involvement during treatment.

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JUNE 2016 MICHAEL D. YAPKO, PH.D.

Strategic Brief Interventions: Identifying and Hitting Meaningful Targets

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The value of being heard is incalculable. But, therapists can do more than just listen empathetically, valuable as that is. Therapists can quickly identify specific targets for meaningful intervention and, even in a single session, can do much to help move this person's life in a better direction. In this two day workshop, we'll explore the kinds of subjective patterns of self-organization that typically give rise to these common problem themes, and how these can be targeted for sensible interventions that can yield long term improvement. This practical training will focus on the use of experiential methods such as hypnosis and mindfulness and the use of strategic tasks and skill-building exercises.

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PEER REVIEWED ARTICLE

Deconstructing the Criminal Defence of Insanity

By Gary Lilienthal

PHOTO: 123RF.COM

Abstract

The significance of this article is in its deconstruction of the criminal insanity defence in a meta-legal critical context. The article's objective is to critically review beliefs that the insanity defence was designed solely for public protection from insane violent people, or, for criminal deterrence. In this way, the key psychotherapeutic issues can be identified or inferred. Arising from the long and continued use of the Roman Law concept of *non compos mentis*, the question arises as to what has become of the practical meaning of the term "insanity", when used as a defence.

The article tries to show that the defence of insanity is a public act of judicial denunciation against the accused, while the accused may have no effective responsibility for the crime. Argument begins with a critical discussion on the character of common-place denunciation as an appeal to public agreement. Then, it follows how the idea of "manifest criminality", of the 1800s, might be cognate to modern ideas of "manifest madness", linking into the origins of the English special verdict of insanity.

This will allow a short critical analysis of the M'Naghten Case. Argument is completed with analysis of a psychologists' expert construct of insanity and its relationship to jury perception. The article will suggest strongly that arguments based on the common law rules of insanity tend to expose juries more to denunciation of the accused, than to a reasoned account of the nature of his insanity and to the defects in his responsibility. Duly persuaded jurors would tend to acquiesce and participate in the denunciation of an accused person, whose unusual and unhealthy behaviours emanated from his sufferings by dint of his unbearable circumstances.

KEYWORDS:
criminal insanity defence, public protection, criminal deterrence, *non compos mentis*, judicial denunciation, common-place, delusion.

Introduction

The significance of this article is in its deconstruction of the criminal insanity defence in a meta-legal critical context, so that the reader might better understand the underlying purpose of the defence as an instrument of governance. The article's objective is to critically review ideas that the insanity defence was designed solely for public protection from insane violence, or, for deterrence. In the old Roman law, insanity came under the term non compos mentis. This technical term's meaning subsists to this day. Sir Edward Coke provided the following classification of non compos mentis.

> (a) *Idiota* which from his nativity by a perpetual infirmity, is *non compos mentis*;
> (b) He that by sickness, grief, or other accident, wholly loseth his memory and understanding;
> (c) A lunatick that hath sometime his understanding, and sometime not. Aliquando gaudet lucidis intervallis, and therefore he is called *non compos mentis*, so long as he has not understanding.
> (d) Lastly, he that by his own vicious act for a time depriveth himself of his memory and understanding, as he that is drunken. (Co. Litt., 246b)

Coke's formula appeared to base insanity on the person's capacity for understanding, a concept intimately related to a capacity to reason, and manifested in apparently disconnected actions. Mills asserted that unconscious phantasy is embedded necessarily within reason, such that unconscious values always intervene to determine the outcome of any act of thinking, especially conscious fantasy. (Mills, p. 11)

Therefore, both full and partial delusion, in its ordinary meaning, may be considered a determinative part of all people's thinking. Yet, people through the ages have never settled on a singular name denoting a definition of insanity. It is as if insanity is a bundle of adverse public perceptions, evidenced by the public's general dislike of an acquittal on the basis of insanity. (Moran, 1981) At the same time, the learned appear to have reasoned a cogent meaning for the nature of insanity as *non compos mentis*, in the form of various legal maxims. However, they appear to have kept their reasoning largely out of the domain of public debate by failing to synthesise these maxims into a cogent statement.

To illustrate how this could be done, consider first that Noy defined accepted custom as a second law, which could be either of the following two kinds. The first was general customs, in use throughout the realm, called maxims. The second was particular customs used in some certain county, city, town or lordship. He added that every legal maxim was a sufficient authority to itself as operative common law, and only the courts could finally determine what operated as a legal maxim. This was because these maxims were known only to the learned. He stated that a maxim should be construed strictly. However, a particular custom should be pleaded and tried by twelve men, unless it was a record in some court. (Noy, pp. 39-41) It may be argued that the common law has been fully cognizant of the concept of insanity, through its legal maxims, the maxims of the learned: *furiosi nulla voluntas est*, (Justinian, 50. 17. 40) concerning a madman's absence of will, *furiosus absentis loco est*, (Justinian, 50. 17. 24. 1) concerning a madman's effective absence, *furiosus nullum negotium contrahere potest*, (Justinian, 50. 17. 5) concerning a madman's inability in business, *furiosus solo furore punitur*, (Co. Lit., 247b) concerning the madman's punishment solely by his insanity, *furiosus stipulari non potest, nec aliquid negotium agere, qui non intelligit quid agit*, (4 Coke, p. 126) concerning the madman's inability to bargain, and, *furor contrahi matrimonium non sinit, quia consensu opus est*, (1 Blackstone, p. 439) concerning the madman's inability to give consent.

Reasoning a synthesis of these maxims, to better amplify the idea of *non compos mentis*, we might say that an insane man has defective and therefore intermittent will to act, making his presence in society somewhat ineffective. He therefore cannot reach agreement on important matters, and he is incapable of giving reliable consent. From these thwarted desires, he is in a state of suffering. In consequence of these points, and arising from the long and continued use of the Roman Law concept of *non compos mentis*, the question arises as to what has become of the practical meaning of the term "insanity", when used as a defence. This article's meta-legal critical analysis methodology tries to show that the defence of insanity is, in fact, a public act of judicial denunciation against the accused, when he may have no effective responsibility for the crime. This methodology suggests occasional resort to principles of Lacanian critical theory, as well as a theoretical foundation in sophistical oratorical techniques.

This kind of judicial denunciation is a technical art, the skill for which subsists in past ages of sophistical rhetoric. Therefore, argument begins with a reader's technical briefing on the character of common-place denunciation as an appeal to public agreement. Then, to illustrate how this kind of reasoning has become embedded within the criminal law, argument follows how the idea of "manifest criminality", of the 1800s, might be cognate to modern ideas of "manifest madness". With the theory now in a practicable form, argument links it into the origins of the English special verdict of insanity. This will allow a short critical analysis of the M'Naghten Case, still the gold standard in many jurisdictions for the insanity defence. As a control, argument is finalised with analysis of a psychologists' expert construct of insanity and its relationship to jury perception. From these links in the chain of argument, conclusions will be cobbled together.

The article will suggest strongly that courts' procedures tended to oppose the use of psychiatric or psychologists' evidence, raising doubts as to the criminal system's intent to protect the public. Therefore, arguments based on the common law rules of insanity tended to expose juries more to denunciation of the accused, than to a reasoned account of the nature of his insanity and defects in his responsibility. Duly persuaded jurors would tend to acquiesce and participate in the denunciation of an accused person, whose unusual and unhealthy behaviours emanated from his sufferings by dint of his unbearable circumstances.

Common-place denunciation

The progymnasmata were several series of preliminary sophistical rhetorical exercises that began in ancient Greece. They expanded into the Roman Empire. Common-place is one of the oratorical exercises of the ancient Greek progymnasmata. (Kennedy, p. 3) It appears in all the sophistical progymnasmata, at various levels in the gradated oratorical exercises. Common-place is based on *topos*. *Topos* is wordage that amplifies something that is already considered either a fault or an act of bravery. (Kennedy, p. 42) A *topos* is a special starting place from which arguments are always easy to find. Such arguments would be formulated against those who did not agree to admit they were in the wrong. Typically, *topos* denounces a person some time after an assumption of his guilt. (Kennedy, p. 43)

The argument should be constructed from the moral choice made, the magnitude of the evil, the amount of suffering caused in others, and, from the return realised by the actor. (Kennedy, p. 44) *Topos* can be constructed against any common public event, where the term "common" has a technical meaning, known as *koinos*, or, defiled, meaning common, shared, unclean or defiled. It refers to spiritual desecration by treating what is sacred as ordinary. It is the result of a person reducing that, which was holy, down to the status of profane. (Strong, p. G2843)

Hermogenes stated that *topos* might be modified by the Greek concept of *koinos*, to produce what is known as a common-place. Common-place is an amplification of something already agreed, as if the demonstrations were already completed. It is constructed first by investigation of the opposite, then a statement of the subject action, a comparison, then a maxim. It proceeds by attacking the person's past life with conjectures based in the present. Then, the speaker rejects pity by using the "final headings" of the legal, the just, the beneficial, the possible, and the appropriate. This process gives a more vivid outline of the subject action, for persuasion within public rhetoric. (Kennedy, p. 80)

Aphthonius the Sophist characterised common-place as language amplifying those evils said to be typically attached to something. Thus it fitted all, in common, who might take part in a specific deed. For example, a speech against a traitor applied to all in common who shared in the traitorous deed. (Kennedy, p. 105) This made common-place more persuasive in a specific case of one person identified as a member of the defiled group.

Nicolaus the Sophist suggested common-place be positioned after refutation and confirmation within the various forms of the progymnasmata. Common-place amplified either acknowledged evil or human goodness. It was not directed against any particular person, but against a class of people. It set an initial point in argument, from which attacks might be composed against the specified kinds of persons. (Kennedy, p. 148)

John of Sardis set out four parts of a complete hypothesis: prooemion, narration, proofs, epilogue. Together, these elements suggested a strong hypothesis. He suggested that the progymnasmata exercises of fable and narration were positioned, within the strong hypothesis, as prooemion and narration. Chreia, maxim and refutation served as proofs. He opined that common-place was positioned logically as an epilogue to a complete hypothesis, giving its amplifications of mere assumptions the same persuasive power of a fully developed hypothesis. (Kennedy, p. 201) Sopatros added that common-place was used judicially to hone the court, by way of denunciation, to punish either a crime or a non-criminal error. Whereas a crime had a definite punishment by law, and involved a commonly unacceptable action by someone towards another person, an error had no such penalty defined by law. Nevertheless, everyone in the public domain detested such an error. These errors might include such things as wastefulness, drunkenness, fornication, sloth and alike things, or even errors which the court wanted to make the public view as a crime. Thus, the common-place could access people's hatred for non-criminal errors, when in the public domain as popular lay-maxims. When embedded within a judicial denunciation, common-place served as a criminal judgment without a crime. It is said to be unnecessary in common-place to make an account of an acknowledged crime or error, and thus, common-place has instead a goal of amplifying only what has been already acknowledged as erroneous by publicly accepted prejudice or pre-judgment. (Kennedy, pp. 202, 203) The crime would be manifest before the arguments were examined judicially during trial.

Manifest madness: Towards a new Understanding of the insanity defence

Loughnan revived the old rhetorical concept of 'manifest criminality', (Loughnan, pp. 382-384) which pervaded the criminal law as lay opinion about crime, as a structural concept, up until the end of the 18th century. (Loughnan, p. 386) His thesis was that there could be a cognate manifest madness in the criminal context. The first element of "manifest criminality" was that criminality was mirrored in a person's act. According to Fletcher, under "manifest criminality", the crime was discernable objectively at the moment it occurred, suggesting the observer was an ordinary person. (Fletcher, pp. 115-116) The second element of "manifest criminality" was that criminal behaviour was noticeable by neutral external observers, if any such person could ever exist. (Beattie, p. 88) The third element of "manifest criminality" was that crime was a natural category, incorporated into both the language and the legal judgments. (Fletcher, p. 83) However, it does not appear to fit obviously into any of Aristotle's master categories of substance/essence, quantity, quality, relation, location, time, position, habit, action, or passion. Less obviously, crime could subsist as the subjective Aristotelian category of "quality". (Aristotle Categories) "Manifest criminality" meant that whether behaviour was criminal could be determined from the conventional, or common, acceptability of the actor's behaviour. (Fletcher, p. 116)

The elemental construction of madness by constitutive acts appears in the records of criminal trials in the London Old Bailey Criminal Court from 1674 to 1834. One such example of an insane defendant was in the trial of Francis Brereton, (Brereton 1688) charged with killing a servant. Several witnesses stated that Brereton "had been a person abstracted and much discomposed in his mind for some time before". It stated:

> 12 or 14 Witnesses appeared for him upon this account, as also a Minister and Doctor of Physick, whose whole business lies among Persons Distracted, they related several Stories of him to satisfy the jury and the Court, whereby it might appear that he was subject to Frensies and Deliriums, the Tryal held a great while, and the Jury taking all into Consideration, brought him in not Guilty. (Brereton 1688)

Brereton's "Frensies and Deliriums" were arguably his badges of madness, augmented by the status of his narrative witnesses reporting that his actions were, in effect, defiled in the public perception. Porter suggested the key question was "did the accused habitually behave like a lunatic?" (Porter, p. 38) Thus, narratives of a defendant's insane behaviour implied, and still imply, a strong hypothesis of his insanity. (Loughnan, p. 387)

The second element of "manifest criminality" was that criminal acts were regarded as intelligible to neutral observers. Similarly, madness was considered readily comprehensible to people without expert knowledge. They could be confident they knew madness when they saw it. (Loughnan, p. 387) Talking about madness, or even talking about it authoritatively, was not the preserve of any profession. (Porter, p. 18) Madness was treated as a disorder discernible to the untaught eyes of jurors. (Fletcher, p. 838) Evidence of

'manifest distraction' could come from the defendant's neighbours, relatives and associates. (Porter, p. 38) An example was the trial of Thomas Draper, (Draper 1727) where the trial record stated:

> The prisoner instead of making his Defences shewed such distracted gestures as made it evidently appear he was not in his right Senses; to prove which several Persons appear'd and gave such an Account of his Behaviour when he was first taken, and afterwards during the Time of his Confinement, as left it undisputable to the Jury, that he was Non compos mentis, (Co. Litt., 246b) and accordingly they brought in their Verdict, that the Prisoner was a Lunatick. (Draper 1727)

Thomas Draper's trial record indicates that common lay people could decide that the prisoner was a lunatic, and therefore not guilty because he was *non compos mentis*. This competency of lay jurors has survived the rise of the psychiatric profession. (Loughnan, p. 388) Apparently, it meant that the so-called "distracted" behaviour of the subject person indicated he did not understand the neutral observers and could not, or would not, conform his behaviour to theirs. It was a failure of mimesis. In this respect, French psychoanalyst Jacques Lacan viewed psychosis as an essential failure in mimesis, saying that the sane man was a poet. (Miller, p. 9)

Up until the end of the eighteenth century, "madness" was its own separate category, as knowledge about madness was entrenched within a collective consciousness, as a phenomenological issue, apparently requiring all common perceptions to be made uniform, or be regarded as erroneous. (Porter, p. 19) The 17th and 18th century Old Bailey Proceedings contained references to the 'delusions', 'distraction' 'oddness', 'confusion', and "phrensies" of defendants claiming to be *non compos mentis*. According to Porter, such claims to exculpation by virtue of insanity were de facto and informal pleas. (Rabin, p. 11) From this, "delusion" might be interpreted as a failure of a compulsory conformance of perceptions to agreed public mores, where social mores were customs that served to distinguish between right and wrong. (Macionis et al, p. 65) Mores had the authority of facts, and therefore, they could found arguments based on facts. (Sumner, p. 75) What this idea of "delusion" did not explain as manifest madness would be an accused's widespread rejection of prevailing common mores for essentially rational, but politically fraught and therefore erroneous, reasons.

The origin of insanity as a special verdict: The trial for treason of James Hadfield (1800)

THE INITIAL FACTS OF THE CASE

On May 15, 1800, King George III attended the Drury Lane theatre in London, in the times of the French Revolution. Support for the revolution was running high in London, and the king had many systemic opponents. An assassin fired a pistol in the direction of his royal box. The lead ball passed above the king's head. The king was not hurt. (Times May 16 1800, p. 2) The would-be assassin gave his name as James Hadfield, and said "It is not over yet. There is a great deal more and worse to be done". (Bell's May 18 1800, p. 158) Hadfield had fought at Flanders, where he sustained eight saber wounds to his head. He was for four years a prisoner of war, (K.B., 33/8/3/29) and told the examining magistrate that he did not try to kill the King, as he could have killed the king if he had wanted. Hadfield said he was tired of life and wanted to die, but not by his own hand. (Bell's May 18 1800, p. 158) He hoped that the theatre crowd would have killed him. (Times May 16 1800, p. 3) This sounded like distractedness, if reported without its entire surrounding context.

The Privy Council was convened. (Moran, p. 494n) Hadfield was duly interrogated. He was asked if he belonged to the Corresponding Society, a group who met to celebrate the French Revolution. Hadfield answered in the negative. He said he belonged to the Odd Fellows Club, and swore that he had no accomplices. (K.B., 33/8/3/29) He was committed for trial for high treason, and was taken to Newgate Prison. (Times May 17 1800, p. 3)

The Privy Council further examined the evidence against Hadfield, (Moran, p. 488) without apparently examining the evidence for him. A musician from the orchestra, told the council that Hadfield tried to kill the king, by taking a direct and steady aim at him. (K.B., 33/8/3/29) A clerk told the council that on the previous Monday, Hadfield witnessed the flogging of two soldiers. This was at a place where he met the millenarianist Bannister Truelock, who told Hadfield "it was a shame there should be any soldiers; that Jesus Christ was coming; and [that] we should have neither King nor soldiers". (Bell's May 18 1800, p. 158) Bannister Truelock was brought before the council. He spoke rationally without any indicia of mental imbalance, until he characterised himself as a "true descendant of God". Representing himself as the Supreme Being, he resolved to destroy the world in three days. He stated that he told Hadfield he might become a very great man by becoming his son. Truelock stated further, evincing that kind of error requiring common-place denunciation, that the Virgin Mary was "a bloody whore", that Jesus Christ was a mere thief, and that God was a blackguard. (Bell's May 18 1800, p. 159)

Another witness, Sarah Lock, a respected widow in whose house Truelock lodged, said that Bannister told her that King George III was to be assassinated, so that kings would be abolished and the costs of the necessities of life would be reduced. (T.S., 11/223/030250) She added that Truelock was a Revolutionist or Jacobin, (Moran, p. 495) who was constantly reading seditious or treasonous books. (Albion May 26 1800, p. 3) She said that Truelock often denounced the Prime Minister and the government. He believed in the French Revolution and supported the Rights of Man. (Paine, 1791) This arguably was error, by way of delusion, as he did not conform his perceptions to the prevailing social mores.

THE TRIAL

Six weeks after his arrest, Hadfield stood trial, (Moran, p. 499n) in the Court of the King's Bench for attempting to assassinate King George III. (Moran, p. 498) Chief Justice Lord Kenyon presided. The Attorney General, Sir John Mitford, appeared for the crown. Thomas Erskine appeared for the defence. The Attorney General stated that James Hadfield's crime was "compassing and imagining the death of the king; for the law has made that imagination of the mind a crime ... when it is demonstrated of any overt act". Sir John Mitford said that he would prove that Hadfield did these three acts: 1) purchased the pistol; 2) went to the theater at Drury Lane; and 3) fired a pistol at the king, all with the intention of killing the king. (Howell's, p. 1285) The attorney general anticipated a defence-initiated plea of insanity and stated his view of the law on insanity:

> ... if a man is completely deranged, so that he knows not what he does, if a man is so lost to all sense, in consequence of the infirmity of disease,

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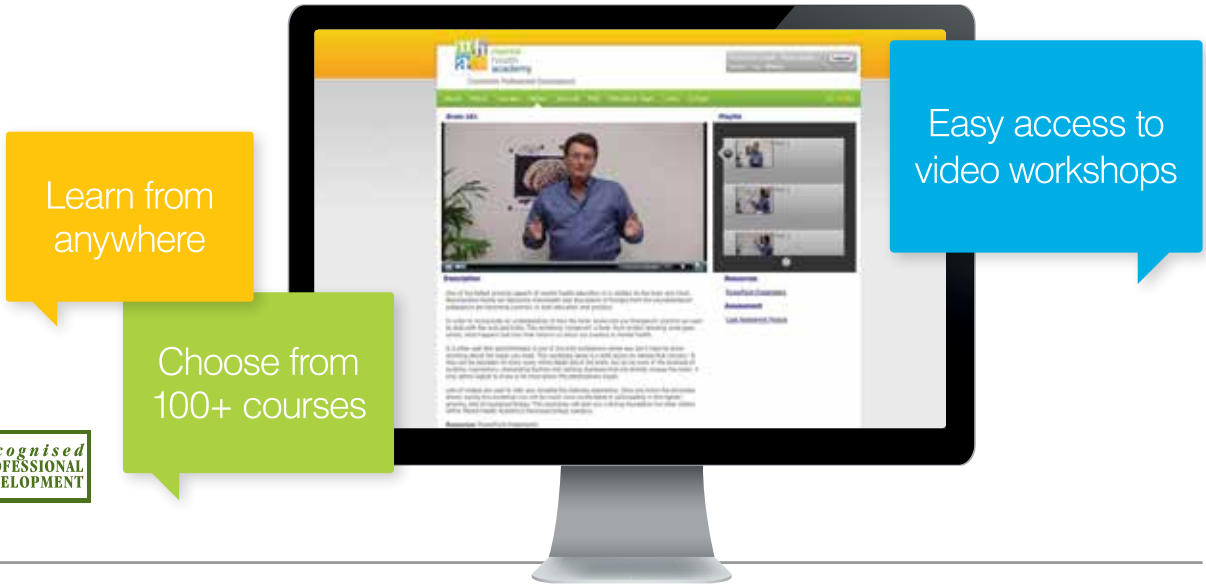

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> that he is incapable of distinguishing between good and evil that he is incapable of forming a judgement upon the consequences of the act which he is about to do, that then the mercy of our law says, he cannot be guilty of a crime. (Howell's, p. 1286)

The attorney general offered that those suffering from an "absolute privation of reason," were excused, because they could not understand the consequences of their acts. A madman in a "phrenzy", or a person with a "violent fever" committing an act where he was "perfectly unconscious" of it, ought not be punished. However, the jury must assess how much discretion the accused had before it decided if he should be exculpated. (Howell's, p. 1286) Mitford continued that if an idiot could discern good from evil, even at a low level of discernment, he could still be responsible. If children knew their acts were wrong, then they could be accountable even while very young. A lunatic, a person occasionally insane but with lucid intervals, might be guilty if his act was during a lucid interval. (Howell's, p. 1287)

The Attorney General cited two cases. The first was the 1723 Edward Arnold case, concerning the malicious shooting of Lord Onslow. It appeared from the evidence that Arnold's mind was deranged. However, as Arnold formed a steady and resolute design, he was found guilty. Mitford explained to the court that not every frenzy and idleness of man would exempt him from punishment. He submitted that, to be exempted, a man must not know his act, any more than would an infant, a brute, or a wild beast. Mitford submitted that this explanation of the law had not been contradicted. (Howell's, p. 1288)

The second was of the 1760 case of Lord Earl Ferrers, tried in the House of Lords for murdering his steward. Lord Ferrers stated he could not know the consequences of his actions because he was under the misfortune of being insane. The House of Lords found Ferrers guilty, because they thought Ferrers could distinguish between moral good and evil, and, at the time of his crime, he was capable of criminal intent. (Howell's, p. 1289)

Mitford told the court he would prove that Hadfield had a sufficient degree of reason to make him guilty, as only a small level of sanity was required. He offered that very few were totally deprived of reason; good and evil naturally made an impression upon the mind, which the mind rarely discarded. From Hadfield's conduct, Mitford would show that he acted as anyone would have acted during the crime. He bought the pistols. He went to the theatre. He was admitted to the pit without prior notice. He discharged the gun at the king from a most advantageous spot. He knew that by law he would lose his life. This showed that he was sufficiently competent to be guilty. (Howell's, p. 1290-1292)

Mitford called several witnesses. Four testified they saw Hadfield fire his pistol at the king. One said Hadfield appeared to take deliberate aim at the king cursed the king thus: "This is not the worst". (Howell's, p. 1295) Others testified they saw Hadfield drop the pistol after the shots, and then they helped to arrest him. (Moran, p. 501) When the Duke of York, entered the witness box, Hadfield jumped to his feet and called out: "God Almighty, bless his good soul, I love him dearly". (Howell's, p. 1298) The Duke testified that Hadfield was rational during his interrogation, and he appeared to understand his act's consequences. The Duke said that Hadfield spoke "connectedly" of his crime, realising that his life would be forfeited. (Howell's, p. 1299) This suggested common-place prejudice.

During his cross-examination, Erskine asked the Duke if he had questioned Hadfield as to why he desired to murder his uncle the king, if Hadfield had such great affection for the Duke. The Duke explained that Hadfield did not intend to murder the king, but was tired of life and thought he might die for this attempt. The Duke insisted Hadfield was "perfectly collected". (Howell's, p. 1298-1300)

There was no testimony from medical experts about Hadfield's mental condition, or about any influence Bannister Truelock might have exerted on him. Erskine stated that he agreed with the Attorney General over the correct principles of law. Thus, the reason of man made him accountable for his actions. The deprivation of this reason acquitted him of the crime. Erskine questioned the formula of total deprivation of memory and understanding, submitting that no such madness had ever existed in the world, as all madmen retained some memory and understanding. (Howell's, p. 1309-1313)

Erskine submitted that delusions, unaccompanied by frenzy or raving madness, constituted the true character of insanity. A person could reason with skill and refinement, but if his premises were false, and could not be upset even with strong evidence, then he suffered from the disease of insanity. For him to be excused from the rigors of the law, his crime must be the immediate, unqualified outcome of this disease. He submitted that a man who only showed violent passions and hateful resentment, but acting on real circumstances, must be accountable. (Howell's, pp. 1313-1314)

Erskine offered the example of a lunatic believing that a man he murdered was not really a man, but was a potter's vessel. If he destroyed this potter's vessel with the malignant intention of injuring the property of its owner, with full knowledge of good and evil, Erskine thought this man could not be found guilty of murder, as he was utterly unconscious that he had killed a human being. (Howell's, pp. 1317-18)

Erskine told the court that James Hadfield was a former soldier in Flanders and was the Duke of York's trusted orderly. Hadfield had risked his life for king George III. Hadfield received several wounds to the head. Erskine showed the jury the exposed membrane of the Hadfield's brain, (Moran, p. 504) where a piece of Hadfield's skull had been sliced off. Erskine claimed this injury caused Hadfield's troubled mental condition, without any fault of his own. Erskine said that immediately following this injury, Hadfield imagined that he had constant intercourse with the Almighty. (Howell's, pp. 1320-21) Hadfield was discharged from the army for insanity. (Moran, p. 504) It appeared that the Duke himself had sent his loyal valet Hadfield to his fated injury.

Two nights before his attempted murder of the king, Hadfield tried to kill his own child. Erskine explained that Hadfield was obsessed with the idea that he must be destroyed, but should not destroy himself. (Howell's, p. 1323) This sounded like a soldier's conditioning.

Erskine explained that Hadfield was under the influence of Bannister Truelock, a millenarianist who overpowered his mind. Truelock told Hadfield that Jesus' second coming and the final dissolution of mankind were both at hand. This kind of madness, along with Hadfield's insane delusions, caused him to fire his pistol towards the king, without wishing the king any harm. Truelock was already in a lunatic asylum, and Erskine implied that the same should await Hadfield. (Howell's, p. 1327) Interestingly, a conformance to the church teachings was considered madness.

The most significant medical witness

was Mr. Henry Cline, a surgeon. He said that three of Hadfield's four head wounds were enough to cause brain damage. Doctor Creighton testified that Hadfield was insane, probably from the head wounds. This physician also testified that Hadfield spoke rationally on other matters. Hadfield thought that he was destined to die, as did Jesus Christ, having been conditioned by the church to conform his life to that of Jesus. The doctor added that the prevailing hot weather may have made Hadfield worse. Mr. Lidderdale, another surgeon, testified that Hadfield was discharged from the army because of insanity. (Howell's, pp. 1332-1336)

David Hadfield gave evidence that in the hot weather, under a full moon, his brother Jim discussed Jesus Christ and proclaimed himself to be God. (Howell's, 1336-39) Mary Gore, Hadfield's sister-in-law, agreed that the hot weather affected Hadfield's mind. She added that her sister's husband and Truelock planned to build a house to live together, Hadfield as God and Truelock as Satan. (Howell's, p. 1343)

The chief justice Lord Kenyon stated that the material question was whether at the time of the act Hadfield's mind was sane". He added that the facts suggested Hadfield was in a state of derangement. (Howell's, p. 1353) This suggests that the judge determined an argument based on facts as implying the kind of error requiring common-place denunciation.

Lord Kenyon began: "I do not know that one can run the case very nicely: if you do run it very nicely, to be sure it is an acquittal". Kenyon continued: "such a man is a most dangerous member of society". "The prisoner, for his own sake, and for the sake of society at large, must not be discharged". (Howell's, p. 1354)

THE AFTERMATH OF THE TRIAL

Erskine persuaded the court to accept proof of delusion as a valid defense of insanity. Yet, arguably, Hadfield was not deluded. However, the Hadfield case did not establish a legal precedent. The defense of "delusion" did not figure prominently as a precedent in subsequent cases until the trial of Daniel M'Naghten in 1843. This is no doubt because of the court's acceptance of Hadfield's head wounds as the cause of his mental disorder. (Moran, p. 508) The acquittal of James Hadfield did not create any public outrage, suggesting an absence in the common mind of any perceived error. Certainly, Chief Justice Kenyon's statement that the king's would-be assassin would be disposed of properly helped to calm public concern. At the end of the trial, the Attorney General told the court that "It is laid down in some of the books, that by the common law the judges of every court are competent to direct the confinement of a person under such circumstances".Chief Justice Lord Kenyon opined that he only had the power to remand Hadfield back to Newgate Prison. (Howell's, p, 1356) This procedure was governed solely by the practices of the judges, again suggesting judicial action consequent on common-place error rather than on criminal law.

Hadfield's detention as a dangerous lunatic could have been ordered under the Vagrancy Act of 1744. The act provided authority to lock up dangerous lunatics in a secure place, and seize their property, to pay the cost of securing and healing them. However, Hadfield could be confined only until he regained his senses. Hadfield was perfectly sane on everything except religion and royalty. These were the subjects of his delusions. He could be released during one of his lucid intervals. Hadfield was confined on the precedent established in the 1790 case of John Frith. (T. S., 11/ 223/030250) Frith believed he was St. Paul, and was arraigned for throwing a stone at George III's coach. Before to his trial, Frith was examined by the king's household physician and

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declared to be mad. (Macalpin et al, p. 313) Lord Kenyon heard the evidence of Frith's mental condition, and the jury said that John Frith was quite insane. (K.B. 33/8/3/29 030238) Kenyon declared him unfit to plead and remanded him back to Newgate, with the awareness that he would be released when arrangements were completed to confine him somewhere else as a lunatic. (T.S. 11/223/030250)

Within 4 days of Hadfield's acquittal, the Attorney General had prepared a Bill for the regulation of trials for high treason, and also, for the safe custody of insane persons charged with offences. It appeared the trial might have been in the crown's sole interests as a solely predatory action. The Attorney General said that his objective was to make the attempted murder of the king into an ordinary felony. In the second part of the Bill, which empowered the continued confinement of accused criminals who had been acquitted because of insanity, the Attorney General explained that it was important for a statute to provide for post-acquittal incarceration of defendants found not guilty by virtue of a derangement of their minds. He added that several murderers had gone free after a verdict of not guilty because of insanity, as if freedom were not indicated in cases of common-place error. The Bill contained almost nothing about the rules or conditions for confinement of those acquitted. The Times of London expressed reservations about the lack of legal safeguards in the Bill, but concluded that sweeping powers were required because not all cases could be anticipated. (Parliamentary History of England 1819, p. 389)

The House of Commons committee was permitted to divide the Bill into two, "for the sake of simplicity". (Parliamentary History of England 1819, p. 389) On July 11, 1800, the bills were again debated in the House of Commons. Only seven or eight members debated the new law, suggesting a lack of political support for the crown's ministerial agents in the Parliament.

The secretary of war commenced the debate by arguing that some punishment should follow any attempt on the king's life, even when acquitted for insanity. The secretary agreed it was repellant to penalize an insane person. He defended his stance by arguing that all punishment was revolting. He further argued that it was a well-known aphorism that a man should be punished, not because he had stolen something, but because theft should be prevented. Secretary Windham argued, apparently without supporting source authority, that madmen could be influenced by fear of punishment, possibly more so than could ordinary people. He recommended that the focus of the trial should be altered from determining the guilt or innocence to whether or not the defendant could possibly have been influenced by punishment. Thus, in Lord Ferrers' case, the question to be put to the jury should not have been whether Ferrers could distinguish between moral right and wrong, but rather, whether Ferrers could apprehend a horror of punishment. The Secretary apparently believed that law by the spectre of fear was effective domestic government. (Parliamentary History of England 1819, p. 389)

A Tory Member of Parliament, Mr Nicholls, disagreed strongly with the secretary of war's view of the purpose of the criminal law. Nicholls explained that in order for the law to find a person responsible for a crime, the defendant must be capable of criminal intent. He said: *Actus non facit reum, nisi mens sit rea*: (3 Inst. 107) an act itself does not make one guilty, unless done with guilty intent. Nicholls said that since punishing a madman could not prevent crime, he urged that the House of Commons might never again be made to listen to such opinions.

Sir William Grant, a member of the prosecution in Hadfield's trial, also spoke. He advised the Parliament that, sometimes in ancient law, madness was not an excuse from punishment. (Parliamentary History of England 1819, p. 393)

The New Statute of 1800

The Criminal Lunatics Act of 1800, (39 and 40 Geo. III, c. 94) drafted in a mere 4 days, contained four sections. The first section, made apparently applied retroactively to Hadfield. It provided for the special verdict of insanity, such that, if a person charged with treason, murder, or a felony was acquitted for insanity, the court should order him into strict custody until "His Majesty's Pleasure be Known".

The second section of the act concerned persons indicted for any offense, who were found to be insane upon arraignment. The court was thereby empowered arbitrarily to hold the person in strict custody until "His Majesty's Pleasure be Known." The section also applied to persons who appeared to be insane during a trial, and others discharged for want of prosecution.

Section 3 of the Act denied bail to any "persons discovered and apprehended under circumstances that denoted a derangement of mind, and a purpose of committing a crime". If a Justice of the Peace committed a person as a "dangerous person suspected to be insane," that person could not be bailed, unless by two Justices of the Peace. One Justice had to be either the judge who issued the original warrant, or by one of a Justice of the King's Bench, the Lord Chancellor, the Lord Keeper, or the Commissioners of the Great Seal. The king's magnates became the judges. Clearly they were considered as directly interested.

Section four of the Act gave the Privy Council, or a Secretary of State, authority to detain anyone appearing insane, and trying to secure admittance to His Majesty's palace or other residence. These people could be detained until a special-purpose jury could assess their insanity. Thus, desiring to see the king could be an act of madness indicating some kind of delusion.

The M'Naghten Case

The M'Naghten Case brought the issue of delusion to the fore, as a specific defence in criminal matters. The rules laid down in this case have been accepted in the main as an authoritative statement of the law. But they have been adversely criticised both by legal and medical text writers. Daniel M'Naghten was tried at first instance in 1843 in the Central Criminal Court, Old Baily, before Tindal CJ, and Justices Williams and Coleridge. In *Daniel M'Naghten's Case* the facts were as follows. Mr M'Naghten was indicted for shooting in the back a Mr Edward Drummond, feloniously, wilfully, and with malice aforethought. Mr Drummond died from the wound. Mr M'Naghten pleaded not guilty. Witnesses were called to prove that Mr M'Naghten was not, at the time of committing the act, in a sound state of mind. The medical evidence consisted of the following points.

- That persons who were usually of sound mind, could be affected by morbid delusions. Mr M'Naghten was so affected by morbid delusions.
- Anyone suffering a morbid delusion, could still sometimes have a moral perception of right and wrong. This was hardly surprising as a morbid delusion would be one in which the deluded person simply had an abnormal and unhealthy interest in unpleasant subjects such as death and disease.
- In M'Naghten's case, his delusion overpowered his own control, depriving him of his moral perception of right and wrong.
- Mr M'Naghten was not capable of exercising any control over any of his acts, connected with this state of delusion. Again, this is hardly surprising as, arguably, phantasy intervenes to determine the outcomes of all human thoughts.
- It was the character of Mr M'Naghten's disease, that it might go on gradually until reaching a climax, bursting out with an irresistible intensity. This suggests that indeed Mr M'Naghten had controlled quite successfully the consequences of his delusion, until he could take it no more. Again, this would be quite a normal human response.

Thus, according to the court, any man might go on for years quietly, under the influence of morbid delusions, but could break out spontaneously into extravagant and violent worsening of his symptoms.

Some of the medical witnesses had examined the prisoner prior to the hearing. Others only saw him for the first time when he appeared in Court. They formed their views by considering the evidence of the other medical witnesses, arguably a quite defective way of gaining access to a man's mind, but a very effective way of accessing the public view of his errors. From issues contained with the above statements, and after Queen Victoria wrote to the Prime Minister of her concern about the court's verdict releasing him for insanity, the House of Lords gathered a cohort of judges, posed key questions to them, and from their answers, formally expressed the following binding statements of law.

- Notwithstanding a party accused did an act, which was in itself criminal, under the influence of insane delusion, with a view of redressing or revenging some supposed grievance or injury, or of producing some public benefit, he is nevertheless punishable if he knew at the time that he was acting contrary to law. This point of law was quite astounding, considering how much of the law is quite unknown to the ordinary person.
- That if the accused was conscious that the act was one, which he ought not to do; and if the act was at the same time contrary to law, he is punishable. In all cases of this kind the jurors ought to be told that every man is presumed to be sane, and to possess a sufficient degree of reason to be responsible for his crimes, until the contrary be proved to their satisfaction: and that to establish a defence on the ground of insanity, it must be clearly proved that at the time of committing the act the party accused was labouring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or as not to know that what he was doing was wrong. This formula does not appear to follow necessarily from the pre-legal and ethical issue of "ought not to do". It suggests that a man may not conduct his own ethical deliberation.
- That a party labouring under a partial delusion must be considered in the same situation, as to responsibility, as if the facts, in respect to which the delusion exists, were real. This piece of arguably judicial legislation treats phantasy as reality, suggesting common-place error.
- That where an accused person is supposed to be insane, a medical man, who has been present in court and heard the evidence, may be asked, as a matter of science, whether the facts stated by the witnesses, supposing them to be true, showed a state of mind incapable of distinguishing between right and wrong.

Of these rules of law, the following additional points can be made. First, there was still no definition provided for the concept of "insane delusion". A person in a state of psychotic anxiety might well

qualify. But a hallucinating person may not, as hallucinations are characteristic of all three psychoanalytic structures of neurosis, perversion and psychosis, structures which cover all people. (Fink, p. 84) The formula 'a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing' is arguably inaccessible to a jury. Most juries could neither assess a defect of reason, a disease of the mind, nor a causal link between the two. Arguably, all delusions are partial delusions, and are in the character of all people. (Mills, p. 11) Arguably, a medical man is no expert in the philosophies of right and wrong. The rule requires a medical man possibly only because he is a government-registered licensed official, and therefore his evidence is less susceptible to the force of attack.

The practical consequences of these rules are that M'Naghten jurors are free to disregard details of any disease of the mind. A finding of a disease of the mind, or other such defect, follows virtually automatically when they find that a defendant did not know the nature, quality, or wrongfulness of his actions. Hence, under the M'Naghten rules, there is no need to emphasise the medical question of illness. (Kuh, p. 785)

Although the M'Naghten rules circumscribed the issues of insanity and causation, they concentrated only on the outwardly manifested symptom. They judge by the defendant's erroneous acts, which are supposed to indicate not knowing right from wrong. Thus, if the defendant's act manifests a symptom, which a lay juror can recognize, then the necessary "disease" is deemed to exist. (Kuh, p. 790) This suggests common-place denunciation, and more, according to Kuh, any reasonably skilled lawyer would be certain to adduce some tendency evidence of the defendant's abnormal behaviours, other than his criminal or other non-criminal, but antisocial, acts. (Kozol, p. 116) These so-called abnormal behaviours would appear to the jury as common-place error.

Evaluating Insanity: A Study of Construct Validity

With the M'Naghten rules making it more likely the jury would find insanity on the basis of common-place error, the question arises as to what would happen if the juries were constrained to expert psychiatric evidence of mental disease. Up to and including 1983, the legal definition of insanity, in much of the United States, was that of the 1962 American Law Institute standard. At that time, it was employed in 29 states and in all federal jurisdictions. (Weiner, 1980) The American Law Institute standard was as follows: (a) A person is not responsible for criminal conduct if at the time of such conduct, as the result of mental disease or defect, he lacks substantial capacity either to appreciate the criminality (wrongfulness) of his conduct or to conform his conduct to the requirements of the law. (b) As used in this standard, the terms "mental disease or defect" did not include an abnormality manifested only by repeated criminal or otherwise antisocial conduct. (Roger et al, p. 295)

In order to get at the correct meaning of mental disease or defect, Rogers et al arranged a construct of insanity defence outcomes on the basis of five scales, or master elements, with attendant sub-elements. (Rogers et al, pp. 298, 299) The five scales were patient's reliability, organicity, psychopathology, cognitive control, and behavioral control. Validation of this construct required the demonstration that patients judged as insane showed, at the time of the commission of the crime, more severe psychopathology, having a consequently greater impact on the criminal behavior than those defendants judged as sane. The study hypothesised that those evaluated as insane would demonstrate a more severe psychopathology associated with an organic or major mental disorder, as well as a greater loss of cognitive and/or behavioural control than those defendants judged as criminally responsible. The general hypothesis was that insane patients would show more severe mental disorders, having a greater effect on their criminal behavior. Both the general and specific hypotheses were substantially satisfied. (Rogers et al, pp. 300-302)

What this meant was that juries were more likely to determine the meaning of mental disease or defect in accordance with the more serious mental disorders showing evidence of more serious psychopathology. Only expert evidence could supply this kind of proof. Application of the construct appeared to eliminate the possibility of common-place denunciation.

Conclusion

A carefully constructed judicial common-place could trigger ordinary lay people's hatred for non-criminal errors. When embedded within a judicial public denunciation, common-place served as a criminal judgment without a crime. It is said to be unnecessary in common-place to make an account of an acknowledged crime or error, and thus, common-place has instead a goal of amplifying only what has been already acknowledged as erroneous by publicly accepted prejudice or pre-judgment. Thus, the accused might be declared insane even before his trial.

Insane persons were those alleged to be acting on the basis of delusions. From the actualities of the case law, "delusion" might be interpreted as a failure of a compulsory conformance of perceptions to agreed public mores, where social mores were customs that served to distinguish between right and wrong. Although this should more properly be tested in court, it could be orated by way of common-place. Mores had the authority of facts, and therefore, they could ground arguments based on facts, and thereby, get around

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the law. What this idea of "delusion" did not explain as manifest madness would be an accused's widespread rejection of prevailing common mores for essentially rational, but politically fraught and therefore politically erroneous, reasons. Such an example may have been the reality of Hadfield's case.

Hadfield's alleged attempt on the king's life precipitated a heavy-handed crown response well beyond punishing a mere attempt. It was quite arguable that Hadfield never aimed his gun at the king, and therefore, never attempted to murder the king. Hadfield had been seriously injured, arguably at the directing hand of the Duke of York, to whom he was a trusted valet. He thus might have been subjected to the Duke's treachery attended by military conditioning, after which a piece of his head was sliced off in battle. In his trial, Hadfield was denounced and detained without apparent legal authority. The Criminal Lunatics Act 1800 was the material knee-jerk Parliamentary response to the Hadfield trial, fully drafted in a fast 4 days. This suggested that the Hadfield trial was run mainly to make an example of Hadfield to deter future English adherents of the French Revolution. The most vocal Parliamentarian in favour of such deterrence was the Secretary of War. The later M'Naghten Case picked up the specious issue of delusion as a legal precedent.

Although the M'Naghten rules, entrenching delusion as the foundation of insanity, circumscribed the issues of insanity and causation, they concentrated only on the outwardly manifested symptom. These rules allow judgement by the defendant's erroneous acts, in a common-place sense, which were supposed to indicate not knowing right from wrong. Thus, if the defendant's act manifested a symptom, which a lay juror could recognize as erroneous, then the necessary "disease" would be deemed to exist. This suggested common-place denunciation.

Any reasonably skilled lawyer could easily adduce some tendency evidence of the defendant's abnormal behaviours, other than his criminal or other non-criminal, but antisocial, acts. These so-called abnormal behaviours would appear to the lay jury as very persuasive common-place error.

Properly advised by experts, juries were more likely to determine the meaning of mental disease or defect, in accordance with the more serious mental disorders, showing evidence of more serious psychopathologies. Only expert evidence could supply this kind of proof. Application of the construct tested by Rogers et al, appeared to eliminate the possibility of common-place denunciation influencing the jury. Removing this expert evidence would permit a resumption of common-place denunciation of the defendant as insane.

The courts' procedures tended to oppose detailed psychiatric and psychological evidence. Arguments based on the common law rules tended to expose juries more to common-place denunciation than to a reasoned account of the nature of the accused's insanity. As carefully chosen lay people, jurors would tend to be influenced by common-place oratory. They would participate in the denunciation of the defendant, whose unusual and unhealthy conduct emanated from his sufferings in impossible circumstances. This could have the effect of hiding the real culprit who triggered the chain of causation, resulting in the subject criminal act.

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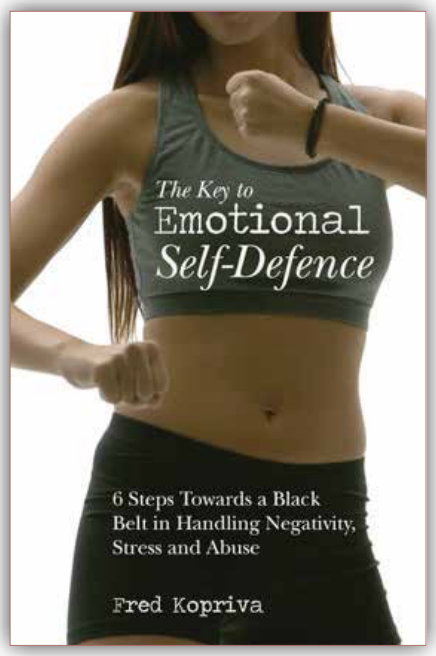


The Key to Emotional Self-Defence

Review by Jeanette Russell.

On the whole I found the book to be a very interesting and informative read. Some fascinating and enlightening information was contained within its pages. Different subjects, strategies and some great learning pieces contained in the book kept me wanting to read throughout. Had a few light bulb moments and found many useful tools incorporated in the book as well as helpful insights. The only aspects questioned during this critique were as follows. The use of the word "should ", which for me personally is a word I try not to use.

For me it brings up connotations of duty, expectations and obligations, and even judgements. Could, can, may, or even might be a good idea, are lighter words and do not carry the same implications. Should I think can also conjure up the idea that one is not good enough or needs to do, or be, more? (Rant over on that one) .The only other query was in chapter 5, on the section called Healthy communication, was there any stereotyping here when mentioning how "women are especially sensitive to "....?

The beginning of the book is about thinking. Listing ways of thinking that can distort reality or cause stress. Fred then describes the 3 Rs that are ways of replacing thinking habits which don't serve us well. Within this chapter is writing about unpacking and processing emotions. Included as well is talk about goals, goal setting as well as their purpose.

Chapter 2 involves emotions, facing and working through them. Integrated here is having more control over our emotions e.g anger. Relaxation exercises are noted to help calm and control and even combat anger.

Amalgamated within chapter 3, are psychological traits. We can assess the key traits within our personality, by answering questions. I learnt something about myself in the measuring of these traits, and can see areas where I can make improvements. Even being more aware of these traits may, I believe help to lessen stress for individuals. The next section is about building self esteem. Statements can be rated and I found this gave me some insight into my own self esteem. I felt it is a handy tool. Informative pages followed on self confidence and worth, and on increasing gratitude.

Some fascinating material, on senses helped make some sense of matters, in chapter 4.. The information could assist people to tie aspects together from their growing up years and adulthood, in relation to, perceptions, personality traits and subsequent thoughts, feelings and behaviours. Handy are pieces on nourishing the brain, stress busting techniques and communication tools both positive and negative within relationships.

Encapsulated in the 5th chapter is relationship data. Stages of love, the meaning of love, healthy communication, and perfect partner expectations to name a few.

In the last chapter about relationship abuse verbal attacks, emotional abuse and coercion in relationships are outlined along with other entities involved in relationship abuse. The chapter also encompasses what the signs of emotional abuse in a relationship are, and some advice on how to verify this and also seeking help, if needed.

All in all I enjoyed the book, very much, found it valuable, thought provoking, and for me it certainly, joined some of the dots, regarding emotional self defence.

Jeanette Russell
Jeanette is a registered, practicing Level 1 ACA Member.

The Key to Emotional Self-Defence
Fred Kopriva
Available at: www.amazon.com au
Price – Kindle: $4.16

Neuroscience for Counsellors

Review by Adrian Hellwig

So read the blurbs on the back cover, but does this book live up to its promise? The book deals with; Plasticity and how the brain works, Learning and memory, Other workings of the brain, Specific Dysfunctions, and Recommendations. But this is no dispassionate treatise or research paper. The author has very personal reasons for pursuing this topic as she states within the opening pages:

> "… my eldest has suffered a number of mental and behavioural difficulties, which, as I began this work, were stopping him from fulfilling his potential and from leading the life that he would choose to live if he could."

Does this detract from the work? I don't think so but it does need to be kept in mind for I feel it definitely 'colours' the approach to the topic.

I think the main value in this book lies in the fact that it highlights to counsellors the fact that neuroscience isn't just for neuro-scientists or even psychologists; who have been far quicker in their attempts to integrate it into their practice [perhaps, as the author points out, because of their field's "greater emphasis or research and learning" – though some might choose to debate this]. So, what is the purpose of neuroscience learning for counsellors?

As neuroscientists and psychologist look more and more into the 'how it works' it is the counsellor who is ideally placed to take that knowledge, examine its functionality, and pass it on in a practical way. That is to say, helping their clients make use of that knowledge to mould and shape the solutions to their own issues. After all, it is for us as counsellors to empower our clients and give them the tools to become their own healers.

Should you feel that the neuroscientific jargon is all too much and you can't cope with it, the author does attempt to avoid jargon where possible and where it is not possible she has provided a very useful glossary of terms at the back of the book. Also located there are four labelled diagrams.

These are useful but would be more so if located in the text where these things are being talked about. While on the topic of diagrams, I for one, would like to see a

lot more of them. More tables and graphs would also be useful for those among us who are visual learners.

Sometimes the best review is a quote from the book itself as it gives insight to style, content and relevance. I'll finish then on one such quote:

Counsellors, who encounter clients who lack empathy for others, or who present with issues that suggest poor social skills, may want to support those clients to seek opportunities to regularly observe and imitate those who have more competence in these areas. Research into mirror neurons supports the value of regular social mentoring programmes.

"If you are looking to reinvigorate your practice and enhance your understanding of clients' needs, this is the perfect place to start."

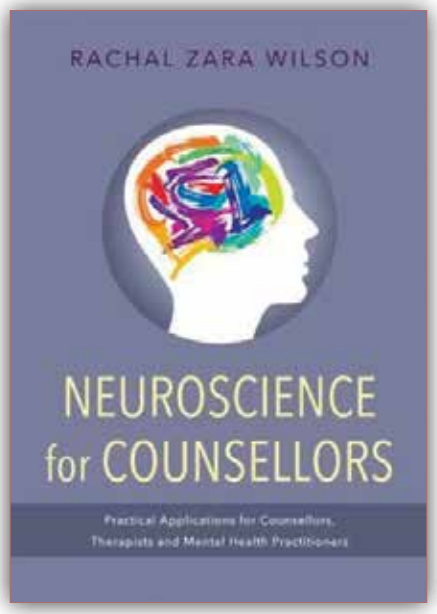
For a rich and pluralistic perspective on how neuroscience informs counselling practice, this is an exceptional book."

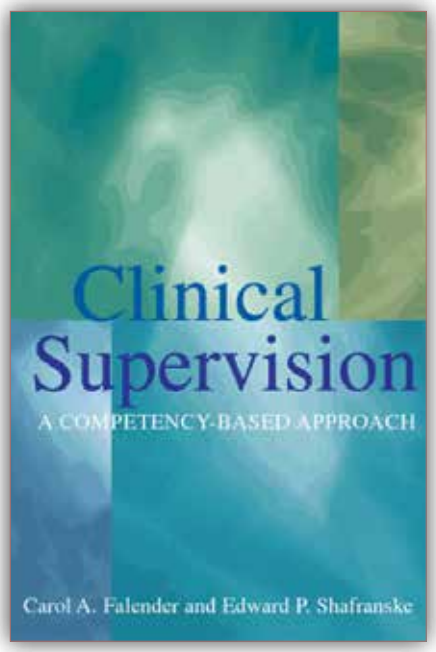
"This superb resource presents new discoveries in the field of neuroscience that will help counsellors make a difference in their work with clients."

In this work, Rachal Zara Wilson has made the complexity of neuroscience research accessible to practicing counsellors…."

Adrian Hellwig
Adrian is not only a Fellow FACA ACA member; he is also the head of complaints tribunal committee.

Neuroscience for Counsellors
Rachel Zara Wilson
Jessica Kingsley publishers, London, 2014
Available at: www.amazon.com.au
Price – Kindle: $23.23





Clinical Supervision: A Competency-based Approach

Review by Prathiba Subramaniam

***Clinical Supervision: a competency-based approach*, written by US based psychologists Caroline Falender and Edward Shafranske, provides a sound foundation in understanding the supervision theories, models and practice principles. This book which is in its 7th edition is thorough and will be a useful resource to both supervisors and supervisees ranging in their skills from being a beginner to an experienced practitioner/supervisor.**

The authors have a strong passion to promote an ethical service to clients by advocating the recognition of "supervision as a distinct clinical practice" (p. 19) that would urge psychologists, and mental health professionals to undergo formal education and training to deliver a competent based supervisory practice.

The book is organised well with the early three chapters introducing the factors that contribute to a good supervision model. One can begin to conceptualise their own model of supervision by taking into consideration the needs and preferences as a supervisor in their working context.

And empirical information collected in what constitutes a good and worse supervision process facilitates an understanding of the needs from the perspective of the supervisee in their different stages of learning. The reader is also given practical tools that both the supervisor and supervisee can use to measure competence through a collaborative process.

As a practicing psychotherapist, I found the authors dedicated two chapters (4&5) to look at the important therapeutic elements underpinning the development of a good supervisory relationship from highlighting the need to understand the value based nature of the relationship (such as forming an alliance, intentional and unintentional disclosure), manifestation of these values into the supervisory practice (such as shame, ruptures, boundary violations).

I find the use of some models can act as an externalising tool for the supervisor and supervisee to maintain attention, and explore the therapeutic issues through the relationship in a safe and secure manner.

Multicultural competency model and skill development of a therapist in Chapter 6 presents the current needs and barriers in the field of psychology and mental health for an ethical orientation to diversity, training areas that could potentially address the knowledge gaps for therapists and supervisory tools to assist the ongoing skill development with diverse clientele.

The last chapters raise the organisational aspects that would influence the supervisory relationship from a legal, ethical and risk management perspective.

Throughout the book, the authors keep drawing knowledge ideas and practice tools for a good supervisory practice – by having an ongoing evaluation process of the supervision and holding accountability for both the supervisor and supervisee.

The reader will find each chapter linked well with appendices which has helpful competency evaluation tools (checklists and forms) that is recognised by the authors as "being written primarily for the field of professional psychology, but could be readily applied to any of the allied mental health professions" (p. 35).

Prathiba Subramaniam
Prathiba has 10 years of knowledge and experience in working with children, young people and their families in rural and remote communities (Indigenous and non-Indigenous). Using current learnings of neurobiology in trauma recovery, her clinical framework in offering individual therapy using narrative based systemic family therapy model and group/family therapy using expressive arts for mind-body integration.

Clinical Supervision: a competency-based approach
Falender, C. A and Shafrankse, E.P (2010).
American Psychological Association.
Available at: www.apa.org
Price: $39.95

Handbook of Positive Supervision for Supervisors, Facilitators, and Peer Groups

Review by Nancy Grand

This latest tome from clinical psychologist, trainer, coach and mediator Fredrike Bannink delivers exactly what the title promises: a concise, practical and well-organised guide to Positive Supervision for supervisors and managers of all persuasions – not just psychologists and counsellors.

Bannink's vast experience in the fields of Solution-Focused Therapy (SFT) and Positive Psychology allow her to speak with convincing expertise about the practical application of these modalities to professional supervision. Positive Supervision focuses on "working with what works", or uncovering and encouraging the strengths of supervisees in the practice of their chosen profession. It is client-focused and involves the supervisor "leading from behind", an expression familiar to all SFT practitioners.

Experienced SFT practitioners will be familiar with most of the concepts in this book and for those with no SFT background, the language is basic enough to be understood with no prior exposure to SFT.

The author divides the practice of Positive Supervision into four "pillars", entitled goal formulation, finding competence, working on progress, and reflection, all of which will resonate with those familiar with SFT. But the volume is also rich with examples and case studies that give life to the theory as well as practical exercises that readers will find useful in the practice of supervision.

There is a chapter devoted to the administrative bones of supervision such as supervision agreements, writing reports, audio and video recordings, reporting to third parties, and supervision via e-mail and/or Skype.

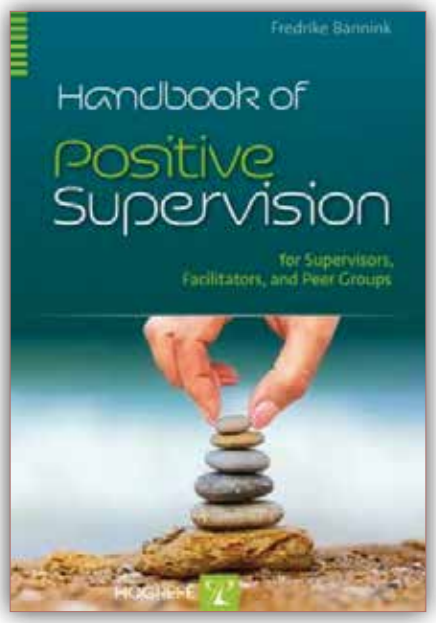
A chapter entitled "Twenty-Two Frequently Asked Questions" tackles the "what ifs" of Positive Supervision and provides suggestions for handling situations where the supervisor may be stuck even though the standard SFT practices have been followed, acknowledging that SFT sometimes seems to provide a simple formula, but it is often not as easy as it seems.

Finally, there is a short collection of Appendices that summarise the protocols of Positive Supervision along with a Session Rating Scale and a Questionnaire for Supervisors.

In this reviewer's opinion, Fredrike Bannink's Handbook of Positive Supervision is a little treasure box for anyone interested in this topic and would be a valuable addition to any supervisor's bookshelf.

Nancy Grand
Nancy is a highly qualified Counsellor and Professional Supervisor certified at Level 4 with the ACA. She is fully trained in Solution-Focused Brief Therapy, a positive, forward-looking modality that facilitates rapid change, enhanced well-being and emotional growth. She employs practical, targeted strategies to support clients in attaining success in their chosen pathways. Strength-based, client-centered counselling, mindfulness and relaxation techniques and expressive therapies are also employed. Nancy has worked extensively with adolescents, adults and families to facilitate mutually respectful and loving relationships and to cultivate peace and harmony in their lives .She is happy to travel to Gold Coast high schools to counsel teenagers or teachers or to provide individual or group supervision to other Counsellors.

Handbook of positive supervision for supervisors, facilitators, and peer groups.
Fredrike Bannink
Published 2015 by Hogrefe Publishing
Available at: www.booktopia.com.au
Price: $93.95



Bannink's vast experience in the fields of Solution-Focused Therapy (SFT) and Positive Psychology allow her to speak with convincing expertise about the practical application of these modalities to professional supervision. Positive Supervision focuses on "working with what works", or uncovering and encouraging the strengths of supervisees in the practice of their chosen profession. It is client-focused and involves the supervisor "leading from behind", an expression familiar to all SFT practitioners.

Holy Divorce: A Mindful and Spiritual Act of Self-love

Review by Sue Moore

The back cover synopsis says:

This is a diverse self-help handbook and novel inspired by licensed clinical counsellor Barbara Kiao's personal and professional work with her clients. She shares healthy ways to face your own fears, reach your highest self-understanding and fulfilment of your authentic self and create true love and happiness.

And this is an accurate description. Though it doesn't mention the myriad of helpful and true insights that fall from the pages.

Using an unusual 'novel' style and in the way of a play with acts and scenes rather than chapters, this book is an engaging and easy read.

Each act begins with a quote which are insightful in themselves eg Act I: *Reality Hits*……"When someone shows you who they are, believe them the first time!". Maya Angelou. And Act II: *The Beginning of the Journey (A Slow Awakening)*. "A person does not have to be behind bars to be a prisoner. People can be prisoners of their own concepts and ideas; they can be slaves to their own selves." Maharaji

At the end of each act, and there are four, there is an aside labelled Back Stage. This is a pause for self-reflection and awareness and draws upon the material from the previous section or 'Act' in the form of self-help questions; eg Are there things happening in your life right now that you are ignoring to see and/or refusing to examine? In what ways are you disrespecting your own feelings, desires and needs?

The style, that Barbara Kiao uses, causes the reader to feel like being a fly on the wall of her counselling room watching her skills and use of them as she attempts to help her client (the same one throughout the book) to explore what is really happening for her. The reader is also the fly on the wall of her mind as she details some of her own triggers as she offers therapy to her client.

Her own issues in life are challenged and another area of insight explored. Though the client, also a professional therapist, is unaware of these triggers and the mutually beneficial nature of their sessions.

Due to geography some sessions are held over the internet using Skype and insight is gained as to the advantages and disadvantages of this method of counselling through the narrative.

I found this book an easy and very helpful read in terms of insight into the real struggle a person goes through to move from operating out of fear to operating out of love in the deepest life relationships.

The tough struggle it can be to free oneself as a prisoner of false versions of love, concepts, ideas, histories, understanding how they are at work in one's life, and to live an authentic, fulfilling life.

The tough struggle it can be to learn to freely love and be loved, and be set free to explore creatively true love and happiness.

I have a list of people I would like to hand this book to who, I believe, it would 'hit the spot' for. Thank you, Barbara Kiao!

Sue Moore
Sue loves the opportunity to counsel people and be able to offer all that counselling is. She values particularly the engagement with courageous people helping them 'fine tune' solutions on the road to life improvement and healing.

Holy Divorce: A Mindful and Spiritual Act of Self-love
Barbara Kiao
Available at:
www.bookstore.balboapress.com
Price: $12.99

Australian Counselling Association

Published Research Competition

Are you interested in winning $2,000 or a free trip to Adelaide?

ACA is running a competition for all students who are currently completing an ACA approved course of study who submit an article for publishing in our peer reviewed journal "Counselling Australia".

Competition: Submit an article to CA for publishing as per the CA article submission guidelines. http://www.theaca.net.au/contribute.php. The article/paper must be;

a. An original article that has not been submitted for publishing anywhere else, and

b. Has been initially assessed as being suitable for publication in a professional journal by an appropriately qualified lecturer/tutor (this person must be identified on the submission) from your training provider prior to being submitted to CA for the formal review process, and

c. The article must be an essay, research paper, case study etc that was written after the 1st of July 2015.

The submission will be reviewed by a member of the CA review board, all submissions that are recommended for publishing by the ACA review board will have the authors name automatically put into the draw for the prize.

Submission rules:

- Article to be submitted with a covering page requesting a peer review.
- The body of the paper must not identify the author.
- Submission will be reviewed by a CA appointed reviewer who will advise the editor on the articles appropriateness for publication.
- Articles may be returned for rewording, clarification for correcting prior to being accepted.
- Attach a separate page noting your name experience, qualifications and contact details.
- Articles are to contain between 4000 and 5000 words in length not including references.
- Articles are to be submitted in MS Word format via email.
- Articles are to be single-spaced, 12 font and with minimal formatting.
- Articles to be fully referenced APA style.

Submissions that do not meet the above will be returned without being reviewed.

CONDITIONS: Submissions chosen for publishing will remain the property of ACA till the 1st of July 2018 with an understanding that accepted submissions are not to be submitted for publishing elsewhere until after that date. All submissions recommended for publishing will be published in one of the 2016/17 editions of Counselling Australia, 4 editions of the journal are published annually. Submissions not recommended for publishing will be returned to the author.

Submissions must be received by ACA, via email or post, no later than close of business on 1st of July 2016.

STUDENT: For the purpose of this competition a student must be an Australian resident living in Australia who is currently (at the time of submitting their article) enrolled and participating in a counselling/psychotherapy course of study, within the vocational or higher education sector, that has been formally approved/listed/accredited by ACA.

PRIZES: 1st prize for the winning author will be a choice of either $2,000.00 or one free full registration to the ACA 2016 National Conference in Adelaide including travel to and from the conference, two nights' accommodation at the conference venue, meals and attendance at the conference gala dinner. The course provider of the winning author will be given one full page in the March 2017 edition of CA for advertising purposes. The assessor of the winning submission will win a 12 month subscription to CA.

2nd prize $500.00.

- All authors of submissions accepted for publishing will be given a FREE 12 month subscription to *Counselling Australia*.
- This competition is not open to: ACA staff, CA editors or members of the CA review board or their immediate family members. Winners of the competition will be notified on 1st of August 2016.
- Winners names and the name of the training provider will be published in the December quarterly of the 2016 edition of *Counselling Australia*.
- All enquiries to be sent to philip@theaca.net.au

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AUSTRALIAN CAPITAL TERRITORY				
Hun Kim	DOWNER	02 6255 4597	Upon Enquiry	FTF
Karen Rendall	BARTON	0431 083 847	Upon Enquiry	FTF
Mijin Seo-Kim	DOWNER	02 6255 4597	Upon Enquiry	FTF
Brenda Searle	CANBERRA REGION	0406 376 302	$100 to $130	FTF/PH/GRP/WEB
NEW SOUTH WALES				
Leonie Frances Raffan	HAMILTON	0402 327 712	120	FTF/PH/WEB
Joy Ruth Kennedy	OAKDALE	0437 571 424	Upon Enquiry	FTF/PH/GRP/WEB
Sandra Bowden	BATEAU BAY/CENTRAL COAST	0438 291 874	$70	FTF
Patriciah Catley	NARELLAN	02 9606 4390	Upon Enquiry	FTF
Patricia Cheetham	KENSINGTON	1300 552 659	Upon Enquiry	FTF
Brian Edwards	FORRESTERS BEACH	0412 912 288	Upon Enquiry	FTF
Trudi Fehrenbach	EAST BALLINA	0427 678 275	Upon Enquiry	FTF
Jacky Gerald	POTTS POINT	0406 915 379	Upon Enquiry	FTF
Wendy Gibson	KOOLEWONG	02 4342 6746 or 0422 374 906	Upon Enquiry	FTF
Kim Michelle Hansen	PUTNEY	02 9809 5989 or 0412 606 727	Upon Enquiry	FTF
Vicki Johnston	EASTLAKES	02 9667 4664	Upon Enquiry	FTF
Matti Ngai Lee	SYDNEY	0400 272 940	Upon Enquiry	FTF
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Moira McCabe	HAMILTON	0416 038 026	Upon Enquiry	FTF
Rod McClure	BONDI JUNCTION	0412 777 303	Upon Enquiry	FTF
Heide McConkey	BONDI JUNCTION	02 9386 5656	Upon Enquiry	FTF
Judith Reader	STOCKTON	02 4928 4880	Upon Enquiry	FTF
Maarit Mirjami Rivers	CHURCH POINT	0417 462 115	Upon Enquiry	FTF
Hanna Salib	LUDDENHAM	0401 171 506	Upon Enquiry	FTF
Kirilly Smitheram	NEWTOWN	0411 550 980	Upon Enquiry	FTF
Shane Warren	DARLINGHURST	0418 726 880	Upon Enquiry	FTF
David Robert Watkins	ELANORA HEIGHTS	0404 084 706	Upon Enquiry	FTF
Katrina Christou	NEWTOWN	0412 246 416	Upon Enquiry	FTF
Lyndall Briggs	KINGSGROVE	02 9024 5182	Upon Enquiry	FTF
Brian Lamb	NEWCASTLE/LAKE MACQUARIE	0412 736 240	$120 (contact for sliding scales)	FTF/GRP/PH
Penny Bell	CUMBI UMBI	0416 043 884	Upon Enquiry	FTF/GRP/PH/WEB
Michael Morris Cohn	NORTH BONDI	0413 947 582	$120	FTF/GRP/PH/WEB
Leon Cowen	LINDFIELD	02 9415 6500	Upon Enquiry	FTF/GRP/PH/WEB
Linda Elsey	WYEE	02 4359 1976	Upon Enquiry	FTF/GRP/PH/WEB
Karen Morris	NEWCASTLE/HUNTER VALLEY	0417 233 752	$100	FTF/GRP/PH/WEB
Grahame Smith	SINGLETON	0428 218 808	$66	FTF/GRP/PH/WEB
Carol Stuart	BONDI JUNCTION	0293 877 752	$80 pp - % rate $50 for early graduates	FTF/GRP/PH/WEB
John Harradine	CREMONE	0419 953 389	$160; GRP $120	FTF/GRP/WEB

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Gwenyth Lavis	ALBURY	0428 440 677	Upon Enquiry	FTF/PH
Deborah Rollings	SUTHERLAND	0427 584 554	Upon Enquiry	FTF/PH
Michella Wherrett	LAKE MACQUARIE/NEWCASTLE	0414 624 513	$80	FTF/PH
David Edwin Warner	PEAKHURST	0418 283 519	Upon Enquiry	FTF/PH/GRP
David Gotlieb	SYDNEY/BOWRAL	0421 762 236	$40 Grp, $80 Indiv	FTF/PH/GRP/SKYPE
Lorraine Dailey	MAROOTA	0416 081 882	Upon Enquiry	FTF/PH/GRP/WEB
Margaret Hutchings	YAMBA GRAFTON	0417 046 562	Upon Enquiry	FTF/PH/GRP/WEB
Jennifer Blundell	AUSTINMER	0416 291 760	Upon Enquiry	FTF/PH/GRP/WEB
Aaron Elliott	CARDIFF	0408 615 155	Upon Enquiry (flexible)	FTF/PH/WEB
Dr Dawn Macintyre	CLUNES	0417 633 977	Upon Enquiry	FTF/PH/WEB
Karen Daniel	TURRAMURRA	02 9449 7121 or 0403 773 757	$125 1hr; $145 1.5hrs	FTF/WEB
Elizabeth Allmand	QUEANBEYAN	0488 363 129	$120	FTF/WEB/PH
Kathryn Jane Quayle	HORNSBY	0414 322 428	$95	FTF/WEB/PH
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Judy Eckermann	ALICE SPRINGS	0427 551 145	Upon Enquiry	FTF
Rian Rombouts	MILLNER	0439 768 648	Upon Enquiry	FTF
Margaret Lambert	DARWIN	08 8945 9588 or 0414 459 585	Upon Enquiry	FTF/GRP/PH/WEB
QUEENSLAND				
Yvette Marion Johnstone	MURRUMBA DOWNS	07 3496 2861	$70.00	FTF/GRP/WEB
Ligia Emmel Barnett	EMERALD	0419 954 984	Upon Enquiry	FTF/PH/WEB
Margaret Newport	SARINA	0414 562 455	On enquiry	FTF/PH/GRP/WEB
Julianne Cutcliffe	SPRINGFIELD	0425 623 400	$50 Students $60 professionals	FTF/PH/WEB
Laura Banks	BROADBEACH	0431 713 732	Upon Enquiry	FTF
Tanya-Lee M Barich	WONDUNNA	0458 567 861	Upon Enquiry	FTF
Maartje (Boyo) Barter	WAKERLEY	0421 575 446	Upon Enquiry	FTF
Christine Boulter	COOLUM BEACH	0417 602 448	Upon Enquiry	FTF
Sherrie Brook	MURRUMBA DOWNS	0476 268 165	Upon Enquiry	FTF
Robyn Brownlee	NANANGO	0457 633 770	Upon Enquiry	FTF
Jennifer Bye	VICTORIA POINT	0418 880 460	Upon Enquiry	FTF
Christine Castro	ALGESTER	0478 507 991	Upon Enquiry	FTF
Ronald Davis	LABRADOR	0434 576 218	Upon Enquiry	FTF
Erin Annie Delaney	BEENLEIGH	0477 431 173	Upon Enquiry	FTF
Aisling Fry	LOTA	0412 460 104	Upon Enquiry	FTF
Nancy Grand	SURFERS PARADISE	0408 450 045	Upon Enquiry	FTF
Kirsten Greenwood	MUDGEERABA	0421 904 340	Upon Enquiry	FTF
Valerie Holden	PEREGIAN SPRINGS	0403 292 885	Upon Enquiry	FTF
Anne-Marie Houston	BUNDABERG	0467 900 224	Upon Enquiry	FTF
Kim King	YEPPOON	0434 889 946	Upon Enquiry	FTF
Kaye Laemmle	HELENSVALE	0410 618 330	Upon Enquiry	FTF
Neil Roger Mellor	PELICAN WATERS	0409 338 427	Upon Enquiry	FTF
Tracey Milson	ARUNDEL	0408 614 062	Upon Enquiry	FTF
Gary Noble	LOGANHOLME DC	0439 909 434	Upon Enquiry	FTF
Steven Josef Novak	BUDERIM	0431 925 771	Upon Enquiry	FTF
Colin Palmer	KALLANGUR	0423 928 955	Upon Enquiry	FTF
Lyn Patman	BROWNS PLAINS	0415 385 064	Upon Enquiry	FTF

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Penelope Richards	CHAPEL HILL	0409 284 904	Upon Enquiry	FTF
Brian Ruhle	URANGAN	0401 602 601	Upon Enquiry	FTF
Natalie Scott	TARRAGINDI	0410 417 527	0410 417 527	FTF
Deborah Stevens	KINGAROY	0411 661 098	Upon Enquiry	FTF
Frances Taylor	REDLAND BAY	0415 959 267 or 07 3206 7855	Upon Enquiry	FTF
Pamela Thiel-Paul	BUNDALL/GOLD COAST	0401 205 536	$90	FTF
Lynette Baird	MAROOCHYDORE/SUNSHINE COAST	07 5451 0555	Grp $30 or Indiv $90	FTF/GRP
David Kliese	SIPPY DOWNS/ SUNSHINE COAST	07 5476 8122	Indiv $80, Grp $40 (2 hours)	FTF/GRP/PH
Judy Boyland	SPRINGWOOD	0413 358 234	$100	FTF/GRP/PH/WEB
Catherine Dodemont	GRANGE	0413 623 162	$40 Grp; $100 indiv	FTF/GRP/PH/WEB
Rev Peter Gee	EASTERN HEIGHTS/IPSWICH	0403 563 467	$65	FTF/GRP/PH/WEB
Ann Moir-Bussy	SIPPY DOWNS	07 5476 9625 or 0400 474 425	Upon Enquiry	FTF/GRP/PH/WEB
Yildiz Sethi	WAKERLEY	07 3390 8039	Indiv $90, Grp $45	FTF/GRP/PH/WEB
Patricia Fernandes	EMERALD/SUNSHINE COAST	0421 545 994	$30-$60	FTF/PH
Jodie Logovik	HERVEY BAY	0434 060 877	Upon Enquiry	FTF/PH
Judith Morgan	TOOWOOMBA	07 4635 1303 or 0412 372 431	$100	FTF/PH
Diane Newman	BUNDABERG WEST	0410 397 816	Upon Enquiry	FTF/PH
William James Sidney	LOGANHOLME	0411 821 755 or 07 3388 0197	Upon Enquiry	FTF/PH/GRP
Iain Bowman	ASHGROVE	0402 446 947	Upon Enquiry	FTF/PH/GRP/WEB
Sharron Mackison	CABOOLTURE	07 5497 4610	Upon Enquiry	FTF/PH/GRP/WEB
Maggie Maylin	WEST END	0434 575 610	Upon Enquiry	FTF/PH/GRP/WEB
David Hamilton	BEENLEIGH	07 3807 7355 or 0430 512 060	Indiv $80, Students $60	FTF/PH/GRP/WEB
Beverley Howarth	PADDINGTON	0420 403 102	Upon Enquiry	FTF/PH/WEB
Menny Monahan	KIPPA-RING	0419 750 539	$100.00	FTF/PH/WEB
Christine Perry	BUNDABERG	0412 604 701	$70	FTF/SKYPE
Heidi Edwards	GYMPIE	0466 267 509	$99	FTF/WEB
SOUTH AUSTRALIA				
Susan Turrell	BLAKEVIEW	0404 066 433	55	FTF/GRP/WEB
Barry White	PORT ADELAIDE	0488 777 459	Upon Enquiry	FTF/PH
Richard Hughes	WILLUNGA	0409 282 211	Negotiable	FTF/PH/WEB
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon Enquiry	FTF
Maxine Litchfield	GAWLER WEST	0438 500 307	Upon Enquiry	FTF
Pamela Mitchell	WATERFALL GULLY	0418 835 767	Upon Enquiry	FTF
Kerry Turvey	TANUNDA	0423 329 823	Upon Enquiry	FTF
Laura Wardleworth	ANGASTON	0417 087 696	Upon Enquiry	FTF
Carol Moore	OLD REYNELLA	08 8297 5111 bus or SMS 0419 859 844	Grp $35, Indiv $99	FTF/PH/GRP/WEB
Adrienne Jeffries	STONYFELL	08 8332 5407	Upon Enquiry	FTF/PH/WEB
Ellen Turner	HACKHAM WEST	0411 556 593	Upon Enquiry	FTF
TASMANIA				
Pauline Mary Enright	SANDY BAY	0409 191 342	85 per session Group on App	FTF/PH/WEB
David Hayden	HOWRAH NORTH	0417 581 699	Upon Enquiry	FTF

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TASMANIA *CONTINUED*				
Benjamin Donald Turale	HOBART	0409 777 026	Upon Enquiry	FTF/PH/WEB
VICTORIA				
Matt Glover	Croydon Hills, East Doncaster	0478 651 951	Conc: $70, Full: $90 Group: $30/hour	FTF/PH/GRP/WEB
Anna Atkin	CHETLENHAM	0403 174 390	Upon Enquiry	FTF
Marie Bajada	BALLARAT	0409 954 703	Upon Enquiry	FTF
Zohar Berchik	SOUTH YARRA	0425 851 188	Upon Enquiry	FTF
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Molly Carlile	INVERLOCH	0419 579 960	Upon Enquiry	FTF
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Debra Darbyshire	BERWICK	0437 735 807	Upon Enquiry	FTF
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon Enquiry	FTF
Karen Efron	NORTHCOTE	0432 391 887	Upon Enquiry	FTF
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon Enquiry	FTF
Maurice Grant-Drew	ELWOOD	0412 331 301	Upon Enquiry	FTF
Batul Fatima Gulani	MELBOURNE	0422 851 536	Upon Enquiry	FTF
Melissa Harte	PAKENHAM/SOUTH YARRA	0407 427 172	$132 to $143	FTF
Belinda Hulstrom	Williamstown	04714 331 457	Upon Enquiry	FTF
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Beverley Kuster	NARRE WARREN	0488 477 566	Upon Enquiry	FTF
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF
Barbara Matheson	MELBOURNE	03 9703 2920 or 0412 977 553	Upon Enquiry	FTF
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Marguerite Middling	NORTH BALARAT	0438 744 217	Upon Enquiry	FTF
Paul Montalto	THORNBURY	0415 315 431	Upon Enquiry	FTF
Andrew Reay	MOORABBIN	0433 273 799	Upon Enquiry	FTF
Patricia Reilly	MOUNT MARTHA/GARDENVALE	0401 963 099	Upon Enquiry	FTF
Lynne Rolfe	BERWICK	03 9768 9902	Upon Enquiry	FTF
Claire Sargent	CANTERBURY	0409 438 514	Upon Enquiry	FTF
Kenneth Robert Scott	BUNYIP	03 5629 5775	Upon Enquiry	FTF
Karen Seinor	WODONGA	0409 777 116	Upon Enquiry	FTF
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon Enquiry	FTF
Natalie Wild	BORONIA	0415 544 325	Upon Enquiry	FTF
Jacquie Wise	ALBERT PARK	03 9690 8159	Upon Enquiry	FTF
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260 or 03 9786 8006	Upon Enquiry	FTF
Joan Wray	(MOBILE SERVICE)	0418 574 098	Upon Enquiry	FTF
Graham Hocking	PARK ORCHARDS	0419 572 023	Upon Enquiry	FTF
Tabitha Veness	FERNTREE GULLY	0400 924 891	Upon Enquiry	FTF
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF,Skype
Joanne Ablett	PHILLIP ISLAND/MELBOURNE METRO	0417 078 792	$120	FTF/GRP/PH/WEB
Danielle Aitken	SOUTH GIPPSLAND/MELBOURNE METRO	0409 332 052	Upon Enquiry	FTF/GRP/PH/WEB

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Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
VICTORIA *CONTINUED*				
Kathleen (Kathy) Brennan	NARRE WARREN	0417 038 983	$35 Grp, $60 Indiv	FTF/GRP/PH/WEB
Sheryl Brosnan	CARLTON NORTH/MELBOURNE	03 8319 0975 or 0419 884 793	Upon Enquiry	FTF/GRP/PH/WEB
Sandra Brown	FRANKSTON/MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
Rosslyn Wilson	KNOXFIELD	03 9763 0772 or 03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Deborah Cameron	BRIGHTON/HONG KONG	+65 9186 8952 or 0447 262 130	Upon Enquiry	FTF/GRP/WEB
Nyrelle Bade	EAST MELBOURNE/POINT COOK	0402 423 532	Upon Enquiry	FTF/GRP/WEB
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Judith Beaumont	MORNINGTON	0412 925 700	Upon Enquiry	FTF/PH/GRP/WEB
Lehi Cerna	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
Helen Wayland	ST KILDA	0412 443 899	$75 Indiv	FTF/PH/GRP/WEB
Gabrielle Skelsey	ELSTERNWICK	03 9018 9356	Upon Enquiry	FTF/PH/WEB
Cas Willow	WILLIAMSTOWN	03 9397 0010 or 0428 655 270	Upon Enquiry	FTF/PH/WEB/GRP
Lisa Derham	CAMBERWELL	0402 759 286	Upon Enquiry	FTF/WEB
Sara Edwards	DINGLEY	0407 774 663	Upon Enquiry	FTF/WEB
Sandra Robinson	MANSFIELD/BENALLA	0403 175 555	$110 individual 1 hour session. $50 - group per he	FTF/Skype
John Dunn	COLAC SW AREA/MT GAMBIER	03 5232 2918	By Negotiation	FTF/GRP/WEB
WESTERN AUSTRALIA				
Julie Hall	YANCHEP/BUTLER/JINDALEE/ JOONDALUP	0416 898 034	$100	FTF/PH/WEB
Marie-Josee Boulianne	BEACONSFIELD	0407 315 240	Upon Enquiry	FTF
Lynette Cannon	CAREY PARK	0429 876 525	Upon Enquiry	FTF
Karen Heather Civello	BRIDGETOWN	0419 493 649	Upon Enquiry	FTF
Cindy Cranswick	FREMANTLE	0408 656 300	Upon Enquiry	FTF
John Dallimore	FREMANTLE	0437 087 119	Upon Enquiry	FTF
Alan Furlong	WINTHROP	0457 324 464	Upon Enquiry	FTF
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
Genevieve Armson	CARLISLE	0412 292 999	Upon Enquiry	FTF, GRP, PH, WEB
Carolyn Midwood	DUNCRAIG	08 9448 3210	Indiv $110, Grp $55	FTF/GRO/PH/WEB
Sharon Vivian Blake	FREMANTLE	0424 951 670	Indiv $100, Grp $60	FTF/PH/GRP/WEB
Merrilyn Hughes	CANNING VALE	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB
Eva Lenz	SOUTH FREMANTLE/COOGEE	08 9418 1439 or 0409 405 585	$85, concession $70	FTF/PH/GRP/WEB
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
Dr. Patricia Sherwood	PERTH/BUNBURY	0417 977 085 or 08 9731 5022	$120	FTF/PH/WEB
Lillian Wolfinger	YOKINE	08 9345 0387 or 0401 555 140	Upon Enquiry	FTF/PH/WEB
INTERNATIONAL				
Dina Chamberlain	Hong Kong	+852 6028 9303	Upon Enquiry	FTF
Fiona Man Yan Chang	Hong Kong	+852 9198 4363	Upon Enquiry	FTF

ACA SUPERVISOR COLLEGE LIST			Medium key: FTF: Face to face | PH: Phone | GRP: Group | WEB: Skype	
Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
INTERNATIONAL *CONTINUED*				
Pui Kuen Chang	Hong Kong	+852 9142 3543	Upon Enquiry	FTF
Polina Cheng	Hong Kong	+852 9760 8132	Upon Enquiry	FTF
Viviana Cheng	Hong Kong	+852 9156 1810	Upon Enquiry	FTF
Eugnice Yiu Sum Chiu	Hong Kong	+852 2116 3733	Upon Enquiry	FTF
Wing Wah Hui	Hong Kong	+852 6028 5833	Upon Enquiry	FTF
Cary Hung	Hong Kong	+852 2176 1451	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
Lap Kwan Tse	Hong Kong	+852 9089 3089	Upon Enquiry	FTF
Barbara Whitehead	Hong Kong	+852 2813 4540	Upon Enquiry	FTF
Yat Chor Wun	Hong Kong	+852 264 35347	Upon Enquiry	FTF
Eugene Chong	Singapore	+65 6397 1547	Upon Enquiry	FTF
David Kan Kum Fatt	Singapore	+65 9770 3568	Upon Enquiry	FTF
Gan Su Keng	Singapore	+65 6289 6679	Upon Enquiry	FTF
Jeffrey Gim Tee Po	Singapore	+65 9618 8153	$100.00	FTF/GRP/PH/WEB
Saik Hoong Tham	Singapore	+65 8567 0508	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 both arguments and personal opinions 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, Counselling Hypnotherapy and Creative Arts.

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

Get Direct Entry Into A Professional College

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

Flexible And Cost Effective

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

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

PLUS, you'll **save almost $9,000.00** (63% discount to market) and get a second specialty FREE. A Graduate Diploma at a university costs between $13,000 and $24,000. BUT, you don't have to pay these exorbitant amounts for an equally high quality qualification.

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