COUNSELLING AUSTRALIA

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Antidepressants may not be as effective as we thought

Counselling the client with depression- is there a definitive treatment?

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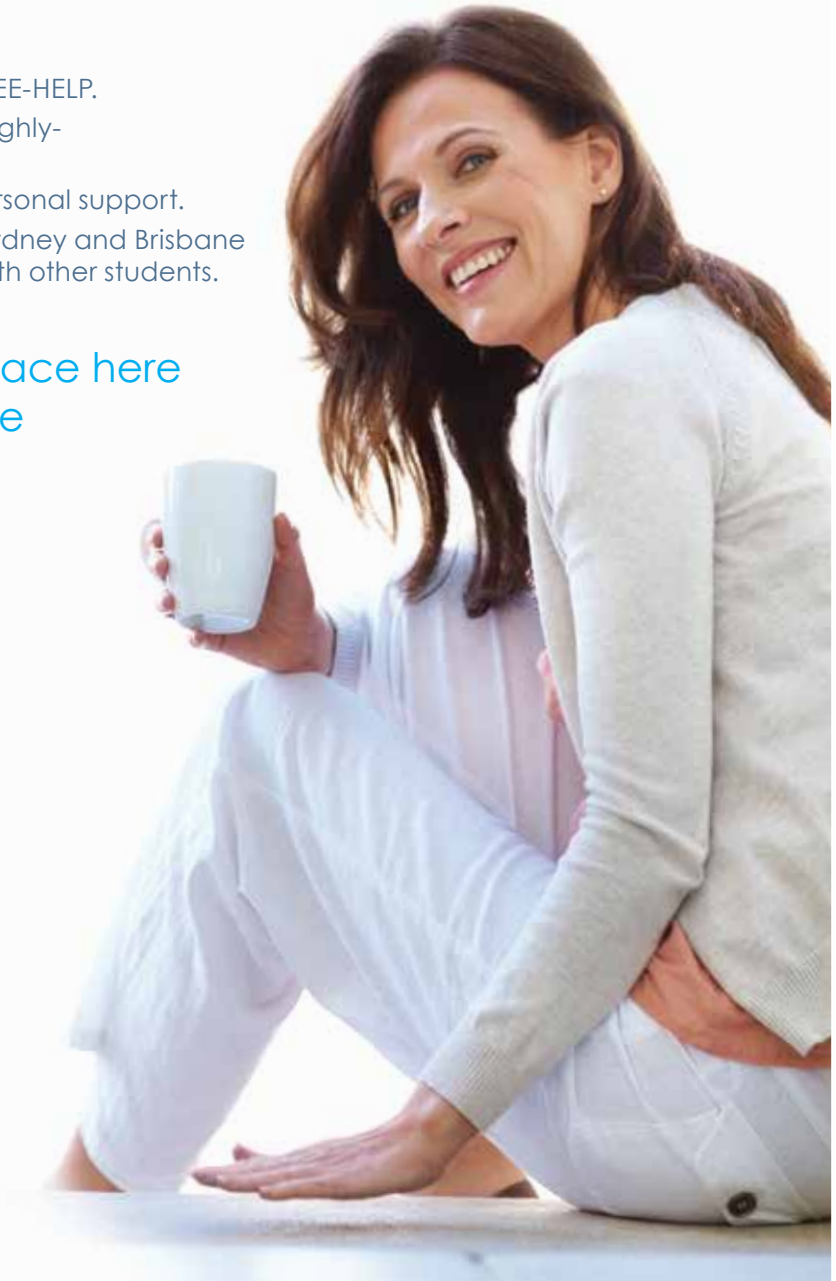

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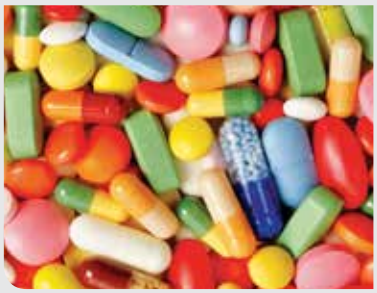

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See page 47 for peer-reviewed article submission guidelines.
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From the CEO's desk

By Philip Armstrong

The last four months have proven to be very challenging for myself, ACA and the mental health industry as a whole. I am typing this editorial one handed whilst I recover from shoulder reconstruction surgery. Over Christmas I was involved in a sporting accident which aggravated an old shoulder injury incurred whilst I was in the Army. I am currently restricted in movement whilst I recover from the surgery and then start the rehabilitation process.

In regards to ACA, its growth rate has been higher than anything we have previously experienced which is good news for ACA and its members. However this has put an extreme strain on our staff and resources as we now manage the growth spurt and all that comes with it. In part our growth is attributable to the introduction of an Industry Liaison Officer (ILO) which has allowed ACA to work more closely with employer groups and educators. There has been a sharp rise in the employment of ACA members with several members sharing with us good news stories as they enter into new employment gained as a direct result of ACA's work and the introduction of the ACA Career Centre. ACA has also experienced a significant rise in student members and new graduates. Much of this is being driven by ACA's work with key stake holders in the industry.

Another influence on ACA's growth rate has been all the ground work we have been doing with National Disability Scheme (NDIS) over the last 12 months. ACA standards are now recognised by NDIS as meeting its criteria to allow counsellors to enter into contract work to supply services to NDIS consumers. Registration with ACA helps meet some of the criteria required to act as a sub-contractor to NDIS as it is rolled out in each state and territory. NDIS requirements are different State by State and Territory, the ACA website can walk members through the process. Again, we have received good news stories from members in Private Practice who have been able to secure contracts as a result of ACA registration.

ACA's growth has now seen ACA move out of our office in the Grange and into a new building in Newmarket. We simply could not continue to operate from our small office which we moved into many years ago. Several thousand members and several more ACA staff have made it impossible to operate effectively in a small space. Along with a new office ACA has employed a junior admin assistant to support our membership officer. ACA now has 6 full time staff working for our members.

Politics this year has been very up and down with changes in Prime Minister along with a new Minister for Health, which mental health falls under, and several changes to the senior adviser (mental health) to the Minister. ACA has met with the Ministers adviser several times this year to get a greater understanding of the introduction of the Primary Health Networks (PHN). PHN will be responsible for contracting service providers, including private practitioners, to provide counselling services within early intervention, primary and secondary care areas. Unfortunately the intervention of the Federal election in July will have a detrimental impact on the roll out of the PHNs. This means we will not know until after the elections what opportunities will exist for counsellors. Regardless of the election ACA is meeting with each of the PHNs to ensure they are well informed of the differences between registered counsellors and non registered counsellors.

The ACA National conference this year will be: Kanyini; A Focus on Counselling in 2016 - Multicultural & Indigenous Mental Health and Well Being in Australia, Differences and Similarities. It will be held between September 23 and 25, in Adelaide.

The conference will incorporate the launch of the ACA professional college: College of Aboriginal and Torres Strait Islander Counsellors. Kanyini is an Australian Indigenous word. Kanyini is the principle of connectedness through caring and responsibility that underpins Aboriginal life. Kanyini is a connectedness totjukurrpa (knowledge of creation or 'Dreaming', spirituality), ngura (place, land), walytja (kinship) and kurunpa (spirit or soul). Kanyini is nurtured through caring and practicing responsibility for all things.

A Focus on Counselling in 2016

Multicultural & Indigenous Mental Health and Well Being in Australia, Differences and Similarities

The 2016 Australian Counselling Association, National Conference will be hosted by ACA between September 23 and 25, 2016 at the Stamford Plaza Hotel in Adelaide.

The conference theme is a focus on "Multicultural and Indigenous Mental Health and Well Being" and has been named Kanyini, the principle of connectedness through caring and responsibility that underpins Aboriginal life.

The conference will explore the differences and similarities of working in a multicultural and/or indigenous environment, whether it be working with Aboriginals, Torres Straight Islanders, refugees, immigrants (new and old) or white Australians. The conference will provide indigenous peoples a voice and platform from where they can express in a constructive manner their unique differences and similarities.

This is a wonderful opportunity to network with some of Australia's finest speakers and researches and to profile your area of expertise in a positive collegial atmosphere.

To register visit
https://www.theaca.net.au/conference/index.php

Kanyini 2016 ACA National Conference
23rd-25th September, Adelaide, Australia

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Technology Update

With Dr Angela Lewis

One thing that never changes in the world of social media is the rapid pace of change and what seems to be the almost daily appearance of new terms, new apps and new technology. With that in mind, I came across a couple of new terms in the last few weeks I would like to share with you, the first of which is 'ghosting'. Ghosting (not of the Casper the friendly ghost type) has come to be used as a verb in the word of social media to mean ending a romantic relationship by cutting off all contact and ignoring the former partner's attempts to reach out.
It is an old relationship-ending tactic known in the psychological literature as avoidance, where a person simply disappears from a romantic interest's life. Now it is applied to the act of avoiding someone by not answering attempted phone calls, texts, emails, Facebook or any other type of social tool that you may be using.

The other term I'd certainly never heard monogamish, thrown into a conversation by a female friend speaking about her latest relationship and how they were using the 3nder app (see more below). This new term describes couples who are mostly monogamous but have an understanding between them which allows for infidelity or non-monogamy under mutually agreed circumstances.

Niche relationship/dating sites

3NDER

3nder, (pronounced 'thrinder) is the dating app very similar to Tinder however it is targeted towards couples looking for threesomes (simply Google search Tinder if you are not familiar with it). While this is the core of its business, 3inder also advertises as providing more options around sexual orientation and gender identity. Like Tinder, you swipe in different directions and it's Facebook-authenticated, but you can choose your own name or pseudonym to ensure privacy from the rest of your family and friends who might also be on Facebook.

LUXY

A few issues ago we looked at a variety of dating applications, including Tinder; now let me introduce Luxy, Tinder's richer, more exclusive cousin. Luxy is a dating site which focuses on participants having either looks or wealth and is colloquially known as "Tinder without the poor people". To join you need to disclose and prove your income (which by the way needs to be above $200,000). Failing that you need to provide evidence that you are a very attractive person, with your acceptance onto the site based on other Luxy members deciding whether you are good looking enough to join without

having a lot of money. Luxy joins others in the market such as the US site known as The League and the UK's Inner Circle.

Riding the social media train

There are currently around 200 social media networks about the place and the number continues to grow each month. The reality is that it is not possible to be across all of them and for many people it becomes quite stressful to decide what to join – and then putting in the time to be active and visible on the chosen networks. If you ask most twenty-somethings, they apparently wouldn't be caught dead using Twitter and many consider Facebook (thanks to its universal use and appeal), as being old hat and "for parents". Instead, the young(er) and hip tend to favour the least labour intensive ways of sharing on social media platforms, using such platforms as Instagram (just send a picture, little typing required) or Snapchat, a social media app which allows the user to send a picture or video with a few words of commentary, which will self-destruct a few seconds after the recipient has viewed it.

Other social network platforms that people are using include Whatsapp, KIK, Wanelo, Vine, Periscope and Peach. If you find yourself exhausted by all this choice, pick one or two that your base of friends are using and be content with that. For myself, I draw the line at using three apps: Twitter (I like it for the news, up to date social commentary and the fact that it is text based), Facebook – well because everybody including my old aunty Pat use it and Whatsapp, because it is a platform that is favoured by my overseas family as it allows us to talk and text at no cost using any available Wi-Fi. Here are a few others and just like as the ones just mentioned above, they use your Smartphone's data plan or Wi-Fi connection to send and receive messages, video or chat.

PERISCOPE

Owned by Twitter, this platform allows the user to video-record and broadcast to anywhere in the world. If you have ever been on Skype, it is a similar experience but instead of video conferencing with one person, you can stream to the masses.

VINE

This is a social media app that lets you post and watch video clips of up to 6 seconds.

KIK, FACEBOOK MESSENGER AND WHATSAPP

All are no-cost instant messaging apps used on mobile devices; KIK for some reason is quote popular with Instagram users. They all allow unlimited messaging/ texting and voice calls to anyone else around the world using the same service.

If you ask most twenty-somethings, they apparently wouldn't be caught dead using Twitter and many consider Facebook (thanks to its universal use and appeal), as being old hat and "for parents".

PROTECTING YOUR PRIVACY ON FACEBOOK

If your friends are using apps (for example games like Candy Crush) on Facebook, they could be giving information of yours way without realising it, as people who can see your information can bring it with them when they use apps. However there is a setting you can use change to control the categories of information others can bring with them when they use apps, games and websites while Facebooking.

1. Go to **Settings** on Facebook.
2. Click on **Apps**.
3. Scroll down to the box marked **Apps Others Use** and click on **Edit**.
4. A box pops own listing the types of information (of yours) that your friends may be able to share. Deselect each option you do not wish to share, if not all of them.

Note: If you want to go a step further and stop apps or sites accessing data such as your Friends list, gender to other public information, locate the **Apps, Websites and plugins** box that is also under Apps, click the **Edit** button and select **Disable Platform**. Be aware that this will disable your ability to use apps and plugins that offer to allow you to log in with your Facebook identity as well as disabling your ability to play games.
I suggest that if you are unsure of this information it would be a good idea if you take the time to read the Facebook help pages as well as doing your own Google research before changing any of the settings.

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.

PEER REVIEWED ARTICLE

Combatting compassion fatigue

in Community Care Professionals using the EAGALA Model

By Michelle Black

Abstract

The phenomenon of Compassion Fatigue (CF), articulated as the cost of caring for clients that have experienced Trauma (Figley, 1995), is presented from a study of empirical research relating to CF among Community Care Professionals (CCPs). The study uncovered, the symptoms, prevalence, risk factors and best practice interventions identified to alleviate individual experiences and symptoms of CF. CCP populations explored include; nurses, counsellors, social workers, hospice care workers, residential care professionals, mental health practitioners and military health practitioners. The research informed the development of a care professional resilience program, Combatting Compassion Fatigue in Community Care Professionals. This program targets a combination of best practice interventions to educate, develop self-care, emotion awareness, emotion management and problem solving skills that foster resilience to reduce the risk and experiences of CF among CCPs. A purposeful sample of 10 CCPs working in residential care facilities in Northern New South Wales, self-selected to participate in the program. To understand the impact of the program and interventions used, a pre and post assessment occurred using the Professional Quality of Life (ProQOL) scale (Stamm, 2010), as a screening tool and the Genos Emotional Intelligence Self-Test (Genos, 2015). An analysis of the variance between the pre and post-tests revealed ProQol scores for Compassion Fatigue and Burnout decreased whilst Compassion Satisfaction scores increased. The Genos Emotional Intelligence analysis found a statistically significant improvement in overall emotional intelligence and statistically significant improvements in the emotional intelligence factors of emotion self-management, emotional expression, emotion self-control and emotion awareness of others.

An introduction to Compassion Fatigue

Traumatologist Charles Figley (1995) emphasised that Compassion Fatigue (CF) among Community Care Professionals (CCPs) is the emotional and physical cost of caring for those that have experienced trauma. Figley positions, to effectively support clients experiencing trauma, the CCPs role centres on helping the client to cope with emotional suffering which requires the use of empathy. Although unintended, this sharing of empathy may result in negative effects on the CCP such as experiences likened to Post Traumatic Stress Disorder (PTSD) found in the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association [APA], 2013), (Craig & Sprang, 2010; Figley, 1995; Schwam, 1998).

A number of terms are used interchangeably to describe the negative effects of caring for those that have experienced trauma (Bercier and Maynard, 2015). These terms include: Vicarious Trauma (VT), Countertransference (CT), Secondary Traumatic Stress (STS) and Compassion Fatigue (CF) (Craig & Sprang, 2010; Figley, 1995; Lee, McCarthy Veach, McFarlane, & LeRoy 2014). Vicarious Trauma (VT) is experienced when the client's traumatic material is retained by the CCP which may negatively affect the CCP's beliefs and view of the world (Figley, 1995; Harrison & Westwood, 2009; Lynch & Lobo, 2012). Countertransference (CT) occurs when the CCP unconsciously sees themselves in the client's situation, overly identifying with the client and unable to separate the self from the client experience (Figley, 1995; Figley 2002; Lynch & Lobo, 2012). Secondary Traumatic Stress (STS), the term most used interchangeably with CF, mirrors the DSM-5 criteria for PTSD with the difference between the PTSD and STS being how the actual experience of trauma occurs. STS is experienced indirectly in the interaction with the client that has experienced trauma, the CCP takes on board the client's experience of the client's trauma whereas PTSD is a direct experience of trauma (Figley, 1995; Lynch & Lobo, 2012; Rzeszutek, Partyka & Golab, 2015). Compassion Fatigue occurs when the relationship founded on empathy between the CCP and the client that has experienced trauma, leads to a psychological response in the CCP that directly effects empathy and reduce the capacity for the CCP to engage with and care for the client suffering from trauma (Figley, 1995).

Additional terms used, however not used interchangeably with CF, include Burnout (BO) and Compassion Satisfaction (CS). BO is a form of physical, emotional and cognitive exhaustion that occurs as a result of long term stress and strain in highly demanding workplace situations. Whist there may be some similarity with CF, the notable difference is that CF may occur from a single experience and BO occurs progressively worsening over time (Conrad & Kellar-Gunther, 2006; Figley, 1995; Lee et al., 2014). CS describes the more positive effect of caring for those that have experienced trauma in that it is used

to describe the positive emotions, feelings of fulfilment and satisfaction that the CCP experiences as a result of their contribution to caring for clients that have experienced trauma (Rossi et al., 2012; Slocum-Gori, Hemsworth, Chan, Carson & Kazanjian, 2011).

Symptoms of CF are recognised to vary and are uniquely individual (Lynch & Lobo, 2012). Physical symptoms of CF include; fatigue, gastro intestinal issues, feelings of exhaustion, hyper arousal, rapid pulse, hypertension and increased physical ailments (Lee et al., 2015; Lynch & Lobo, 2012; Rzeszutek et al., 2015). Psychological symptoms reported include anxiety, depression, sleep disturbance, intrusive images, thoughts and dreams related to the client's trauma (Figley 1995; Hegney, Craigie, Hemsworth, Osseiran-Moisson & Drury, 2014; Lee et al., 2015). The social impacts of CF have been reported as doubting or changing ones values, beliefs and view of the world, isolating oneself, withdrawing from social activities with family and friends, interpersonal disruption, unable to feel a sense of happiness or enjoyment, a reduction in self-esteem and feelings of guilt and cynicism (Hegney et al., 2014; Lee et al., 2015; Robinson-Keiling, 2014).

The prevalence across the literature is mixed. The reported prevalence of note include: a study of 363 Colorado Child Protection Workers (CPW) found 50% of the CPWs had high to very high levels of CF (Conrad and Kellar-Gunther 2006); a study of 178 hospital and home care nurses found 15% of the group reported Professional Quality of Life (ProQOL), scores related to CF (Yoder, 2010) and a study of 109 nurses surveyed across 3 specialty units, found 86% of the nurses had moderate to high levels of CF with no significant differences in scores between nurses across departments including emergency and oncology (Hooper et al., 2010); a study of 3,600 social workers found 15.2% of social workers met the criteria for PTSD (Bride, 2007). This result was overlayed with the reported lifetime prevalence of PTSD in the general population of 7.8% to position that the prevalence of CF among CCPs is twice that of the general population (Bride, 2007).

There are a number of factors that contribute to the risk of CF among CCPs. These include; an absence self-care which has been found to correlate with an increase in CF (Alkema, Linton & Davies, 2007; Fahy, 2007; Figley, 2002); a lower level of education, found to increase stress and vulnerability to CF (Drury, Craigie, Francis, Aoun and Hegney, 2014); a previous history of trauma (Bourassa, 2009; Figley, 1995; Rossi et al., 2012); the CCPs case load and the intensity of the case load (Bourassa, 2009; DePanfilis, 2006; Devilly et al., 2009); the absence of social support and supervision (DePanfilis, 2006; Fahy 2007; Whitebird et al., 2013); and lower levels of experience working with clients that have experienced trauma. (Bourassa, 2009). In addition, the level of Emotional Intelligence and the CCPs personal and professional resilience have been reported to both increase and decrease the risk of CF (e.g. Devilly et al., 2009; King & Gardner, 2006; Samios et al., 2013). Further, the development of emotion awareness and emotion management is advocated across the literature (e.g. King & Gardner 2006; Wagaman, Geiger, Shockley & Segal 2015; Zeidner et al., 2013). It is worth noting that volunteer CCPs may be at greater risk of CF due to their limited training and access to debriefing and supervision (Jenkins and Baird, 2002).

Joinson (1992) conveyed the importance of interventions that target building capability to reduce the immediate experience of CF and reinforced the importance of interventions that also target reducing the risk of developing CF among CCP's. In order to alleviate symptoms and manage the risk of CF among CCP's, it has been recommended across the literature (e.g. Hegney et al., 2014; Drury et al., 2014; Zeidner et al., 2013) that interventions target education to build awareness of CF, screening for experiences of CF and fostering capability to manage and reduce the risk of CF. Best practice interventions found include: screening using the ProQOL scale (Stamm, 2010); education about CF to build awareness of the phenomenon (Figley, 1995); Self-care, (Alkema, Linton & Davies, 2008), Emotion awareness, emotion management and problem focused strategies (Zeidner et al., 2013). The absence or limitation of self-care was found to have a positive correlation with CF (Alkema, Linton & Davies, 2008; Bourassa, 2012; Harrison & Westwood, 2009) and emotion awareness, emotion management and problem focused strategies were reported to lessen the extent of CF (Zeidner et al., 2013).

A combined intervention program by Potter et al., (2013) revealed that learning

how to facilitate self-care, self-regulation and connection in a group of 7 nurses, sustained the ability to manage stress and reduced the negative effects of the nurse's experiences. This study revealed a decline in STS Scores as measured by the ProQOL (Stamm, 2010), immediately following the program, sustained 3 months post the program and further reduced at 6 months post the program resulting in a statistically significant variance between the mean difference, compared to the pre-program assessment (Potter et al., 2013).

A case study of an intervention program facilitated using the EAGALA Model

Informed by the research findings, an experiential intervention program to Combat CF in CCPs was developed to be a) facilitated using the EAGALA Model, the global standard for equine assisted psychotherapy (Eagala ,2015), or b) facilitated through a series of experiential group workshops. The program is founded on the principals of Carl Rogers' (1902-1987), Person-centred therapy (PCT) (Corey, 2013) and Kolb's (1984) experiential learning theory and targets a) screening for experiences of CF, b) education about CF and c) fostering resilience among CCPs through the development of self-care, emotion awareness, emotion management and problem-solving capability. The program is designed to be delivered in small groups of 8-10 participants to maintain the intimacy of the group and develop social support within the group as they share their experiences.

The following presents a case study of the intervention program, Combatting Compassion Fatigue in Community Care Professionals, facilitated using the EAGALA model. The EAGALA model was identified to facilitate the program due to its experiential, solution focused approach, the high professional standards and the reported outcomes that revealed the interventions facilitated using the EAGALA model reduced symptoms of PTSD and significantly improved wellbeing of clients experiencing PTSD. An evaluation of Veterans participating in an EAGALA model intervention program revealed a 72% reduction in symptoms of PTSD and uncovered 50% of the veterans with PTSD experienced a clinically significant reduction in symptoms that were sustained 6 months beyond treatment (Peach Ranch, 2013). In addition, the EAGALA model was found to contribute to significant improvement in the wellbeing of clients experiencing PTSD (Billany, 2016). The facilitation of the program interventions using the EAGALA Model occurred in line with the standards of the model and EAGALA code of ethics.

METHOD

A purposeful sample of 10 CCPs was attained by posting an invitation to CCPs within a northern NSW care organisation to self-nominate to participate in the program. The participants included 9 female and 1 male. The age of the group ranged from 30 years to 61 years of age and the mean age of participants across the group was 49 years. Participant roles included 4 youth workers in residential care, 4 program coordinators, 1 family support services worker and 1 manager. The role distribution equated to 9 of the group participants in front line care working with clients that have experienced trauma and 1 of the group managing the front line care professionals. The participant's duration of experience working with clients that have experienced trauma in this organisation ranged from 6 months to 3 years, and 7 months and the mean duration of time working for the organisation in the participant's role across the group was 1 year, 8 months. Participants were paid by their organisation for the hours they attended the program. All participants made a commitment to attend the full program and all participants provided informed consent, which included the participant's individual agreement for the unidentifiable data to be utilised in publications and presentations.

The program incorporated 7 x 2 hour 30 minute sessions that included: 2 x theoretical workshops 1) at the start introducing the program, key concepts of the program and psychoeducation introducing the autonomic nervous system and the influence of perception on behaviour and 2) at the end of the program reviewing and refreshing the learning from the full program. These sessions incorporated the pre and post testing using a) the Professional Quality of Life (ProQOL) scale (Stamm, 2010), found among the literature as the most utilised assessment for screening experiences of CF, BO and CS and b) the Genos Emotional Intelligence Self-Test (Genos, 2015) utilised for the tests strengths in measuring the use of emotional intelligent behaviours in the workplace.

The body of the program was delivered through 5 x 2 hour 30 minute EAGALA model sessions that incorporated a series of planned activities where participants interacted with the horses on the ground. These activities targeted the interventions of self-care, emotion awareness, emotion management and problem solving. By interacting with the horses on the ground in the planned activities, the group participants were able to experience, recognise and explore their experiences as individuals and as a group.

RESULTS

An evaluation of the program compared the pre and post-test outcomes from the ProQOL (Stamm, 2010) and the Genos, Emotional Intelligence Self-Test (Genos, 2015). The ProQOL (Stamm, 2010), scores revealed the group scores negatively varied across the domains of CF, BO (see table 1.1) and positively varied across the domain of CS (see Table 1.2) This means there was a reduction in the groups score for CF and BO and an increase in the groups score for CS. Further analysis for statistical significance is presented in Table 2. The Genos Emotional Intelligence Self-Test (Genos, 2015), measured 7 factors of Emotional Intelligence. An assessment of the variation in scores at the end of the program revealed a positive variation in overall emotional intelligence and a positive variation across 6 of the 7 emotional intelligence factors assessed, presented in table 3. The analysis of the variance found a statistically significant ($p>0.05$) improvement in overall emotional intelligence and a statistically significant ($p>0.05$) improvement in the emotional intelligence factors of: emotion self-management, emotion self-expression, emotion self-control and emotion awareness of others statistically significant ($p>0.05$), and is presented in Table 4.

DISCUSSION

This program is the first empirically researched program founded on best practice interventions and facilitated using the EAGALA model to combat CF among CCPs. The facilitation of the program interventions using the EAGALA model and the alignment of the model with Rogers Person Centred Theory (Corey, 2013) and Kolb's (1984), Experiential Learning Theory provided a strong platform for the experiential development of self-care, emotional intelligence, relaxation and problem solving to foster

Table1.1
ProQOL (Stamm, 2010) - Compassion Fatigue and Burnout

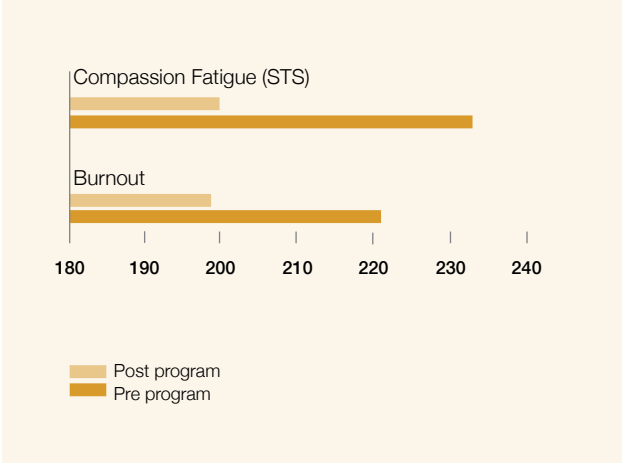

Table 1.2
ProQOL (Stamm, 2010) – Compassion Satisfaction

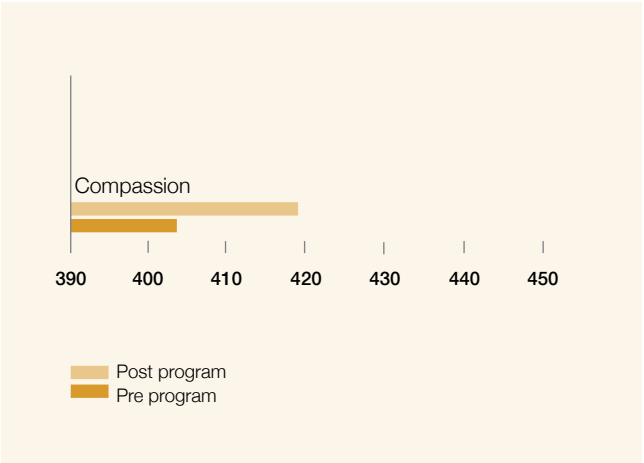

Table 2. ProQOL statistical analysis of the pre and post program variance

One-Sample Statistics

	N	Mean	Std. Deviation	Std. Error Mean
CompSatisfaction	2	409.5000	10.60660	7.50000
Burnout	2	209.0000	15.55635	11.00000
CompFatigue_STS	2	215.5000	23.33452	16.50000

One-Sample Test

Test Value = 0.05				
t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference

Combatting Compassion Fatigue In Community Care Professionals

One-Sample Statistics

					Lower	Upper
CompSatisfaction	54.593	1	.012	409.45000	314.1535	504.7465
Burnout	18.995	1	.033	208.95000	69.1817	348.7183
CompFatigue_STS	13.058	1	.049	215.45000	5.7976	425.1024

resilience among the group of CCPs that participated in the program. The positive reduction in CF and BO scores in addition to a positive increase in CS measured by the ProQOL (Stamm, 2010) although not significant demonstrate a clear directional change in experiences that positively impact the participants and their experiences in the workplace. The finding of the statistically significant improvement overall in Emotional Intelligence across the group using the Genos Emotional Intelligence Self-Test (Genos, 2015) and the statistically significant improvement in the group's emotional intelligence factors of emotion expression, emotion self-management, emotion self-control and emotion awareness of others confirms the program interventions have positively increased emotional intelligence which has been found to foster resilience and alleviate the negative effects of CF among CCPs (Zeidner et al., 2013). The combined analysis of pre and post program outcomes, positively position the program in developing capability to alleviating the symptoms and experiences of CF and fostering resilience by developing self-care, emotion awareness, emotion management and problem solving capability.

The outcomes of this intervention program, contribute to the body of research relating to CF and best practice interventions used to alleviate the negative effects and risk of CF among CCPs Joinson (1992). The program outcomes

Table 3.
Genos Emotional Intelligence Self-Test (Genos, 2015).

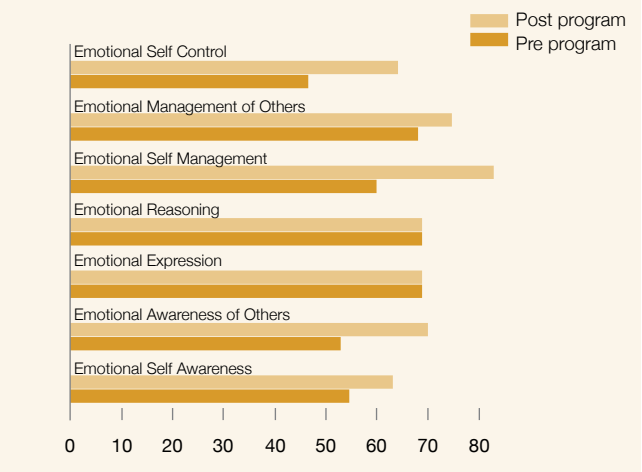

Table 4. Genos Emotional Intelligence, statistical analysis of the pre and post program variance

	N	Mean	Std. Deviation	Std. Error Mean
Emotion Expression	2	67.50	14.849	10.500
Emotion Awareness of Others	2	60.50	12.021	8.500
Emotion Self-Awareness	2	58.00	5.657	4.000
Emotional Reasoning	2	68.00	.000a	.000
Emotion Self-Management	2	70.50	16.263	11.500
Emotion Management of others	2	70.50	4.950	3.500
Emotion Self-Control	2	54.50	12.021	8.500
Overall Emotional Intelligence	2	449.50	65.761	46.500

Combatting Compassion Fatigue In Community Care Professionals

One sample test

	Test Value = 0.05					
	t	df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Emotion Expression	6.424	1	.098	67.450	-65.97	200.87
Emotion Awareness of Others	7.112	1	.089	60.450	-47.55	168.45
Emotion Self-Awareness	14.488	1	.044	57.950	7.13	108.77
Emotion Self-Management	6.126	1	.103	70.450	-75.67	216.57
Emotion Management of others	20.129	1	.032	70.450	25.98	114.92
Emotion Self-Control	6.406	1	.099	54.450	-53.55	162.45
Overall Emotional Intelligence	9.666	1	.066	449.450	-141.39	1040.29

align with the positive results of the program reported by Potter et al., (2013) and the program shares the synergies of the group fostering social-support as participants support each other through the program with Potter et al., (2013).

The aim of the Combatting CF in CCPs program was to reduce the negative effects and risk of CF among CCPs in addition to improving experiences and wellbeing for greater career sustainability and satisfaction. At the close of the program, participants shared the following statements in their feedback about the program: 'The program reminded me of the importance of boundaries and teamwork; the program was relevant both professionally and personally; the program is designed well to reflect the workplace for caring professionals; the physical 'out in nature' experience and the opportunities to connect with self and team were valued; the program helped me re-see how and why I do what I do; facilitation, modelling of boundaries, environment and sharing had a very positive effect for the training; increased awareness and relaxation; the program has given me the tools for myself (self-care) and for assisting others; the program was excellent, very inspiring to see such a profound change in the team'.

The study of CF is an emerging field with limited research in the Australian context and much of the global research emerging from the United States of America. The literature found included few studies with longitudinal measures of interventions utilised and many interventions assessed were in single populations of CCPs including nursing, social workers, residential care professionals, hospice care workers, counsellors, military health care professionals and psychologists.
The current study was limited by the absence of a control group and was conducted in a single CCP population therefore whilst results are considerable, these results may not be generalizable. Further research to understand the impacts of combined interventions, across multiple populations with a control group and longitudinal assessment of outcomes is recommended.

The findings from the research and the outcomes of the Combatting CF in CCPs program, pose a compelling argument for developing: a) awareness of CF across CCP populations, b) to implement early screening for experiences of CF and c) to implement interventions that target an increase in self-care, developing emotion awareness, emotion management and problem solving capability to foster resilience, reducing the risk and negative effects of CF among CCPs. Further, the facilitation of interventions using the EAGALA model immersed the group into 'an alive' environment engaging the group physically, emotionally and socially in the activities, providing a strong platform for individual and group development, allowing participants to find their own solutions through the experience and extrapolate the learnings into the workplace and life.

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PEER REVIEWED ARTICLE

Patient getting into shape: A clinical case study

by Dr John Barletta

Mikey is a great mate, a fellow therapist of sorts, who became involved more in management tasks and less with face-to-face therapy. I say he is a colleague of sorts as his domain is school counselling, as was also my foray from school teacher into therapeutic work. As such, I know many mental health professionals do not consider school counsellors on the same rung, or even same ladder, as themselves who might be similarly trained. Somehow the developmental nature of counselling work in the school context is considered undemanding. As a school counsellor, perhaps because of misplaced confidence, I viewed myself as equal to any graduate-level practitioner who might disparage my role or status. I am aware of the reality and structure of the professional pecking-order and now perpetuate it in my roles as a senior academic and Clinical Psychologist.

Meeting him for the first time, you would think Mikey was going through a midlife crisis. But this term overlooks the history of the antisocial behaviours he exhibits; Mikey put on the gloves as a young man. When he encountered someone, whether it be for the first or fifty-first time, he would push them to prove themselves as a person, a professional, a worthy adversary. Mikey the combatant, the eternal antagonist. A pain in the arse but surprisingly worth the effort if one could keep their ego and pride in check. Now in his late-40's, Mikey's youngest daughter became pregnant to a high school flame who had no intention or potential to be any sort of father to the soon-to-be grandchild. I remember when Mikey told us boys at the Normanby pub that Tundra was pregnant; everyone held their breath and time froze. This is where we expected Mikey to make some pronouncement he was going rip apart the horny little bastard who impregnated his cherished child. A child who was just sixteen and clearly knew about the erotic. After the very brief and uncomfortable questions mates typically ask following news of this sort; about keeping the child, ruling out adoption and seeking support from the boy; it became patently obvious becoming a grandad was okay by Mikey. In fact, as it worked out, it has been his saviour.

"I have some resistance talking to patients over the phone as it is little more than platitudes I can offer, and when it is the concerned paying other on the line it is imperative to avoid promises and conveying a second-rate impression."

When his daughter gave birth, Mikey took leave from work for several months so he could be the stay-at-home grandad. When the time arrived for breastfeeding, he took the infant to the school so it could receive nourishment just as God had planned. His daughter finishing the final year of high school was always on the agenda and the school administrators were accommodating. How could they not be? They knew Mikey! Although a man taking his grandchild to his daughter for feeding seemed a little unusual in some respect, in other ways there was nothing more wholesome to see a man live up to his fatherly duty. As Mikey was not the most attentive husband or father in the first era of his life, this was his redemption. What he did not get right before, he was going to get perfect now. He did a great job. Do not misunderstand, Mikey was still challenging in his belligerence but now had a humorous delivery which showed he knew what was going on, but cared less about making a point at every trivial juncture. He is reminiscent of Sicilian motorists who mischievously trumpet the horn on their Vespa, not in a particularly menacing way, but as a friendly caution. Tundra delivering Mikey a grandchild rekindled his sensitivity and maturity; teachers and lessons materialise in varying guises.

Back to Mikey's shift from his therapist role to a quasi-administrative one. Mikey never really saw what he did as a school counsellor as worthy or additive. His cynicism and generic pissed-off-edness clouded his view of his effectiveness and potence. School guidance was perfect for Mikey as it was a well-paid, holiday-ridden, cushy job with more kudos than a class teacher and with less of the constancy of the attention required. At his age moving into a management role was fine by him and inevitable in an education system that rewarded extended service in this way. I can not help but think now he has what it takes to be an authentic and successful therapist. He has been pushed, stood firm and thrived; now was his time to be a helper.

In spite of Mikey routinely giving me a hard time about my exorbitant professional fees and his long-held belief that my patients are just different forms of the same neurotic, he telephoned to see if I would take a referral of the daughter of a trusted colleague. He called first because over the years I had made it clear to friends and colleagues I was seldom seeing younger people in my practice, unless it was in family therapy, for medico-legal referrals or court-ordered work, all of which pay well. A colleague once remarked it was common for therapists over forty to cease seeing anyone who had not finished university, or at least, was not in a committed relationship or paid employment. My reluctance at seeing younger people rests with my experience in the first decade of my career. I taught, assessed, guided and counselled a generation of mildly interested youth who rarely sought much of what I was trained to do. More to the point, as a senior academic with an sophisticated vocabulary and a keen eye for the intricacies of complex relationships, what I had to offer was best served to fretful professionals in need of symptom interpretation, emotional holding and superior problem-solving. I was wasted working with kids. The omniscience that sheltered a sense of inadequacy lingered.

"How old is this daughter of your friend? Twenty-three. Sure I'll see her. Whose daughter is she? Zoë Hewitt's, why is that name familiar? She's the state paediatric services coordinator? Fuck, another expert whose family's in tatters! I probably recall her name from the time was president of the counselling association. She's a heavyweight and wants to talk with me about her daughter before I see her; fine. A nice person, okay Mikey, no problem, I'll look after her. Hey thanks for the referral, appreciated. Catch ya for drinks next Friday." I hung up the telephone astonished at Mikey's vote of confidence in me.

I have some resistance talking to patients over the phone as it is little more than platitudes I can offer, and when it is the concerned paying other on the line it is imperative to avoid promises and conveying a second-rate impression. Additionally, this was Mikey's first referral to me. Either he currently knew no one else who might be suitable or, heaven forbid, he was showing trust in me and the therapeutic endeavour to which I had dedicated my vocational life. Whatever the reason, I was to work with someone who was very special to an important friend of Mikey. This made it especially important to me.

When I had half an hour between patients I called Zoë. Always important to impress the person shelling out. She initially reminded me we had met at a conference dinner, although she hastened to add she would understand if I did not remember her and that she enjoyed my amusing president's address. I politely mentioned her name was certainly very familiar to me but alas I did not remember her, but would be pleased to see her pride and joy. She was delighted somebody of my calibre would be helping her Carrie. I am always flattered and sceptical of such inanity but appreciate from where it emanates. What else do you say to the person with whom your progeny will launder the family delicates? I thanked her for the confidence and information about her daughter's withdrawal from university and career confusion and I did have a provider number with her private health insurance fund. I mentioned my current practice day was Thursday and Carrie herself would need to call my office to seek an appointment time that was convenient for her. Carrie lived in the family home two hours from the city, hence I additionally suggested a mid-day appointment might be considered which would allow her to avoid the city's rush hours prior to, and leaving, sessions. I like being practical.

Carrie arrived at all but one of her sessions clad in aerobic tights, sweatshirt and pricey training shoes. I often imagined a post-workout perspirative haze trailing from her body as it glided down the corridor to my consulting room. But Carrie never emitted a unpleasant scent, as my modestly-sized therapy room would have revealed it without delay. She kept her hair in an adolescent ponytail looking every part an energetic adolescent, more youthful than her recent 23rd birthday would attest. She was in shape and pretty. Not classic beauty in the sense of Vogue, more a teen magazine presenting the latest complement of talent newly discovered in the suburban mall. Carrie was the eldest of three daughters whose professional parents wanted nothing other than the best for her, and in spite of her attempts to become independent, she scuttled back to the family home when things got tough. She was yet to work out if she could be an adult as that would mean riding out the tough stuff solo. At her very high-priced, prestigious co-ed Anglican school, her mother's alma mater in fact, she shone. Her excellence was spectacular. Academic dux of her final year. Awards for exemplary involvement in cultural activities. Honoured for humanitarian service to the community. Fantastic friends who were now midway through degrees in pharmacy, accounting, medicine and speech pathology who ostensibly remained tight and supportive. If the school had a voice to publicly proclaim its admiration for Carrie, it would have declared; "The

girl most likely to succeed, marry well, change the world and be deliriously happy." So why did this beacon end up in session with me? How was it that at this time she would have simply whispered; "I'm the girl who is adrift and indecisive, not alone yet very isolated."

Fortunately I never had to play Twenty Questions with Carrie, as was often the case with younger patients or those whose significant other spoke to me before the first meeting. She was as delightfully open, reflective and insightful as any of my preferred post-35 professional regulars. Although she was in the final stage of dual degrees in economics-law, this was the last field she wanted to pursue as a career. Lectures were coma-inducingly boring, mind numbing in rote-style presentation and filled with countless upstarts she detested. She was not like other private school snobs doing law who regaled in telling all and sundry they were set on a stunning career in international law or were going to take the financial sector by storm. Carrie was modest; maybe too much so. She was in therapy because she now finally knew what she wanted to do in her life but changing degrees and plans at this point would have disappointed everyone. Everyone except her. She was living a lie, wanted it to stop and needed to get her life back. She wanted to understand who she was, how she ended up in a dead-end and what she had to do to believe her life was worth living.

As Carrie became dissatisfied with studies she became less satisfied with herself. She was not attractive enough. Not sufficiently thin. Shameful of her body. Unworthy of others' admiration. Undeserving of the academic accolades she received. Embarrassed at her plight. Despondent. Suicidal. But she knew this phase and the associated affect was transitory. Thankfully.

Zoë Hewitt simply thought her daughter needed basic career guidance. She was concerned her daughter was simply losing direction with her studies, was petrified she would leave university completely and train to become "just a fitness instructor." This isn't what she wanted for the family trophy. She had no real idea of the reality of the precariousness of the situation in which Carrie was placed. The daughter of a high profile medical heavyweight who I never remembered meeting.

What Carrie desired was to be studying a course she enjoyed, discover a sense of the future that fit, experience a lift in mood and feel more genuinely connected to herself and others. With the existential anxiety she was experiencing, she had developed poor eating habits which included alternating between binging without purging and starving, to the point where she developed amenorrhea five months ago. She had also not stepped on the bathroom scales for longer than she cared to recall for fear of being too heavy. Carrie was tired of crying without reason, had become socially withdrawn whereby she did not initiate social contact, was scared to stay over at a friend's house and was so despondent the only way she implemented control in her life was by exercising at 15 gym sessions a week. Her friends were the endorphins delivered by freestyle and high impact aerobics, pump classes, weights, Pilates, yoga, jogging and exercise bike. To ensure her privacy with newfound neuro-chemical friends, she joined two fitness centres so no one at either centre would know the extent of her attachment; her compulsion. Carrie knew how to cover her trail. She had to become a master in deception to save face. Image was everything.

Given the duration of her amenorrhea and unwillingness to visit her parents' family doctor, I arranged referrals to a GP friend and a dietician. Interviews and tests revealed her general health and organ functioning were all within the normal range. No clinical issue appeared to contribute to, or result from, her sporadic eating, excessive exercise and heightened anxiety. She was a lucky girl. It is prudent to have a medico rule out anything grave for patients experiencing physiological symptoms comorbidly with psychological distress. I err on the side of caution.

Carrie never dated in high school. She had never had a boyfriend in spite of twenty-four first dates since commencing university. The process was formulaic. A guy would see her in a social or academic setting, flirt a lot, beseech her for her mobile number and an outing would be arranged within a week. At every first date she would comport herself like the bitch she wasn't to drive away the suitor. If a reputation circulated about her rude aloofness no one should be astonished. Why was she compelled to behave so poorly? Because she was terrified if a relationship started, the guy would want to put his arm around her and it would become apparent she was fat. Her 45 kilogram (my estimation) athletic frame would let her down. She did not want to be touched, caressed or seen naked so she became an expert in sabotage to avoid intimacy and suppress passion. Dates would never develop into anything past the initial rendezvous. She had never been kissed. Her unrealistic self-appraisal and deprecating position meant Carrie was highly internally conflicted. Anxiety was a constant companion that never delivered her to a doctor who might have seized on her as a case for medication. She needed emotional care not psychopharmacology.

When Mikey told me Zoë was a heavyweight I appreciated the enormous role the head of paediatric services for the health department would entail. So too I learned her father, a specialist maxillofacial surgeon, was a heavyweight; literally. Both in the extreme obese class! Two doctors unhealthy and unsightly. Carrie's uncontrollable exercise was also associated with wanting to avoid replicating their sins. She had to be thin and fit. Physical exercise was the only area of her life where she had implemented control outside of her parents, yet ironically, was now experiencing difficulty

regulating her exhilarating fitness regime.

I struggled to understand Carrie's ignorance of her corporal attractiveness and lack of knowledge of how interesting she was; what did this family and society do to ensure she was not confident? How is it that they are not aware they fuck them up? Who cares? At the conclusion of an early session, my frustration got the better of me and I wanted to, needed to, challenge some of her harsh self-perceptions. Clearly I could not tell her she was nice-looking and incessantly likeable. Instead I inanely offered; "It isn't my job to tell you how attractive you might be, but my hope is that as you can somehow accurately appraise your appearance and friendliness." I ended by commenting if she needed to come back I would be pleased to see her. These felt like fitting and positive comments.

From the first thirty seconds in the subsequent session I knew something was very wrong with the bond we had forged. I could smell it and I take satisfaction in addressing a rupture in the alliance. So a discussion ensured about what she was experiencing, what I might have done. Carrie felt so miserable and discouraged after our last session. She left feeling alone and unable to be helped. She said my remark about her appearance minimised her problems, saying "I wish that's all it would take, someone to tell me how pretty I was and my problems would be over. It's not that easy John. I know I'm attractive but I don't feel it!" Now we were really talking. She was making therapy work. Carrie had been provoked and was finding her articulate voice. Nothing like me stuffing up for her to satisfy her goal to grow in the confidence she so desperately needed. Mea maxima culpa. She added I had also ended the session as thought I thought she was improved and didn't need to see me again. How wrong could I be? She needed me more than ever given this was her first time in therapy and she was doing so well. Explaining my leaving patients to initiate subsequent sessions is less about my dubious appraisal of whether they needed additional therapy but more about giving them the freedom and power to initiate contact, after some space, privacy and reflection.

I used to resist suggesting or compelling patients to set subsequent appointments at the conclusion of a session unless there was an extreme level of psychological distress or indeed if ambivalence itself is the issue. She was now telling me loud and clear she was in need and I had missed it. How could we be so intimate but I fail to notice so much? An apology and detailed explanation helped her understand how I operate, restored her faith in me and my belief in her progress and strength.

She had felt so appalling she wondered if life was worth it. She was in a hole, a pit with barely visible light. Now we were turning another treacherous corner. Travelling fast on a straight road is easy; cornering is the challenge. Exploring how she endured and what she did to get through the tough times revealed no stratagem more sophisticated than crying in her room and avoiding everyone. Given her social and familial isolation and unwillingness to disclose to others concerned me. I made a pact with her to phone me, even on my after-hours number, if she ever felt that way again. She said she would not call as she did not want to inconvenience or burden me.

I plucked a business card from the diminutive white ceramic tray between the obligatory box of tissues and requisite water jug on the side-table. I showed her my mobile telephone number was on my card for good reason and she could rest assured it would not be an intrusion to touch base if she experienced such despair and disaffection. I did not want her to once more feel abandoned and misunderstood by the single person who was getting closer than even she had imagined possible. As I was encouraging her to phone when necessary, my right hand gradually and unconsciously lifted to a position that implored her to swear an allegiance to the contract I was offering. Equally unexpectedly as my hand rose, she gave me a high-five, clutched my hand momentarily in a demonstrative grasp and beamed; she was back, I was with her and she knew it.

Being a good person meant always doing what teachers, parents and friends expected. Be polite. Work hard. Study law. Take care. Dress well. Have respect. Everything except be yourself; until now. To break away from these expectations, which is what she had to do, meant risks. We worked swiftly and it was intoxicating. I liked Carrie because she made therapy easy. I could see in her eyes when she was contemplating her circumstances or considering my contributions. I would ask her instantaneously what was going on for her and she told me honestly. She was a great customer. Ready, willing and exceedingly able.

Carrie thought the confused and overwhelmed feelings she had been experiencing meant she was going insane. She had been inculcated with a perfectionistic and competitive approach to the world. A method that no longer worked. This meant she had sought to be the best at all she did and the approval of others at every turn was critical. Now she didn't need to be the best at everything all the time. She was worth more than that. She wanted to get balance. Self-understanding and the therapeutic relationship grew. Momentum gathered whose impact she needed to maximise. First she had to make some changes that would signal to her, and others, she was asserting herself as an adult responsible for choices.

She completed the vital paperwork and collected the academic's signatures she needed to eliminate the enrolment in her law degree, which at this stage was merely a formality as she had, unbeknownst to others, avoided most law classes for the last few semesters. We agreed this step would bring with it directly informing parents and friends she was no longer the exalted law student. She had to establish her independence and set boundaries. We prepared and practised the speech. "Mum and Dad, I you love you both very much and appreciate everything you have done for me over the years as it has made me the decent person I am. I know you are both anxious that I have a good career and even appreciate your nagging as an expression of your concern for me, but I need to start making decisions for myself. I have dropped my law degree as that is something I never wanted to do, but I will finish the economics degree as it isn't so bad and will be useful. I have decided to pursue the fitness instructor's certificate as I really enjoy my gym work and think for now this could be my career. I might even do physiotherapy at some point down the track." One deception nullified, more to go.

She was staggered and delighted everyone to whom she reported her new academic and vocational status was more concerned with her being happy than they were concerned she was jumping ship mid scholastic voyage. Carrie was learning her fears and anxieties were misplaced. Others did not want her live their dreams, they prayed for her to find and live her own aspirations. Now she heard and trusted they simply wanted for her what she had always wanted for herself.

Next she cancelled membership at her least favourite gym where she had sought solace for so long. She needed to get her life back and spending more time with pumped-up strangers, muscle-toning

apparatus and exhilarating endorphins than people important to her, was not doing her any favours. As with the speech she delivered to her family and friends when she dropped out of law, she also practised the content, delivery and responses she would need to escape in good grace from the people in the fitness centre that assuaged her pain. Role-playing was essential and she was an enthusiastic scholar. When reclaiming control was the goal, Carrie needed to be insulated from feeling like a failure. Objectively appraised, she seldom had been a failure but certainly felt like one, and now that she needed to build success it was imperative there was victory at every turn.

At the sixth session she proudly announced her menstrual cycle had restored. Carrie was regaining herself. Her period returning was a healthy marker of progress. It is intriguing the range of ways success can be measured in therapy. An interesting related development for Carrie and a tangential curiosity for me, was that her mother, who had never asked Carrie specifically about what we spoke of in therapy, decided to seek therapy for herself. The best I could imagine was that Zoë was impressed by the confidence and contentment Carrie had regained that she wanted to explore this endeavour and the possibilities for herself. Good for you Zoë.

When initially meeting Carrie she informed me that before her mother arranged for her to consult me, she had already organised Carrie to see a psychiatrist. Zoë's professional background was telling her that those medically qualified can be useful for every human ailment. The highly regarded psychiatrist her mother had made an appointment for her to see had a waiting list of four months. Lucky him; unlucky patients. During our time together, Carrie finally made the visit. She reported that after a lengthy, comprehensive and intrusive interview, the psychiatrist spent the remaining session time sharing proud stories of his daughter's successful studies and career, a daughter who incidentally had been one of Carrie's classmates. Carrie was duly unimpressed and unhelped. Voluntarily she told me the psychiatrist's plans for her; a popular antidepressant medication and some cognitive-behaviour therapy. When queried about her desire for either of these prescriptions, she stood resolved and politely rejected the recommendations. She would stay with the therapy she found beneficial. Although she visited the psychiatrist to satisfy her mother, she rejected the treatment to gratify herself. She was in control and modestly enjoying it.

During the course of her therapy Carrie severed many of the ropes that bound her. She gained a career direction, established herself as an adult in her family and with friends, tried new activities, gained enormous insight and ultimately felt like a real person for the first time. Although Carrie never dated for the months in therapy, which in all probability was good, she did get herself into shape that would enable her to embark on a relationship without worrying unduly about undermining herself. Carrie was not flawless but she was certainly perfect for what she wanted to do.

Note: As always, I am enormously indebted to those who consult me and privilege me with their stories. As you would expect, the names and identifying details are fictitious.

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Theories of Violence

by Jeni Marin

Causes and beliefs and the influence of the various theories of violence on the client / therapist relationship and the therapeutic approach taken

Violence put quite simply is "an action that harms" (Wilson, 2002 p. 50) and is defined as the physical, sexual and emotional maltreatment of one individual or group by another (Enns, 1997, p.279). Violence may be directed towards a known or unknown individual or group. (Hearn, 1998, pp 14-39)

Voltaire writing in the 19th century posed the rhetorical question "what would happen if two men were stranded somewhere together?" His response claimed that they would 'help one another, harm one another, flatter one another, slander one another, fight one another, and make it up. They could neither live together nor do without one another" (Voltaire quoted in Barash, 1994). Violence according to Voltaire is therefore quite simply a factor of being human and, in particular, being male.

Voltaire suggests that violence is inherent in the human condition, I believe that violence is a choice, (Monte, 1999, p 861) and that perpetrators can learn ways of relating other than behaving violently. Men who act violently, particularly those who have abused their partners, often believe themselves that they do not have control over their behaviour, and are unaware of how much control they do have or the choices they could make. Bringing this into consciousness would be step one in re-educating violent men.

Violence is not an inevitable response to a situation. Many people experience anger, which is a normal emotion. Violence is one of the ways to respond to anger or conflict. There are many other ways which are non-violent. The distinction between the emotion 'anger' and the behaviour 'violence' is critical in understanding that a person chooses to behave violently (Frankl, 1969, p. 65).

Theories on the Causes of Violence

There are a range of theories however which argue that a violent act is not an act of choice, rather that there are a number of biological, psychological, social and political causes of violent behaviour (Hearn, 1998 pp16-17).

Biological Theories of Causes of Violence.

EVOLUTIONARY

Behaviourists hold that behaviour has a physiological basis and various studies have been designed to investigate and prove this claim. Included in these studies have been longitudinal studies of youth who appeared to be lacking adequate control mechanisms to determine whether this is a factor in adult violence (Hearn, 1998, pp 17-19).

THE EVOLUTIONARY EGG

The sperm/egg dichotomy and the male need to ensure that his line continues has been cited as an evolutionary cause of violence (Barash. 1994 pp 61-65, p269, Clanton & Smith, 1998, p173-279). This argument should carry over to animals in general but this does not appear to be born out (Hearn, 1997, p 16-19).

"FLUSH TOILET MODEL" OF VIOLENCE

Also falling under the biological cause of violence theories, is the "Flush toilet model" which Lorenz termed the "displacement model" (Barash, 1994, pp23-25). This theory suggests that like a water cistern, frustration builds up until the cistern (the individual) can hold no more, violence erupts and floods out, once emptied the "anger system", is then at a state of calm until once more frustration and anger build up and require release. Even in accepting the validity of this theory, it the individual's choice to discharge this frustration through violence as there are a number of other ways, from brisk exercise to relaxation techniques, which would release the build up of tension.

GENETIC

There is a genetic argument which claims that propensity for violence is seen in several generations of the one family. However this may well be due to socialisation in the family of origin (Hearn, 1998, pp 19-27, Barash, 1994, p79) and there are many examples of non-violent individuals from violent family backgrounds. There is also evidence to

suggest that parental diagnosis of mental illness together with hostile parenting can be part of the earlier life history of violent individuals (Osgood, 1997, pp.50-59). Again the behaviour once recognised can be overcome.

INTERGENERATIONAL VIOLENCE

Domestic violence tends to be intergenerational with studies revealing that 50% of abused women were abused as children and 42% of male abusers were themselves the victims of childhood violence, but whether this is genetic or socialisation is yet to be determined (Juntunen & Atkinson , 1997, pp. 280-282).

PATHOLOGICAL

Also under the biological causes of violence are such issues as certain illnesses and impairment which precipitate violent behaviour. There is some evidence for example that impaired serotonin and neuro-transmitter functions can set up violent behaviour. Toxic substances or disease that interferes with cortex can have the effect of diminishing ones inhibition leading to violent outbursts (Juntunen and Atkinson, 1997) and central nervous system impairment can lead to impulsivity and diminished ethical constraints (Megargee in Hogan, Johnson & Briggs, 1997, p 589) and steroid abuse and use of PCP has been proven to cause violent behaviour in some males (Hearn, 1998).

This may be the cause of some but certainly not all violent behaviour (Osgood, 1997 pp.50-59). Violence stemming from pathology would be unlikely to respond to therapy, as such behaviour in this instance could only be addressed by medical means.

CHROMOSOMAL/CHEMICAL.

Reductionism argues that behaviour is caused and regulated by biochemical processes. Studies of violent offenders have suggested a link between XYY chromosomal structure and violence but if this was the case there would not be millions of XYY males living normal non-violent lifestyles. The same argument and counter argument exists for levels of testosterone, where there have been studies to detect a causal link between high levels of testosterone and male violence (Hearn, 1998, p18). Again, as with pathological causes of violence, biochemical causes would call for medical intervention.

SUBSTANCE ABUSE

Substance abuse is seen as a common factor in domestic violence. Whilst they often go together, there is no evidence that intoxication itself causes domestic violence but that some people use alcohol and drugs as an excuse to behave abusively and violently. Working from a psychoanalytical framework and a Freudian belief that evolutionary continuity means that we have little or no control over our conscious behaviour would bring the unconscious into consciousness (Monte, 1999 pp 864-869).

Psychological

"Although man has acquired an impressive degree of power over nature, his knowledge and control over his own inner being is very limited. This wide gulf between man's inner and external powers is one of the important and profound causes of the individual and collective evils which afflict our civilization" (Assagioli, 1984, p4). This rather depressing view of human nature would negate any attempts at therapy. However Determinism argues that behaviour is never random, accidental or spontaneous (Monte, 1999, p 861) but is a choice of the actor. Therefore non violence can also be a choice.

MENTAL ILLNESS

Men who behave violently usually do not suffer from mental illness. Studies have shown that psychiatric disorders are no more common than the general community amongst these men. Often these men show quick changes in behaviour from being abusive to seeking closeness which can cause confusion for the woman. An understanding of the cycle of violence puts this behaviour into perspective. (Hoskinson, 2002, p. 95)

Sociological and Political Theories of Causes of Violence

NATURE VS. NURTURE ARGUMENT

Studies indicate that parental force has a positive co-relationship with sibling violence (Enns 2002 p286) and potentially generalised violence. The quality of attachment to the original caregiver can also predict adult behaviour for good or ill. Anxiously attached children contain anger in a nominalised way. Coercively attached children experience anger along with a desire for comfort and fear and many of their interactions have an angry quality (Goldberg, Muir & Kerr, 2000, pp. 380-386). Learned behaviour however can be unlearned, with time and patience on the therapist's part and willingness to change on the part of the client.

Domestic violence tends to be intergenerational with studies revealing that 50% of abused women were abused as children and 42% of male abusers were themselves the victims

NEED FOR FOES

Some theories argue that there appears to be something in the human psyche that yearns for violence and therefore pushes the individual to define differences between friends and enemies (Barash, 1996 p23). Enemies therefore can be the legitimate target of violence. This could be regarded as having an evolutionary cause but could just as readily be considered under learned sociological behaviour. Like the genetic argument however if this is the case it may well be because violence is a socially accepted reaction to threats from outside (Hearn, 1998, pp 19-27).

PERSONALITY TRAITS

Personality trait is a biological, psychological and social mixture that predisposes a person towards specific kinds of action under specific circumstances (Allport cited in Monte, 1999) This includes violent behaviour. Personality factors of the violence prone individual include personal isolation, emotional neediness, sense of worthlessness, conflict in family of origin, coping mechanism which are marked by aggression, anxiety, impulsiveness, defensiveness. Group Therapy might be a positive mode of Therapy to educate the violent person to stop and reflect and hopefully stay away from situations which

provoke the violence (Kottler, 2000).

Field, (1999) identifies characteristics of the "bullying personality" as being an individual who lacks judgement and the ability to think ahead, demonstrates selective memory and paranoia, lacks personal insight and is deeply prejudiced. There is also some evidence that the bullying personality holds a grudge even after minor slights, has a compulsive need to control, is rule bound and obsessed with cleanliness and is unable to learn from experience. Group therapy to expose the bully to non violent education cold be a therapy of choice (Kottler, 2000).

There are a range of other theories that suggest that thought processes and personality traits create violent behaviour. Un-met demands are hypothesised as a cause of violence. Unfulfilled beliefs, demandingness of approval, unrequited need for achievement, un-met need for comfort, catastrophising and blowing things up out of proportion, all have been cited as underlying factors for explosive angry and violent outbursts. The over reaction to these situations suggests that the person is rejecting in an externalising form their own fears confirming their negative self image. This could be changed using a cognitive therapy approach (Alford & Beck, 1982) to dispute the beliefs.

SOCIALISATION

Fear that being nice puts one at risk manifests itself on an individual and national level (Wilson, 1992). The international arms race for example is motivated by this fear (Barash 1994, p39). A therapist who accepted "stranger anxiety" (Barash, 1994, p83) as a cause of violence may be able to influence the violent client by using systematic desensitisation or other behavioural techniques to lower the anxiety level and thus, theoretically, eliminate the violent behaviour (Spiegler & Guevremont, 1993, pp. 39 -43).

Social causes of violence are cited as poverty, stress, poor living conditions, lack of community cohesiveness and inability to access goods and services, but if this was always the case, all underprivileged groups would manifest violent behaviour. This is not the case as many underprivileged communities are not affected adversely by violence (Hearn, 1997, pp 23-27).

Living in a violent family system, a child may discover that manifesting the need for tenderness brings a foresight of anxiety and pain (Monte, 1999, p 521) and to survive the child may behave in an aggressive manner as a coping strategy. Cognitive Behaviour therapy could be a model of choice to unlearn coping strategies of this nature, (Alford & Beck, 1991, Hearn, 1998, pp 21-25) as could Narrative Therapy which would thicken the alternate non violent story enabling a new self image, new possibilities for relationships and a new future to be created (Morgan, 1996, p16, White, 1997).

MEDIA

Studies have been conducted on the effect of violence as it is portrayed in films to determine if filmed violence particularly if factored in for thrills and excitement predicts violent behaviour in the viewer (Barash, 1994, p33). If violence is a learned behaviour then Behaviour Therapy should result in extinguishment (Spiegler & Guevremont, 1993, pp. 39-41).

PATRIARCHY

Violence prevails wherever there is male dominance. Male gender role conflict leads to restrictive emotionality and overvalue of control and power. There is some evidence that perpetrators of violence both inside and outside the home are people who have homophobic tendencies, sexualise intimacy and have an obsession with success and achievement (Enns, 2002, p284). The interest of "power holders and those subject to that power often clash" (Clegg, 19920 p143). In a patriarchal environment the male would be the holder of power and the female the one subject to the power holder, a challenge to this power can provoke violence (Clegg, 1992).

A therapist might consider using Narrative Therapy to deconstruct a story of patriarchy and male privilege if he/she believed that the male dominated social roles and social conditioning in the extended family of origin created the dominant story in which violent behaviour was the established norm (White, 1997, Morgan, 1996).

Stress of modern living resulting in hypertension is defined as persistent elevated diastolic arterial blood pressure which adds to repressed angry emotions repressed since childhood (Millenson, 1995 pp.75-117). This fits with the "flush toilet" model from a sociological point of view and anger management and relaxation therapy could be indicated (McQuaid, 2004).

Political violence is the violation, by force or psychological means, of the prevailing group over a minority individual or group(s) and stems from a need for power (Clegg, 1993). A victim of political violence would need sensitive, on-going support regardless of the model of therapy chosen. (Vivekananda, 2002, Matsakis 1996)

THE ID

The id has been likened to a cesspool of instinctual drives and motives, the ego and superego insufficient to counteract the working of childhood negative

programming and humanity's inherent "dark nature" (Millenson, 1995, p 44). If a therapist believed that the unconscious is at the root of violence, psychonalytical therapy would be effective in uncovering the unconscious causation of violence, bringing the realisation to the surface and re-educating the violent individual.

Therapeutic Involvement with Perpetrators of Violence

In working with a perpetrator the belief the therapist holds regarding the cause of violence would factor quite strongly into the choice of the model of therapy selected. (Hearn, 1998, pp 33-36). Males are more prone to violence that females and three types of violent males have been identified. Type I, is violent both inside and outside the home, he blames others for any negative things that happen to him, this type often abuses alcohol then blames the alcohol for his behaviour. Type 2, builds up stress and resentment and holds in anger till it erupts, this type of male although often remorseful nevertheless does not accept responsibility for his behaviour. The third type is described as erratic and volatile and will erupt with the slightest provocation. Studies of violent men indicate that regardless of the modality chosen both the Type 1 and Type II violent males show short term benefits which usually dissipate in the long term. 20% of Type III who are identified in some research as "cobras" show no remorse and will continue to behave in a violent manner (Enns, 2002, pp 292 -296).

My belief that violence is a choice would cause me to insist that the perpetrator accepts responsibility for their behaviour before any form of therapy can be effective. The style of perpetrator identified by Enns (Juntene & Atkinson, 1997) as the one who normally represses anger and then experiences remorse after a violent episode genuinely believes that he will not re-offend. Statistics indicate that he will. With these clients I believe that unless the client is willing to accept responsibility any therapy would be of little avail. If however the client was genuinely able to accept responsibility, CBT has had some positive results in that the client is educated to accept that their underlying beliefs and not actions of the victim have precipitated the behaviour (Alford & Beck, 1991)

If the biological model as the cause of violence is accepted by a therapist, he/she would educate the violent individual to control their behaviour. This could be by teaching relaxation therapy techniques to lessen the build up of tensions or for the violent individual to learn methods to allow the violence to erupt in controlled circumstances. Anger Management groups could be a favoured model of therapy (Kottler, 2000, Hearn, 1998). Looking at the idea of violence being a choice made by a perpetrator

Depending on the therapist's choice of model, he or she might choose Cognitive Therapy to uncover and dispute underlying beliefs (Alford and Beck, 1991) or Gestalt to enable the perpetrator to experience the world from the victim's role (Beiser, 1970, pp.77-80). Narrative Therapy to privilege the non violent alternate story, might also be used effectively. Narrative Therapy could encourage the violent person to see the violence as an unwelcome visitor rather than an inherent part of his personality. (Morgan, 1996, White, 1997, Payne, 2000) and the violent person can be educated to refuse to allow this 'visitor' entry.

The therapist may consider it worthwhile to undertake Family Therapy in an attempt to re-educate the entire family. (Kerr & Bowen, 1998, Hunter, 2001, pp 82-84) A danger in using this model of therapy however could be that it suggests that the victim should also accept responsibility for the violence in effect this may serve to "revicitimise" the victim (Hunter, 2001, p 84).

One theory exists that some people may have an addiction to violence (Frankl, 1969, p46) and that these people are those who need to direct and control others and have a high level of task orientation (Frankl, 1969, p48). This would suggest that a narrative approach could be used to thicken and privilege the non controlling secondary story (Morgan, 1996, White, 1997, Payne, 2000) or a Solution Focus Approach to uncover exceptions where the violent person was not in control and no negative consequences ensued. (Anderson, & Goolishian, 1992 pp. 25-39, Anderson, 1991, pp.42-68)

At this stage there is no definitive empirical evidence as to the cause and successful treatment of violence, but violence is an increasing problem in or society and in particular the too long ignored iceberg of domestic violence. A report on ABC TV on 21 March 2005 included the following 'According to the survey by Access Economics for the Federal Office of the Status of Women, Domestic Violence is the biggest single health risk factor for women aged between 15 and 44. It is also the biggest single cause of early death or disability in women. They estimate a health cost to the nation of more than $8 billion' (online: 2004). The human cost is too high for this issue to remain unresolved and further research needs to be carried out.

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Jeni completed her Social Science degree in 1994 and then went back to do both a Bachelor and Masters Degrees in Counselling (the Masters is scheduled for completion in November 2005).

PEER REVIEWED ARTICLE

Animal-Assisted Therapy for Children

by Sally Baldwinson

Animal-Assisted Therapy (AAT) has been practiced in different forms for many years but literature is now trending toward aiming to meet the growing demand for the demonstration of its efficacy through research. A unified framework is required so that it is seen as an empirically based approach. This review covers literature sourced from newspaper articles, websites, a handbook and journals published within the last eight years. The focus is on studies involving children with emotional problems or insecure attachment as a result of trauma such as sexual abuse or neglect. The animals included in the literature are varied; dogs, horses, birds, hamsters, rabbits as well as a zoo-based program. This review does not include studies where animals are used for the purpose of education or recreation and the literature has been selected on the basis of its intriguing nature as well as its current and promising findings. There are numerous benefits that humans can experience from safe nurturing animal interaction and children in particular can gain enormous therapeutic outcomes.

Premise

AAT is a type of therapy that involves animals to help improve emotional, cognitive or social functioning. The Delta Society is one of the main organisations for certifying therapy animals and its definition of AAT is widely employed in the literature. They state it utilises the human/animal bond and an animal that meets specific criteria is an integral part of the goal-directed intervention. A therapist working within the scope of his/her practice guides the interaction between client and animal, measures progress toward meeting therapy goals and evaluates the process (Geist, 2011), (Dietz, Davis & Pennings, 2012), (Kemp et al, 2014). Parish-Plass (2008) makes the important distinction from Animal-Assisted Activities or Animal-Assisted Education as these types of programs are not usually run by therapists with therapeutic goals in mind, rather teachers or volunteers working in an educational or recreational context. The Delta Society website tends to blend education and therapy assumingly in an effort to offer support to a larger number of people.

AAT may be viewed as less traditional or scientific than verbal therapies but its foundations are rooted in Bowlby's attachment theory, psychotherapy, play therapy and expressive therapy

AAT may be viewed as less traditional or scientific than verbal therapies but its foundations are rooted in Bowlby's attachment theory, psychotherapy, play therapy and expressive therapy (multiple references). Children in particular need a safe, non-intrusive environment where they can explore freely any painful issues. It is about engaging them in a way that enables them to undergo therapeutic change (Geldard et al, 2013). Children with insecure attachment have reduced capacity to regulate their emotions and may experience emotional and behavioural distress. Therapy animals such as dogs can help facilitate healthy attachment experiences and improve interpersonal relationships through the human-animal bond. Geist (2011) contends that intervening with AAT can break the sequence of negative automatic thoughts and help develop a healthier self-concept and attachment.

For hundreds of years people have seen animals as positively influencing human functioning. Nimer and Lundahl (2007) note that in the 19th century Florence Nightingale suggested a bird may provide pleasure to sick and bed-bound people. Geist acknowledges Boris Levinson as the founding father in the field of AAT as it relates to psychotherapy. In the 1960s he theorised that animals could act as 'co-therapists', mediating between the "known terrors of outer reality and the unknown realities of the inner world" (2011, p. 252). His main goal was to use animals as the motivator for children who were resistant to therapy. Levinson's belief that animals could act as a transitional object between us and our alienation with nature is linked with Object Relations Theory. The presence of animals enables children in particular to re-enact social situations and project objects on to them that helps them to safely process the issue (Parish-Plass, 2008). Most of the literature acknowledges Levinson's contribution to this area.

These historical theories continue to be scientifically proven today. A recent article in the Los Angeles Times cited Stanford University research findings that were published in the journal Science. Healey (2015) describes that the study explores how the bond between human and dog is not unlike the relationship between parent and child. It offers the explanation that when dogs gaze into our eyes with a look of devotion; our bodies are filled with oxytocin which is the hormone of love and nurturing that cements the bond between people. This type of research strengthens the historical and current premises of AAT, and is published in widely-read forums. Another well-known source of information is the Delta Society website. It states that AAT can have cognitive effects such as memory stimulation and problem solving, and emotional effects such as self-esteem, acceptance from others, calming effect, lifts mood often provoking laughter (Delta Society, 2015). There is a significant body of information on this website which is easily accessible and highly appealing to professionals, pet owners and carers alike.

Research Summary

AAT is a relatively new and undeveloped field of scientific investigation. There is a strong push by professionals and universities to build upon the evidence base that supports animal-assisted interventions. (Lead the Way, 2007). All the literature examined in this review asserts promising findings that promote AAT as another effective strategy to reach out to and connect with traumatised children. Specifically, findings are suggesting that AAT is a unique catalyst for achieving safety, attachment and adaptive strategies in relation to separation or loss (multiple references). In a strictly Australian context; an evaluation by CAPRA, the collaboration between the Australian Childhood Foundation and the Monash University's Injury Research Institute (MIRI) found that traditional models of therapy alone can be ineffective in helping children recover from trauma (Mudaly, 2011). And Kemp et al (2014) found, unlike other studies, that there was no gender or age-related differences in efficacy.

A meta-analysis by Nimer and Lundahl (2007) reviewed an impressive 49 studies of which 12 involved children under the age of 12. Written in an authorative manner, they assert that at the time of publication there was no known quantitative review of AAT studies published. Geist (2011), while publishing in a social work journal, attempts to provide a sound conceptual framework and describes a number of experimental and case studies. The article has excellent content but it is not drawn together as neatly as it could. Dietz et al (2012) published the first study to examine group therapy incorporating AAT for child sexual abuse survivors. It includes 153 children aged 7 to 17 and is insightfully analysed. Kemp et al (2014) evaluated a therapy program involving horses which included 30 sexually abused children aged 8 to 17 using several psychometric outcomes and found significant improvements in symptoms of depression in what is a fairly rigorous assessment. All these articles are written by researchers or academics with the exception being Parish-Plass who is a child therapist. She describes a number of interesting case studies on children with insecure attachment and provides a persuasive rationale for breaking the cycle of abuse (2008). Some of these studies attempt to provide practice-based evidence and some aim to provide evidence to be used in practice.

Evaluation, Trends and Assertions

In general, several positive outcomes emerge from these studies such as increases in self-esteem, self-efficacy, coping abilities, social confidence, empathy, improved peer relations and reduced anxiety (multiple references). However, research design and rigour differ greatly and there is criticism that studies lack rigour such as having too small population sizes or lacking comparison groups. The researchers do concede limitations to their studies too. For example, Nimer and Lundahl (2007) admit their outcome classifications were too broad and Dietz et al (2012) admit that random assignment and having a control group were not feasible. Furthermore there are often factors that are difficult to control in an area of research like this, such as the type of animal or background of the handler therapist (Dietz et al, 2012). While exciting and promising research is emerging, indeed Nimer and Lundahl describe AAT as a "robust intervention worthy of further use and investigation" (2007, p. 234), such variance means that there is no universal understanding of what AAT is and how it is used. Ultimately, this means further research is required. Also nothing could be found in the literature

on whether improvements were sustained over time so a comprehensive longitudinal study would also be pertinent.

The authors are in agreement that AAT should not be seen as a stand-alone treatment; rather it should be used to enhance existing therapeutic strategies (multiple references) and be seen as an additional tool for reaching the inner world of the client. There is unanimity too, and as mentioned above, that more research is needed. For example, one conclusion drawn is that there is a need for more concrete findings on measurable parameters and specific outcomes. MIRI is hoping to provide just that: The next phase of their two year pilot study will administer psychometric measures of trauma and empathy at the beginning and end of programming to provide concrete evidence of changes in the children (2013).

Not addressed in detail are the ethical and welfare considerations for both the animals and clients. And there are numerous practical and safety issues around hygiene and handling for both therapists and children. How the animals are housed and fed properly and how issues around biting, saliva or defecation are dealt with are all worthy questions. There is also the contraindication when children are scared of animals such as horses or large dogs which may increase their sense of danger (Parish-Plass, 2008). Evans and Gray (2012) discuss this issue in length but others do not consider it at all. While in a social work context, they do highlight important ethical and safety considerations such as potential animal stress, and call for the urgent development of best-practice approaches to AAT in ways that do not ignore the needs of the animals themselves. The other studies do not adequately account for this. So there needs to be standardised regulation around the training of therapy animals and their handlers, as well as registered animal therapy organisations that provide liability insurance. One such training is the Certificate IV in Companion Animal Services training course (Delta Society, 2015).

So three principal questions emerging from the literature are 1) whether studies can be designed to account for the variable nature of this therapy, 2) whether a universal understanding of AAT with measurable parameters can be achieved 3) whether a specific body of knowledge can materialise to guide and inform best-practice approaches to AAT in relation to both client and animal.

Therapy animals can offer unconditional love and acceptance and this is undeniably powerful.

Practice Implications

The authors highlight that this is a unique therapy due to the diverse nature of delivery. It can be applied flexibly for a number of different presenting concerns and within different approaches: in a one-on-one or group therapy setting, as part of play or expressive therapies, or in psychotherapy and attachment-informed practices. A common theme across the literature is why AAT is particularly effective with children. Importantly it can be a non-verbal therapeutic modality which is highly relevant with children who may be distrustful of adults or find face to face conversation difficult or confronting, and children generally are more accepting of an animal's influence (multiple references). The 2013 Monash pilot study makes similar claims. Geist (2011) points out that the counsellor can observe attachment behaviour of the child to the animal, which can then be transferred, almost in silence. Parish-Plass (2008) says that the therapist-child relationship is more easily established than in other therapies, so this is a fantastic outcome for practice. Kemp et al (2014) agree that animals facilitate the development of the therapeutic alliance but they assert that therapies utilising horses have an added bonus of empowering the client because of learning skills of caring for and working with such a large animal. Empowering the client is highly relevant for counselling practice.

Both Geist and Parish-Plass provide clinical examples helpful for practice. They cite case studies that clearly highlight positive outcomes such as developing empathy and self-concept for children who have suffered severe abuse or neglect. They state that the presence of the animals provides a calming and less threatening environment for therapy enabling the child to work through trauma. In relation to such varying research parameters, Parish-Plass also points out a crucial implication for practicing professionals. She emphasises that practitioners who wish to use AAT to supplement their counselling may not be able to until scientific evaluation of its effectiveness is apparent which can then legitimise and fund deliverable programs. However she clearly articulates that AAT is a valid method to reduce the chances of intergenerational transmission of abuse, and this is certainly a common challenge that counsellors face today. MIRI (2013) agrees with this and state that it can help break the cycle of violence and abuse so that children do not carry trauma through life. Finally, a useful resource for practitioners working in AAT is the Handbook on Animal-Assisted Therapy (2010). It is an excellent guideline and provides comprehensive information on the positive effects for vulnerable children, procedures, design and implementation of mental health interventions, and understanding the animal as the 'co-therapist'.

Therapy animals can offer unconditional love and acceptance and this is undeniably powerful. There is a growing body of literature that offers strong support for using AAT as a supplementary tool for working with traumatised children. However the same literature agrees that more rigorous testing is needed as well as a universal utilisation of a concrete and professional therapeutic framework. Broadly speaking, there is a need to achieve positive outcomes for

clients as well as be mindful of the ethical considerations around using animals to help children. It is exciting that this type of therapy is being embraced and that there is a community determined to empirically prove its efficacy. The readings have clarified many of the complexities around AAT and created a sound basis for continuing research in this area.

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Sally is a qualified counsellor with experience working with children and adolescents. She is also a qualified teacher with twelve years' experience working in the education sector.

Sally likes to work within a person-centred and strengths-based framework when providing counselling and support services and is confident in her ability to build strong rapport with her clients. Her areas of interest are Acceptance and Commitment Therapy and creative therapies (eg music and art), with a special interest in mindfulness.

Qualifications:

- SACE (South Australian Certificate of Education, Walford Anglican School for Girls, 1993)
- BA (Bachelor of Arts majoring in Psychology, University of Adelaide, 1996)
- Grad Dip Ed (Graduate Diploma in Education, University of Adelaide, 2004)
- MCP (Master of Counselling & Psychotherapy, University of Adelaide; degree to be conferred 31/12/2015)
- Recipient of Certificate of Merit for Outstanding Academic Achievement 2014 (with an 86% average)
- Student Mentor within the Program in 2015

Experience:

Executive & Project Officer
Mar 2012 – Jun 2013 Flinders University
Program Support Team Leader
Oct 2010 – Jan 2012 Eynesbury College
Administration Assistant/PAAug – Oct 2010 Catholic Education Office
HR Officer & Program Manager
Oct 2009 – May 2010 Bradford College
Academic Support Officer
Jul 2007 to Sept 2009 Bradford College
English Teacher Jan 2005 – Jul 2007
Bradford College Teacher / Tutor
2003 – 2004 China

PEER REVIEWED ARTICLE

Antidepressants may not be as effective as we thought

By Christopher Davey, University of Melbourne

The treatment of depression too often means treatment with antidepressants. Australia has one of the highest rates of antidepressant use in the world. This continues to increase despite mounting evidence they are not especially effective.

My colleague Andrew Chanen and I have just published an article that describes the apparent falling effectiveness of the medications. We argue that doctors have become too reliant on them. When medications are used to treat depression they should be part of an overall treatment plan and shouldn't be the treatment plan.

The falling effectiveness of antidepressants

Why are antidepressants becoming less effective? Partly because we haven't always had all of the data. The clinical sciences have a problem with negative trial results – trials where the experimental treatments don't appear to work. They are seen as uninteresting, and as undesirable by drug companies, and have often gone unpublished.

Drug trials are, however, regulated and require registration with authorities before they begin. So, over the past decade, researchers have tracked them down. Once they have found the registered-but-unpublished trials, they have included the data in their overall assessment of the medications' effectiveness. Unsurprisingly, the result has been that the recorded effectiveness of the medications has fallen.

Early drug trials are usually conducted in highly controlled university research environments. The researchers, often working in partnership with the pharmaceutical companies, enrol uncomplicated, motivated, middle-class patients into the trials in an effort to give the trial medications the best chance of success.

Later, researchers are keen to see if the medications work in "real world" patients: the sorts of patients we see in mental health clinics and GP practices, who may not only be depressed but also anxious, drinking too much and distressed about their mounting bills. The medications don't work as well in these patients.

The increasing effectiveness of placebos

Perhaps the biggest reason for the declining effectiveness of the antidepressant medications is that placebos are becoming more effective. The gap between the medications and placebos is steadily narrowing.

The placebo response is a complicated phenomenon. In part it illustrates the statistical concept of "regression to the mean", where a measure that is extreme when first measured (depressive symptoms in this case) will tend to be less extreme when remeasured.

The other component of the placebo response is a positive expectation bias. When people expect to improve, this makes it more likely they will improve. This is particularly important for depression, because by providing someone with treatment, if only a placebo pill, we are directly addressing the sense of hopelessness that is one of depression's core symptoms.

The increasing placebo response rate in depression is likely driven by an increasing expectation that treatment will work. Notwithstanding recent evidence about the declining effectiveness of antidepressant medications, there is a broad cultural belief – one that has been emphasised in recent decades – that taking a pill can help depression.

Our task as researchers is to work out the characteristics of the patients who are most likely to respond to particular treatments, so that we provide evidence for delivering the treatments to those patients.

Combining treatments

Antidepressants might not be as effective as we once believed. But, overall, they are effective. Other treatments have similar problems with declining effectiveness. In fact, there are no well-studied treatments for depression that have consistently strong effects.

This suggests combining treatments might be the best approach. And the evidence bears this out: combined treatment with medication and psychotherapy is more effective than either alone. We should be moving beyond a simplistic view of alternative treatments as competition for medications and consider whether they might be usefully combined to deliver even more effective treatment.

Treatment recommendations

When medications are used they should be part of a broader treatment plan. When therapy is available – and it isn't always – there can be few good reasons for not recommending it. Medication should be considered when the depression is reasonably severe, when psychotherapy is refused (not everyone wants to see a therapist), or when psychotherapy hasn't been effective. When medication is used, it should be used in a way that maximises its chances of being effective. This means not remaining on the same ineffective low dose for months and months. It means close monitoring by a doctor, so when the medication isn't effective there is consideration of a dose increase or a change to an alternative medication.

Other treatments can also be added. Improving diet and exercising more are good for depression, and combining antidepressants with nutraceuticals – food-derived nutrients such as fish oil and vitamin D – has been shown to improve the effectiveness of the medications.

Future treatment approaches

It is unlikely we are going to see treatments with significantly greater effectiveness than existing treatments in the near future. Drug companies have reduced their investment in developing new drug treatments for mental illnesses, largely because they have been burnt by so many failures.

And the psychotherapies, while requiring a lot of training and skill to deliver competently, essentially comprise two people in a room talking. It is difficult to see how new therapies could be much more effective than existing ones.

Our task as clinicians is to consider the broad range of treatments that are available, and how they might best be combined in treating the particular patient in front of us. Our task as researchers is to work out the characteristics of the patients who are most likely to respond to particular treatments, so that we provide evidence for delivering the treatments to those patients. There is still much work to do.

The Conversation, Medical Mental Health, www.medicalobserver.com.au
Christopher Davey is a Consultant Psychiatrist and Head of Mood Disorders Research at Orygen, The National Centre of Excellence in Youth Mental Health, University of Melbourne

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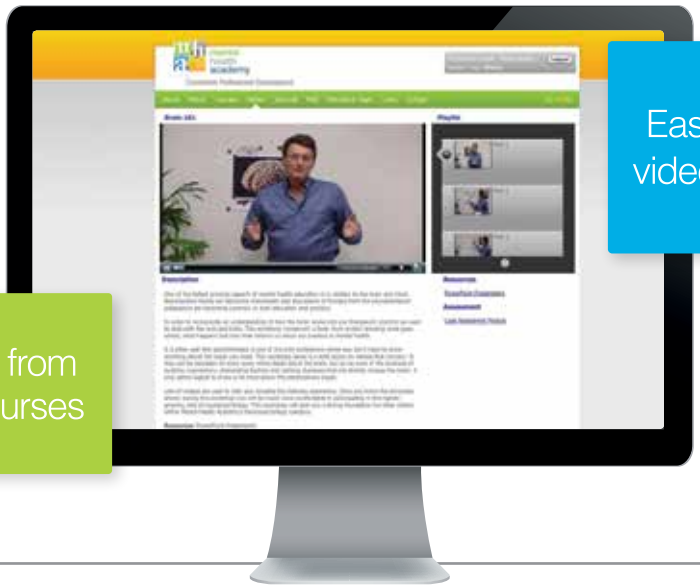

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Understanding Will

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

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

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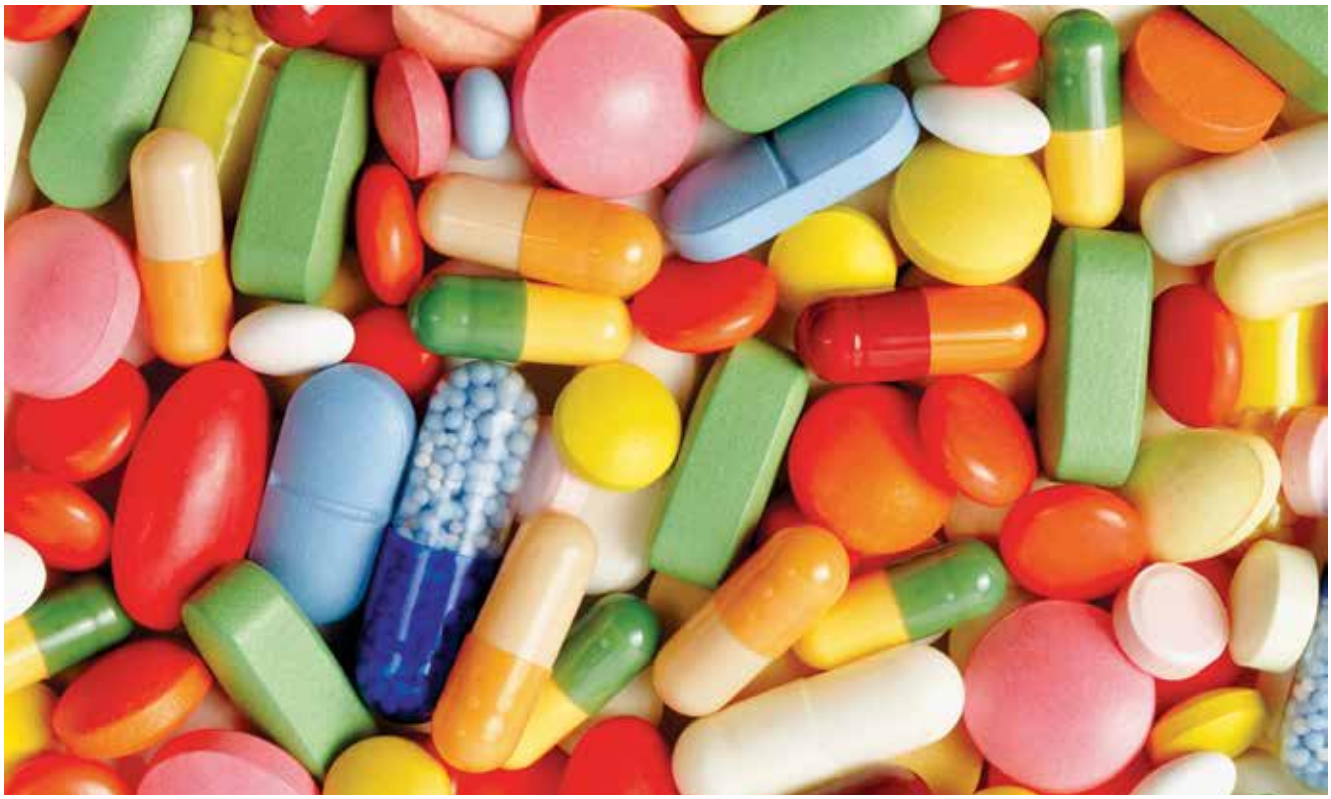
PEER REVIEWED ARTICLE

A Treatment Plan for Benzodiazepine and Alcohol Misuse – A Case Study

By Tara Hamilton



Case Formulation

PRESENTING PROBLEM

Jill has been misusing her benzodiazepines, engaging in 'doctor-shopping' and purchasing Valium over the Internet to increase her supply. Jill also drinks alcohol three or four days a week, consuming a bottle of wine or more on each day that she drinks. This has been a long-standing habit over many years. Jill alternates her days of alcohol consumption and benzodiazepine use and sometimes combines them together which causes her to feel 'out-of-control' and 'messy'. Jill also suffers from anxiety.

PREDISPOSING FACTORS

Jill first started drinking in high school and used to drink large quantities on a regular basis with her former partner. She has also suffered with anxiety for as long as she can remember, and as an adult this has arisen with her work. The anxiety became particularly severe after the separation from her long-term husband two years ago.

PRECIPITATING FACTORS

The factors leading to Jill's self-referral include her increased use of benzodiazepines, as well as her use of the Internet and 'doctor-shopping' to increase her supply. Also, her anxiety has particularly worsened since the breakup from her former husband. Lastly, Jill was recently asked to babysit her sister's children, but drank a bottle of wine when the children went to bed and has not been asked to do it again.

PERPETUATING FACTORS

Jill is presently unemployed and living alone. She has no children and feels socially isolated. Jill is currently living on her savings, which is rapidly diminishing. Jill has lost social contact with her friends after the breakup with her husband. She suffers from anxiety and is feeling pessimistic about her ability to change.

PROTECTIVE FACTORS

Despite Jill's pessimism, she is very eager to change and improve her situation. Jill has previously taken pride in her appearance and keeping fit, which demonstrates a good premorbid personality. She also has one good friend and a younger sister with a partner and children who she sometimes visits.

Treatment Recommendations

As a substance use treatment practitioner, I would assess Jill's substance use to match the most appropriate treatment. During

assessment, I would adopt a motivational assessment style, while ensuring the physical environment is comfortable and conducive to disclosure. Respect and confidentiality are also important factors as well as documenting relevant information such as Jill's alcohol and drug history. During the assessment phase, I would assess Jill's pattern of use through a self-report measure such as the Quantity-frequency measure and biochemically (urine analysis for drugs and blood alcohol level for alcohol). I would then assess her emotional and psychological functioning through a self-report measure such as the DASS-21. To compete the assessment phase, I would refer Jill to a specialist neurologist for a test of her cognitive functioning.

For treating Jill's benzodiazepine (BZD) use, cognitive behavioural therapy (CBT) will be my treatment of choice. In combination with CBT, Jill's benzodiazepine use will be tapered gradually as abrupt withdrawal can cause both physical and psychological symptoms (Vikander, Koechling, Borg, Tonne & Hiltunen, 2010). CBT will additionally be useful in treating Jill's prevalent anxiety.

As Jill self-referred for her benzodiazepine use only, I would provide a brief intervention delivered at the primary care level for her alcohol consumption. Research has found that motivational interviewing (MI) is an effective brief intervention for treating alcohol-related problems, which is what I will use to treat her alcohol misuse (Lundahl & Burke, 2009; Vasilaki, Hosier & Cox, 2006),

Finally, in terms of Jill's limited social support, I would recommend a therapeutic community (TC) program where she can meet others struggling with addiction. A TC will provide Jill with social support and possible friendships throughout her treatment. It will also provide additional treatment for Jill's substance use (Malivert, Fatséas, Denis, Langlois & Auriacombe, 2011).

Treatment Rationale

COGNITIVE BEHAVIOURAL THERAPY PLUS TAPER

In treating Jill's benzodiazepine misuse, cognitive behavioural therapy will be the treatment of choice. At this stage, there is insufficient evidence in terms of effective treatments for treating BZD use, however CBT plus taper has shown effectiveness at least in the short term (Vikander et al., 2010). CBT is a psychosocial intervention that was derived from a cognitive model of drug misuse (Beck, 1993). Cognitive behavioural therapy is a time-limited treatment and aims to identify and modify irrational thoughts, and manage negative mood. CBT is based on the belief that addictions are learned behaviours and are capable of being modified (Vikander et al., 2010). The cognitive approach aims to change the behavior by changing the client's dysfunctional beliefs, promoting positive cognitions or motivation to change behaviour. The behavioural aspect aims to modify behaviours strengthened through conditioned learning.

In a recent Cochrane review, Darker and colleagues (2015) reviewed 25 studies, including CBT plus tapering BZD use, CBT without taper, MI, letters, relaxation oriented interventions, e-counselling and advice from a general practitioner (Darker, Sweeney, Barry, Farrell & Donnelly-Swift, 2015). The authors found a significant difference between CBT plus taper and taper in terms of a successful discontinuation of BZDs within four weeks post-treatment and at three months follow-up for the CBT plus taper group. However, no significant findings were demonstrated for six months and beyond. A limitation of this review was that some of the studies were targeting other substances such as amphetamines, thus the results are difficult to interpret. Moreover, the results from this review should be considered tentatively due to the low participant numbers, the few manualised studies and the short-term follow-ups (less than 12 months). As there is evidence to support the use of CBT plus taper in reducing BZD in the short-term, future research could look into longer-term effectiveness, especially as BZD use is a serious health issue.

Cognitive behavioural therapy combined with gradual BZD discontinuation has also demonstrated effectiveness for facilitating benzodiazepine cessation among patients with generalized anxiety disorder (GAD) (Gosselin, Ladouceur, Morin, Dugas & Baillargeon, 2006). This is applicable in Jill's case as BZDs were originally prescribed because of her anxiety. The authors found that almost 75 percent of clients in the CBT condition completely ceased benzodiazepine use compared to the control group. The results also revealed that maintenance of complete discontinuation occurred up until 12 months with rates twice as high in the CBT condition. Additionally, patients who no longer met GAD were higher in the CBT condition. Although this study provides promising research for future studies, a limitation of this study in regards to Jill's case concerns the generalisability of the results. Specifically, the study exclusively included patients with GAD and thus the treatment may work differently for patients with other anxiety disorders or comorbidities such as depression. Despite these limitations, this study is the first to look at individuals with GAD, who are a population at risk for developing BZD dependence. Future research could include individuals with other types of anxiety and comorbidities to determine whether CBT is still effective for other populations.

Gradual tapering is an important process during treatment as distress, withdrawal symptoms and reoccurrence of the original problem may appear (O'Connor et al., 2008). In a study by Vikander and colleagues (2010), long-term BZD users were followed over one year following graded BZD withdrawal. The authors found that the frequency and severity of clinical and withdrawal symptoms decreased over time and showed four heterogeneous patterns. First, a gradual decrease over the 50-week period was demonstrated; this included an affective, cognitive, motivational and illness component, and symptoms related to anxiety. Second, there was an increase in the severity of symptoms due to the onset of tapering, however a decrease in severity for the remaining time. Third, there was an increase in the severity of symptoms four weeks post BZD tapering which were all related to affect. The final pattern included symptoms that were resistant to change including those related to anxiety and reactive depression, as well as perceptual disturbances. As has been evidenced from this study, there are many patterns of BZD withdrawal symptoms to consider throughout the treatment process. However, it should be noted that participants were all long-time users averaging 15 years; therefore the treatment may work differently for a short-term user such as Jill who also drinks on alternate days.

MOTIVATIONAL INTERVIEWING

Individuals who attend for health conditions other than alcohol problems will often be referred to an opportunistic or primary care brief intervention (Heather,

1996). One type of brief intervention that has demonstrated effectiveness for treating alcohol-related problems is motivational interviewing (Vasiliki, Hosier & Cox, 2006). MI is a client-centered style of counselling that aims to elicit behaviour change by helping clients explore and resolve their ambivalence (Flanagan & Flanagan, 2014). MI is closely linked to the Stages of Change model developed by Prochaska and DiClemente, in which the therapist begins to motivate the client at the pre-contemplation stage (Miller & Rollnick, 2002). MI has been summarised as consisting of four central principles (Juarez, Walters, Daugherty & Radi, 2006). First, the client is respected and the counsellor is non-aggressive. Second, the counsellor raises awareness of the negative consequences of drinking. Third, the counsellor avoids arguing about change and does not voice their opinion. Lastly, the counsellor encourages the client and uses self-efficacious statements.

Research has found that brief interventions delivered in primary care settings can reduce excessive drinking (Kaner et al., 2009). In a meta-analysis by Kaner and colleagues (2009), 22 studies were evaluated and after one year, patients who received a brief intervention in a primary care setting showed a significant reduction in alcohol consumption when compared to controls. However, the brief interventions significantly reduced the quantity of alcohol consumed for men only. This could be due to the fact that out of 29 trials they ran tests on, only five included separable data on women. Moreover, 70 percent of the participants were men, thus there were few women to begin with. Consequently, it is clear that future studies need to report sex-specific outcomes or include more women in brief intervention studies.

In a meta-analytic review, Vasiliki and colleagues demonstrated that brief MI is an efficacious treatment strategy for reducing alcohol consumption (2006). Specifically, 87 minutes of MI was more effective than no treatment in reducing alcohol within three months, and 53 minutes of MI was more effective than an aggregated set of varied comparison treatments. Moreover, it has been argued that an increase in the duration of MI may lead to positive outcomes in the long-term. However, the study demonstrated that MI is more effective for young adults who are heavy- or low-dependent drinkers, which limits the generalisability of the results. Despite this limitation, the review does provide evidence for the effectiveness of MI in reducing alcohol use and its potential for long-term effectiveness. Future studies should focus on the components of MI that are more influential in producing long-term changes.

Several controlled research studies have demonstrated that MI is between 10 and 20 percent significantly more successful for treating alcohol-related problems than a controlled sample and when compared with existing treatments, success rates ranged from no advantage to almost 20 percent (Lundahl & Burke, 2009). Although MI is a brief treatment, it has shown higher cost effectiveness than its alternatives. Furthermore, the outcomes have shown effectiveness for up to one year post-treatment. Motivational interviewing is successful for individuals regardless of age, gender, severity and even for some ethnic minorities, thus it appears to be a promising treatment for Jill. The review also revealed that MI delivered individually is more effective than delivered in a group format, although it has proven to be effective in a variety of formats. Moreover, MI has been found to work best as a prelude to a longer-term treatment, although a dose effect was found in two of the studies in which more time in MI was associated with better outcomes. A longer treatment will most likely be required for Jill as her alcohol has been a long-standing issue since she was in high school. The findings from this review are somewhat limited, as the studies did not utilise designs that could isolate the main ingredient of MI. Thus, future research could include only those studies that are able to isolate the unique effects of motivational interviewing so that a better understanding of how MI works is available.

SOCIAL SUPPORT

Research has demonstrated that social support is particularly important throughout both the treatment process and post-treatment for substance abuse (Broome, Simpson & Joe, 2002). As Jill has limited social support, it is particularly important that she has someone to support her through her treatment and for when she returns home. Strong social support has been associated with greater treatment retention and behavioural improvement during treatment (Broome et al., 2002). Moreover, reports of 'spontaneous recovery' demonstrate the importance of social relationships. In a study by Broome and colleagues (2002), the impact of treatment on reduced drug use and crime a year later for patients maintained on methadone was partly a function of increased support from family and friends. Furthermore, attributes of patient social support networks mediated the effects of treatment.

Social support has also shown effectiveness in reducing benzodiazepine use, which is highly relevant in Jill's case (O'Connor et al., 2008). In a rigorously controlled study by O'Connor and colleagues (2008), two cohorts were included; the initial cohort who received taper only and physician counselling and the second cohort who received either group support (GS) or CBT plus taper which was delivered through the Program Aimed at Successful Severance (PASS) of benzodiazepines. The findings demonstrated no significant difference in satisfaction ratings between the GS and PASS groups, although the GS group had a higher attrition rate. Further, the PASS group scored higher on the self-efficacy measures demonstrating that confidence in coping with difficult situations played a more central role in the PASS group. Aside from these differences, the study revealed that the components of social support and other non-specific psychosocial factors are as effective as specific CBT strategies in tapering BZD use. A limitation of this study was the small sample sizes, which may have affected the power. Moreover, the generalisability is limited as other anxiety disorders and comorbidities were excluded. Future studies could include a larger and more heterogeneous sample to

ascertain whether CBT is efficacious for other populations.

One way of providing Jill with social support is through a therapeutic community program. A TC is a drug-free modality that can be conducted in a diversity of settings, although it is usually conducted in a residential setting (DeLeon, 2010). Within the therapeutic community, people with addiction live together in a structured way to learn how to assimilate social norms and develop more effective social skills (Malivert, Fatseas, Denis, Langlois & Auriacombe, 2012; Smith, Gates & Foxcroft, 2008). Therapeutic Communities adhere to a person-oriented view and consider addiction to be a consequence of psychological and interpersonal problems (Debaere, Vanheule & Inslegers, 2014). TCs can take several forms and are open to people with a range of substance abuse problems that also may have additional problems including multiple drug addiction, involvement with the criminal justice system, lack of positive social support and mental health problems such as anxiety (NIDA, 2002). A major limitation with TCs is the high attrition rates as most residents drop out within the first 30 days (Malivert et al., 2012). Therapeutic communities are considered to be an effective method of rehabilitating drug users in the USA and parts of Europe, however most of the research evidence is from poorly controlled studies (Smith et al., 2008). Thus, future trials are necessary with the aim of minimising attrition during the early stages.

Summary

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PEER REVIEWED ARTICLE

Domestic violence and risks during pregnancy

By Suzanne Craig

"A small group of thoughtful people could change the world. Indeed, it's the only thing that ever has."
Margaret Mead

In 2015 Australian of the Year Rose Batty accomplished a great deal in raising awareness and promoting discussion about the once taboo subject of family violence against women and children. Indeed, many women suffer in silence at the hands of their partners, experiencing a wide array of abuse resulting in intense significant physical and psychological injury, and isolation. This article will explore the complexity of factors associated with violence in intimate relationships, specifically the broad range of considerations when working with women whom are pregnant and at risk from domestic violence.

Definition

In the latest New South Wales (NSW) Government Domestic Violence "It Stops Here" reforms (2014) domestic and family violence (D&FV) is defined as behaviours used in an intimate or family relationship to control, dominate, intimidate, terrify or coerce a person, which results in them fearing for their own or another person's safety (p. 4). It encompasses physical, sexual, verbal, psychological, mental and emotional abuse, including stalking, harassment, and economic abuse, denial of freedom and choice, controlling access to family and friends (p. 5), as well as inflicting damage to property, and injury or death to animals or pets (p. 7). An intimate relationship refers to people whom are presently or have previously been in an intimate partnership, either sexual or non sexual, including heterosexual, lesbian, gay, bisexual, transgender, intersex or queer (LGBTIQ) relationships (p.7). "Family" encompasses the broader scope of relationships including biological relatives, as well as those connected through kinship networks, marriage, defacto, foster care, or adoption. Depending upon dynamics, non intimate cohabitants, and people living in residential care may also come under the definition of Family violence (p.7).

Prevalence & Costs

The personal and community costs of violence against women are enormous. In NSW approximately 125,000 incidents of Domestic and Family Violence are reported to police annually, with estimates another 300,000 incidents go unreported (NSW Auditor General, 2011). A review of domestic violence homicides in NSW revealed that D&FV is the single greatest cause of death, ill health and disability for women under forty five, and is attributable for three quarters of female homicides, (NSW Government, 2012) and attempted murders (NSW Domestic Violence Death Review Team, 2013). When considering pain, mortality, and health services, the cost to the economy is estimated at 4.5 billion dollars each year (NSW Government, 2014) escalating to 8.1 billion dollars when other factors are considered such as property, child protection services, justice system, victims compensation, financial support, loss of employment and productivity (Australian Bureau of Statistics, 2007).

Context of domestic violence

Societal views about gender, masculinity, power and relationships are strongly associated with the prevalence of domestic violence (NSW Government, 2014, p. 14). Key social and economic factors that contribute to D&FV include beliefs and practices relating to gender roles particularly beliefs about male entitlement (ABS, 2007 p. 7; Brownridge, 2011), weak support for gender equality, sexism in peer and organisational cultures, pornography (ABS, 2007 p. 4) economic exclusions and poverty, inherited grief and trauma, particularly in Indigenous culture, as well as dispossession, loss of traditional language and cultural practices (NSW Government, 2014, p. 14). Increased rates of domestic violence during particular seasons and events have also been studied (Braaf & Gilbert, 2007), with hotter months, specific holidays such as New Years Eve and Christmas, and large sporting events coinciding with increased reports of domestic violence.

For women it seems there are many barriers to seeking support or disclosure (Indermaur, 2001) with less than one third of victims seeking professional help (ABS, p. 5; McMahon, 2011). Women may be resistant to disclosing for numerous reasons including fear of retaliation (ABS, p. 5), fear of being blamed or misunderstood, concerns about confidentiality, fear of being reported to child protection services and losing children (Bullock, Bloom, Davis, Kilburn, & Curry, 2006), of losing control, psychological and/or economic dependence upon their abuser, hope based on promises of change (Bailey, 2010), fear of being forced to leave the relationship (Grauwlier, 2008; ABS, 2007) or difficulty trusting others (Warshaw, Sullivan, & Rivera, 2012).

Additionally, there are many complex reasons women may stay in relationships, or require multiple attempts to leave (ABS, 2007 p.4). Many women make a conscious judgment it is safer or more viable to stay than to risk leaving and experiencing direct repercussions from the perpetrator, or indirectly, through loss of housing, income, security, social networks and connections (Grauwiler,

2008). At other times the decision to stay is based on hope that things can be better (Warshaw, 2013), often deciding to go it alone because they become exhausted by the "service runaround", and the stress of dealing with the legal system (Grauwlier, 2008). Those whom enter Emergency accommodation often encounter another range of stressors including loss of social support, uncertainty, crowded accommodation, social isolation in the community, difficulty with the rigid rules of shared living and with some of the staff or residents, disruption to children's lives and networks, and a general feeling of loss "everything I worked for was just gone" (Grauwiler, 2008, p. 316).

It is evident that D&FV is a complex community problem to which the NSW government is endeavouring to develop a holistic integrated response where workers can actively contribute in terms of participation in prevention and early intervention activities, implementation of standardised risk assessments, and provision of tertiary level interventions such as support, counselling, advocacy, referral, and participation in Safety Action Meetings which are being implemented via local networks to ensure timely, co-ordinated and appropriate support for victims whom are identified at risk of serious harm (NSW Government, 2014 p. 19).

High risk populations

The Safer Pathway Response (NSW Government, 2014) summarises the key issues around domestic and family violence, stating D&FV has been found to be perpetrated at least 70% of the time by males against females. Several population groups have been identified as being at significant risk, particularly Aboriginal women whom are six times more likely to be victims of domestic and family violence, and thirty one more times likely to require hospitalisation than non Aboriginal Australians. Similarly females with disabilities are at estimated at 37 % more risk than the general population. These groups along with women who live in remote communities, whom suffer from mental illness, abuse substances, or from culturally and linguistically diverse or LGBTIQ backgrounds, may face significant and complex barriers in accessing supports and reporting D&FV (NSW Govt., 2014; O'Reilley, 2007 p. 2). Finally, whilst some groups are over represented in statistics, it is important to acknowledge that domestic violence occurs in varying degrees across all socioeconomic groups and cultures. Worldwide, almost one third of all women who have been in a relationship have experienced physical and/or sexual violence by their partner, with approximately 38% of all murders of women committed by intimate partners (World Health Organisation, 2013).

Violence during pregnancy

In Australia, it has been identified that up to two thirds of women reporting domestic violence were pregnant at some time during the violent relationship, 36% experienced physical violence, 17% for the first time during pregnancy, with others reporting an escalation in psychological abuse during pregnancy (Indermaur, 2001). In a more recent review of the literature Taillieu (2010) also found that a substantial minority of women globally experienced what they considered to be violence for the first time during pregnancy, with a large proportion reporting that whilst physical abuse ceased during pregnancy, other forms increased. Women whom reported physical violence continuing throughout pregnancy were identified as being at risk of the most severe forms of violence both

Apart from physical injuries, women in abusive relationships are at much higher risk of mental health problems including clinical depression

during (Brownridge, et al., 2011) and post preganacy (Martin, Macy, Sullivan, & Magee, 2007). Furthermore domestic violence is reported as one of the leading causes of maternal death by murder or suicide in many developed countries (Lancaster, Singh, Campbell, Flynn, & Gold, 2011), with women who attempt to separate or divorce during their pregnancy at greatest risk of Femicide (Martin et. al., 2007). O'Reilly (2007) highlights that the majority of women killed by their partner were in the process of leaving, and in most instances were leaving for reasons other than abuse, which suggests that they did not necessarily identify their experience as abusive.

In relation to risk during pregnancy, some research suggests specific population groups may be more vulnerable including young women, particularly adolescents (Indermaur, 2001), single, separated or divorced women, those with lower educational achievement (Bullock, Bloom, Davis, Kilburn, & Curry, 2006), and women from minority groups. Other socioeconomic factors such as low income, unemployment, lifestyle instability, and social isolation have also been identified as possible indicators for risk (O'Reilly, 2007; Taft, 2002). Personal histories involving previous childhood abuse (ABS, 2007), alcohol and drug abuse by victim or spouse, increased number of pregnancies, unintended pregnancy from contraception failure or partner rape, pregnancy from a previous partner, and termination of pregnancy have also been identified as factors linked to increased risk of victimization during pregnancy (McMahon, 2011; Finnbogadottir et. al., 2014; O'Reilly, 2007). Interestingly one longitudinal study (Hellmuth, Gordon, Stuart, & Moore, 2013) found a high prevalence of perpetration of interpersonal violence amongst pregnant victims of domestic violence. They suggest the reasons for this phenomenon were complex and require more research but strongly recommend this aspect be introduced into screening as it was potentially associated with a range of detrimental outcomes throughout the pregnancy and post partum period.

Whilst many risk factors have been identified, it appears these results are not clear cut as many of the associations demonstrated with bivariate analysis such as education, income levels, and multiple children, disappeared or became less than

significant under multivariate analysis, additionally the relationship between other factors such as age, ethnicity also become less clear (Brownridge et. al., 2011; O'Reilly, 2007). It may be that risk is more closely associated to socioeconomic indicators (O'Reilly, 2007; Taillieu, 2010). Factors that maintained strong associations included violence in family of origin, being single, separated or divorced (Brownridge, et al., 2011). Other studies suggest the only reliable predictor of abuse was higher educational attainment by women, placing them at ten times greater risk of being killed by their less educated partners (Taylor & Nabors, 2009). However a difficulty of comparing research and determining the practical relevance of findings relates to the diversity of measures utilised in studies (O'Doherty, et al., 2014), with definitions of Domestic and Family Violence varying greatly in terms of their inclusion of aspects of violence beyond the overt physical, and the common omission sexual violence.

Furthermore many of the studies of interventions for interpersonal violence reviewed by Warshaw and associates (2012) suffered from poor retention rates in both the long and short term, with the majority of drop outs identified as younger, less educated, suffering from higher degrees of depression and anxiety, guilt and shame, and were more likely to have suffered severe abuse, and alcohol use. It is possible dropout rates could also be attributable to barriers associated with accessing support such as competing demands, and practical matters such as homelessness, stress, transport, childcare and so forth (Warshaw, Sullivan, & Rivera, 2012). Thus the capacity of research studies to fully reflect the experience of women, and specifically pregnant women in violent relationships have some limitations given their strict parameters in terms of behaviours, timeframes and context, inadequacies of various standardised measurement tools, and exclusion of high risk populations such as women whose pregnancies did not result in live births (Taillieu, 2010). Given the diversity of factors and reported sequelae, Taillieau (2010) suggests that certain pregnancy related factors could be associated with different outcome trajectories, therefore recommends further research to illuminate this area.

In relation to offenders, studies focussing on specific characteristics have identified higher risk of offending by males whom have experienced violence or abuse as children, tend to hold more traditional and rigid attitudes relating to gender roles, abuse alcohol or drugs, exhibit jealousy and anger, particularly in relation to paternal uncertainty, resentment towards unborn child, whom are more likely to be experiencing financial stress, unemployment, low education (Brownridge et. al., 2011; Taillieu, 2010).

IMPLICATIONS FOR WOMEN AND THE FOETUS

Apart from physical injuries, women in abusive relationships are at much higher risk of mental health problems including clinical depression (Martin, Macy, Sullivan, & Magee, 2007), post natal depression (Finnbogadóttir, Dykes, & Wann-Hansson, 2014), post traumatic stress disorder, particularly if they have experienced previous trauma (Warshaw, et. al., 2012), and up to nine times greater risk of mood or anxiety disorders and subsequent hospitalisation (ABS, 2007). Women may commonly present with self harming behaviours and suicidal ideation, and trauma symptoms such as hyper arousal, avoidance, or intrusive memories (Taft, 2002), impaired social skills and emotional regulation (Warshaw, et. al., 2012) commonly associated with fear, guilt, shame (Morgan & Chadwick, 2009), shock, disbelief, confusion, terror, isolation, and despair which all undermine self esteem and self concept (McMahon & Armstrong, 2004; Warshaw, et. al., 2012). Women may also deny or minimise their experience (ABS, 2007). Behaviourally women may appear timid, anxious, submissive or perfectionistic (Taft, 2002). They may also report disturbances of sleeping and eating. Indeed presentations are likely to be quite complex for those women who have experienced chronic and severe interpersonal trauma throughout their lives (Herman, 2001; Van Der Kolk, 2014; Briere, 2008).

Commonly reported pregnancy and health related complications include low maternal weight gain, ante partum haemorrhage, kidney infections, caesareans, miscarriage, uterus rupture and are also at higher risk of sexually transmitted diseases, hypertension and gestational diabetes (Taillieu, 2010; Finnbogadóttir, Dykes, & Wann-Hansson, 2014). It has also been reported that women living in violent situations may seek out terminations (O'Reilly, 2007). Increased alcohol or substance use has also been reported (ABS, 2007). Of great concern is the risk of homelessness, with almost one third of people seeking assistance from NSW homelessness services reporting D&FV as an issue (NSW Government, 2014).

Other factors affecting the health of the developing foetus include maternal delays in accessing prenatal care (Taillieu, O'Reilly), increased risk for premature birth and decreased birthweight (Finnbogadóttir, Dykes, & Wann-Hansson, 2014), the later two associated with high risk of neonatal morbidity and mortality, and linked to potentially long term complications such as cognitive and motor delays, behavioural and psychological problems, and generally poor health throughout childhood (ABS, 2007; Taft, 2002). Furthermore living in violence increases the risk of the child experiencing abuse or neglect (Mouzos & Makkai, 2004, p. 4) thereby facilitating the transmission of generational violence (NSW Government, 2014, p. 9).

ASSISTING WOMEN EXPERIENCING VIOLENCE DURING PREGNANCY

Given the ongoing threat of physical and psychological abuse, safety takes priority over therapeutic interventions (Rothschild, 2011; Warshaw, 2013; Herman, 2001; Briere, 2015). In terms of a broad structure for working with women living in violence, Warshaw (2013) reviewed a variety of interventions identifying that complex trauma models such as those proposed by Judith Herman (2001), Van Der Kolk and associates (1996) generally consist of three dimensions; initially the main focus is on the present in terms of establishing physical, psychological and emotional safety, building a therapeutic relationship, assistance to enhance skills to modulate emotions and stress (Rothschild B. , 2011), and psychoeducation about D&FV (Jahanfar, Howard, & Medley, 2014). The second phase which Herman (2001) refers to as "remembrance and mourning" is focussed on processing the trauma, developing a coherent and meaningful narrative of events, and the processing of grief, guilt and shame which often keeps people stuck in trauma (Rothschild B. , 2010). This stage endeavours to deal with physical, sexual, emotional abuse in a holistic manner, which assists in locating the trauma in the past thereby reorientating to the present (Warshaw, Sullivan, & Rivera, 2012). It is imperative however, that physical and psychological safety continues to be monitored to ensure clients experience safety whilst "remembering danger" (Briere & Scott, 2015, p. 104), otherwise there is a great risk of overwhelming the survivors capacity to cope. The final phase focuses on what has been referred to as post traumatic growth where clients discover more about their strengths and capacities, finding meaning and purpose, and importantly reconnecting to community life in a way that is no longer dominated by the effects of abuse and trauma (Rothschild, 2010; Van Der Kolk, 2014; Warshaw, Sullivan, & Rivera, 2012).

Immediate needs: Safety & making connection

In order to assess ongoing **risk** and determine appropriate intervention, regular empathic, culturally sensitive assessment, in a client friendly environment is necessary. These assessments aim to identify current and past traumas, including severity and duration of abuse sensitively utilising specific behavioural language (McMahon & Armstrong, 2012). Awareness of the increased risk of harm as a result of helpseeking is essential. It may be that the offender is using therapy against them, eg. confirmation of their inadequacy or "madness", or undermining their attempts to seek support (Warshaw, Sullivan, & Rivera, 2012). It can also potentially increase their risk of harm if the offender feels as though he is losing control. An assessment of coping strategies and responses will indicate what level of internal safety a person is experiencing at any given stage, whether they be at the social help seeking stage, in fight or flight, or have collapsed into the freeze response (Van Der Kolk, 2014). Care needs to be taken not to pathologise or appear to be judgemental of responses, for example heightened sensitivity or passivity are likely to be adaptive in order to avoid or minimise further abuse (Warshaw, Sullivan, & Rivera, 2012). It is also important to enhance their connection to internal resources and external supports, and develop a holistic view of their current situation, including the needs of any accompanying children (Warshaw, Sullivan, & Rivera, 2012).

Practitioners need to be mindful of the significant **barriers** to accessing assistance, and competing demands for the woman's time and energy. In a review of trauma treatments Warshaw and associates (2012) identified practitioners found it necessary to be flexible in these circumstances; considering the needs of women in terms of child care, access to transport, offering fewer sessions in a shorter space of time, utilising the window of opportunity when it presents, and acknowledging that longer term regular therapy sessions were not always possible. Furthermore, cultural sensitivity and awareness of the needs Aboriginal and CALD communities is crucial as well as an acknowledgement of fears relating to government agencies. The disadvantage and trauma experienced by Indigenous Australians is well documented, therefore culturally sensitive responses require flexibility such as meeting in spaces other than formal offices. Barriers for women from CALD backgrounds include potential misunderstandings what services can offer, a lack of appropriate translators, fears about residency or citizenship status, (Mouzos & Makkai, 2004) , or previous negative experiences with authorities in country of origin resulting in lack of trust in government services.

Apart from safety, other **immediate needs** require attention prior to any trauma specific therapy (Warshaw, Sullivan, & Rivera, 2012) including risk of homelessness, negotiating the legal or child protections systems, attempting to secure financial stability, attending to medical and pregnancy related needs, and dealing with other associated factors of social disadvantage and chronic trauma. Many women with children identified a desire to build their confidence around parenting, especially given they too were suffering from trauma reactions (Grauwiler, 2008). This highlights the importance of collaborative case management, advocacy and referrals to specialist agencies, including violence specific services and other appropriate supports (McMahon & Armstrong, 2012) particularly relating to mental health, alcohol and drug use, homelessness, legal responses, and needs of children (Hellmuth, Gordon, Stuart, & Moore, 2013).

In terms of **engagement**, it is of absolute importance to not mimic the dynamics of abuse. Practitioners need to maintain awareness of the power dynamics within the therapeutic relationship, acknowledging their privileged and powerful position which can be best moderated by maintaining a position of "disinterested neutrality" to ensure that the client remains central rather than therapist's agenda (Herman, 2001, p. 135). The focus is on empowering the client to facilitate their own recovery (Herman, 2001) within a safe therapeutic relationship built on empathy, compassion (Briere & Scott, 2015) non judgment, accountability, collaboration, transparency,

(Grauwiler, 2008), particularly in relation to issues of consent, and limitations of confidentiality. Within this therapeutic context an eclectic approach (Briere & Scott, 2015) is required to ensure therapy is tailored to the individual needs of the client (Rothschild B. , 2011) allowing them to explore and develop coherent narratives about the trauma experience, to address related harmful and debilitating beliefs and assumptions, whilst also processing relational issues (Herman, 2001; Briere & Scott, 2015). It is generally understood that working with people with histories of chronic and complex trauma will present challenges in maintaining the therapeutic relationship given that they may have potentially idealised expectations of an "omnipotent rescuer" (Herman, 2001, p. 137), are more likely to be hypersensitive to interpersonal danger, have experienced attachment and abandonment issues, and developed protective strategies such as learned helplessness, controlling or demanding behaviours, which are most often driven by intense fear (Briere & Scott, 2015).

Processing trauma and reconnecting

Theoretical constructs generally approach Domestic Violence from a sociological, feminist or systemic perspective. Other psychological theories which are encountered in the literature include Bandura's Social Learning Theory (1971), attachment theory of Ainsworth & Bowlby, which has been criticised for its neglect of the socio-political context in which violence occurs (Buchanan, 2013), Evolutionary Psychology explores male sexual proprietariness and jealousy (Taillieu, 2010, p. 30), learned helplessness (Bargai, Ben-Shakhar, & Shalev, 2007), and Stockholm syndrome in terms of its relevance as a coping mechanism (Demarest, 2009).

Trauma theory assesses for post traumatic stress responses and utilises therapies such as Cognitive Behavioural therapy (CBT) and Eye Movement Desensitisation Reprocessing (EMDR) in conjunction with psychosocial rehabilitation (Australian Centre for Post Traumatic Mental Health, 2013, p. 28). Other considerations when people have failed to respond to psychotherapies include adjunctive group work, stress inoculation training, pharmacology, exercise, and acupuncture (Australian Centre for Post Traumatic Mental Health, 2013). CBT has been proven effective for depression and PTSD, however limitations have been identified with some survivors of interpersonal trauma (Warshaw, Sullivan, & Rivera, 2012). Others have acknowledged that whilst CBT has been found useful for phobias and anxiety, it is less useful complex trauma. Van Der Kolk (2014) reports therapies which include exposure tend to suffer from high dropout rates, and have not been proven helpful for guilt and other complex emotions that stem from trauma, especially interpersonal trauma.

Generally an awareness of a **variety of models**, as well as a capacity to work with the complexity of chronic trauma, its effects on mental health and substance use (Rothschild B. , 2011), and an appreciation that symptoms act as coping strategies which should not be dismantled but rather expanded upon to broaden peoples options (Briere & Scott, 2015). Psychoeducation is highly recommended to assist women in understanding the ways trauma and stress impact upon them and their relationships, to normalise symptoms, and acknowledge adaptive strategies (Jahanfar, Howard, & Medley, 2014). Solution focussed approaches addressing domestic violence recommend a therapeutic goal of assisting female survivors to reconnect with their own resourcefulness in resisting, avoiding, escaping and fighting against the abuse, assisting women to develop of vision of living a life free from violence, and empowerment by supporting them to notice and build on small attainable goals (Mo-Yee, 2007). In a similar vein to Narrative therapy, this approach strongly advocates the position where clients are seen as the experts in their own lives, actively searching for exceptions which counter their experience of powerlessness, helplessness and erosion of self that occurs within the context of domestic violence. Grief modelsalso have relevance, including the concept of disenfranchised

grief (Doka, 1998) with one woman expressing it so eloquently "*there is no special day or time to grieve, no public acknowledgement or support... you just remember the day you nearly died, the time you thought about taking your own life because you were so terrified what would happen next...you don't get the support or understanding like people do when someone dies*" (Dean, 2005).

Considerations for **referrals** could include mediation, mindfulness and yoga. Mindfulness based in Buddhist practices assist clients to focus on the present, connect to their sensory experience, and integrate information. Van Der Kolk (2013) reports physical movement, breathing, mediation and body work such as massage or Feldenkrais have demonstrated measurable benefits in calming sympathetic nervous system responses and states of frozen immobilisation, enhancing emotional regulation, and reducing patterns of physical tension. Yoga, including yogic breathing, has also been found to be an effective adjunctive treatment for depression and trauma (Van Der Kolk, 2014 ; Cabral, Meyer & Ames, 2011). However as with any strategy it is important safety issues be considered in order to determine when these strategies may, or may not be useful (Rothschild B. , 2011).

Generally it is recommended that a culturally respectful strengths based approach (Warshaw 2013), which attends to safety issues may be helpful in conjunction with psychoeducation about the dynamics and effects of violence, and cognitive and emotional skill building to assist with symptom and stress management (Briere, 2015; ACFPTMH 2013). Strengthening quality social supports is also considered crucial when assisting people in crisis (Van Der Kolk, 2014; O'Reilly, 2007; McMahon & Armstrong, 2004) and is beneficial in reducing the isolation experienced by women in domestic violence (Brownridge, et al., 2011; Grauwiler, 2008). Regardless of theoretical approach, Buchanan (2013) strongly argues the necessity of considering the dynamics of violence in relationships within a social, political, cultural and historical context.

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Vicarious Trauma and Clinical supervision GPP

In terms of practitioner development, ongoing training is beneficial in terms of improving confidence and capacity to identify and support women with psychosocial issues during pregnancy (Gunn, et al., 2006; McMahon & Armstrong, 2004), and to broaden knowledge of psychology, physiology of trauma and post traumatic stress (Rothschild B. , 2011). Furthermore, working with trauma has the potential to illicit vicarious trauma in practitioners, therefore attention should also be given to adopting a healthy lifestyle, adequate self care activities and regular supervision (ACPTMH, 2013).

Brief reflections and conclusion

It is quite challenging to condense the diverse and complex factors which need to be considered when endeavouring to identify and support pregnant women at risk from domestic violence. The statistics are shocking, and the risks are high with attempted murder or femicide realistic possibilities to be considered. At the very least I would encourage practitioners to find ways to offer flexible services in order to engage women whom face significant physical and psychological barriers to accessing assistance. The challenges to successfully engage these vulnerable women are numerous, and all contacts require constant mindfulness to ensure we do not inadvertently duplicate or exacerbate the dynamics of abuse. Furthermore it is essential to work as part of a team to support the family and connect them to community resources. Just as important is the need for ongoing professional development, clinical supervision and self care. Finally, becoming involved in prevention and early intervention initiatives can go a long way in helping to turn the tide of domestic violence in your community.

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Suzanne Craig:
Since 1994 I have had the privilege of working in various case work, counselling and management positions providing support to many amazing women, young people and children who have struggled with life transitions, battled disadvantage, and survived physical, mental or sexual trauma. I have also been extremely fortunate to work with a variety of early childhood organisations, including a mobile service which provides fantastic support and learning opportunities to children living in rural and isolated areas.

PEER REVIEWED ARTICLE

Counselling the client with depression – is there a definitive treatment?

By Karen E. Rendall

ABSTRACT
This article discusses the application of counselling skills to a client with depression. The article will cover the definition of depression, the possible causes of depression and the types of treatments likely to be seen within counselling. It will be seen that there is no currently no definitive treatment for depression but rather a range of possible treatments including medical intervention, practical advice, provision of other services and counselling.

Most people have experienced feeling 'down in the dumps', perhaps about a relationship, work, or the future. When the mood is severe, lasts for more than 2 weeks and interferes with our ability to function at home and work it is considered to be depression (Black Dog, 2005). Signs of depression include a loss of confidence, difficulty in concentrating and making decisions, inability to settle, sleeping too much or not being able to sleep and changes in eating habits (Healey 2005, p. 23). Individuals with depression can become sad, feel hopeless and lose their zest for life. They may experience a lack of pleasure in hobbies and pastimes they previously enjoyed and in motivation for usual activities. There may be a slowing down of thoughts and actions, a feeling of fatigue and loss of energy (AIPC 2000, p. 210). A depressive person may find their thoughts are dominated by a specific problem and this self-pre-occupation can drive others away. Often the depressive person desires the attention and affection of others and the inevitable rejection causes them to withdraw socially (Kennedy & Charles 1990, p. 202). Until recently, depression was thought of as a single disorder which could only be differentiated by the severity of the symptoms (Prendergast 2006, p. 20). It is now believed by many that depression is not a single, distinct medical condition but rather one that can be experienced by people in different ways. There continues to be considerable debate, however, on the classification of the various forms of depression.

Prendergast (2006, pp. 22-26) suggests that there are classifications even within the broad descriptions of 'mild' and 'severe' depression, however, there are some common symptoms. Mild depression is diagnosed when a person has depressive symptoms that impact on their life but they can still function on a day to day basis. With moderate depression the person usually has a detectable reduction in self-confidence, no interest in normally enjoyed activities and a real lack of motivation. Healey (2005, pp. 16-17) believes that severe depression causes considerable distress and the symptoms will likely be severe enough to be noticed by others. In addition, the client with severe depression can lapse very quickly into feelings of hopelessness and despair, triggering suicidal thoughts.

Depression can have an acute onset or can appear gradually over months or even years (AIPC 2000, p. 208). The reasons why a person can become depressed are varied. Some people become depressed as a consequence of illness, a severe loss, bereavement, chronic unemployment (Geldard & Geldard 2000, p. 197) or there may be an organic reason for the depression such as problems with body chemistry (Hudson-Allez 1997 as cited in AIPC 2000, p. 208). There is also strong evidence of some people having a predisposition towards developing depression (Healey 2005, p. 23). According to Black Dog (2005), depression is generally caused by a mixture of pressure combined with a vulnerability or predisposition to depression. With so many different symptoms, types and causes of depression

The reasons why a person can become depressed are varied. Some people become depressed as a consequence of illness, a severe loss, bereavement, chronic unemployment, or there may be an organic reason for the depression such as problems with body chemistry.

it is no surprise that there is no optimal treatment which suits everyone. It appears that there are a number of skills and techniques which a counsellor can use, depending on their personal style and the client's needs.

Regardless of the counselling technique chosen, it is important that the client understands their rights and responsibilities with regard to confidentiality and privacy. It is also crucial that the client is aware of the process of counselling and what will be expected from them. Counsellors working within an agency may be required to create a written agreement with their client regarding the goals of treatment, mutual and individual responsibilities and the length of the therapy. Counsellors working within a private practice may wish to adopt a less formal approach. What is apparent, however, is that a contractual approach engages the client from the beginning, gives structure to the sessions and allows evaluation by the counsellor and the client (Sutton 2000, p. 157).

Once the practical matters are completed, the counsellor can identify the client who needs to be referred for specialist counselling and/or medical or psychiatric assessment (Geldard & Geldard 2001, p. 248). In order to achieve this, the counsellor needs to develop a practical understanding of the multidimensional treatments, both medical and psychological for depression. The current opinion is that treatments should be selected according to the clients' type of depression. Depression that has a biological origin is more likely to require medication and less likely to be helped by counselling alone whereas other types of depression respond similarly to medication and counselling (Healey 2005, p. 24). It is also vital that the counsellor establish whether the client is having suicidal thoughts. How the counsellor deals with a suicide client may depend on their agency rules (if they work in an agency) but strategies will probably include; attending to the anger behind the depression, looking at alternatives, looking for the trigger and focusing on the client's ambivalence (Geldard & Geldard 1998, pp. 261-273). The counsellor should also gain input from

their supervisor in this situation.

The client may inform the counsellor that they are taking medication for their depression. Knowledge of the likely side effects of particular medications are important in counselling because they can effect the way a client presents themselves within sessions. According to Black Dog (2005), current pharmacologic treatments for depression comprise of drug treatments (antidepressants) and Electroconvulsive Therapy (ECT). A person with depression may be administered antidepressants to help elevate their mood. The type of depression and the client's symptoms will determine the type of antidepressant that is suitable.

Antidepressant drugs act in different ways to increase neurotransmitter levels which appear to be low in many cases of depression. Various medications can be prescribed, including; Monoamine oxidase inhibitors (MAOIs), Tricyclic antidepressants and more recently serotonin reuptakes inhibitors. Side effects for tricyclic antidepressants include dry mouth, blurred vision, constipation and urinary retention (Atkinson et al 2000, pp. 592-593). There are a number of dietary restrictions in the use of MAO inhibitors and individuals who use this medication are required to avoid any food or drink that contains tyramine. This substance is present in a number of common foods, including cheese, coffee and raisins. A person taking a MAO inhibitor may experience an extreme and sudden elevation in blood pressure if they eat foods containing tyramine (Falvo 2005, p.196). Examples of serotonin re-uptake inhibitors are the brand names; Prozac, Anafranil and Zoloft. These newer drugs tend to produce fewer side effects than the older antidepressants but can still cause nausea and diarrhea, dizziness, inhibited orgasm and nervousness (Atkinson et al 2000, p. 593).

Electroconvulsive therapy (ECT) is used primarily for severe depression when other treatments have not worked. This form of treatment involves a mild electric current applied to the brain to produce a seizure similar to an epileptic convulsion. Some people report a side effect of memory loss before the treatment and an inability to retain new information for a month or two after treatment (Atkinson et al, 2000, p. 594). ECT has been used as a treatment for depression for over 50 years and is still the most rapid and effective treatment for acute severe depression (Pardell & Stein 2003, p. 90).

Many people, however, are not comfortable about taking psychotic drugs or ECT and there are also portions who do not respond to these treatments (Corney1989, p. 166). For these people, there are a number of therapies, such as cognitive behaviour (CBT) and interpersonal therapy that have repeatedly proved successful in treating depression (Corey 2001, p. 488). These therapies differ in strategies, however, they all aim to develop a trusting relationship between the counsellor and the client.

CBT can be extremely useful for some individuals with depression but not everybody will find it useful (Healey 2005, p. 25). According to Parker (2004, p. 117), clients who seem to benefit from CBT have good coping skills, are responsible and relate well to the counsellor. In CBT, the counsellor is interested in assisting the client in making alternative interpretations as it is thought that people with depression often hold negative thoughts about themselves without considering circumstantial explanations. The counsellor does this by asking the client to examine their thoughts and beliefs and trace them back to earlier experiences in their lives. The inference is that the client is arriving at decisions about themselves without evidence or is being influenced by faulty information from the past. People with depression often carry high expectations of themselves and these perfectionist goals may be impossible to gain. There may be a tendency to adopt polarised thinking and interpreting everything in all or nothing terms. For example, a client may consider that others are always correct but they are always at fault. By asking the client if they would be as harsh on someone else as they are on themselves, the CBT counsellor demonstrates the cognitive distortions and excessively critical behaviour.

According to Beyond Blue (2007) there appears to be no conclusive evidence to prove whether antidepressants or therapy are more effective in the treatment of depression.

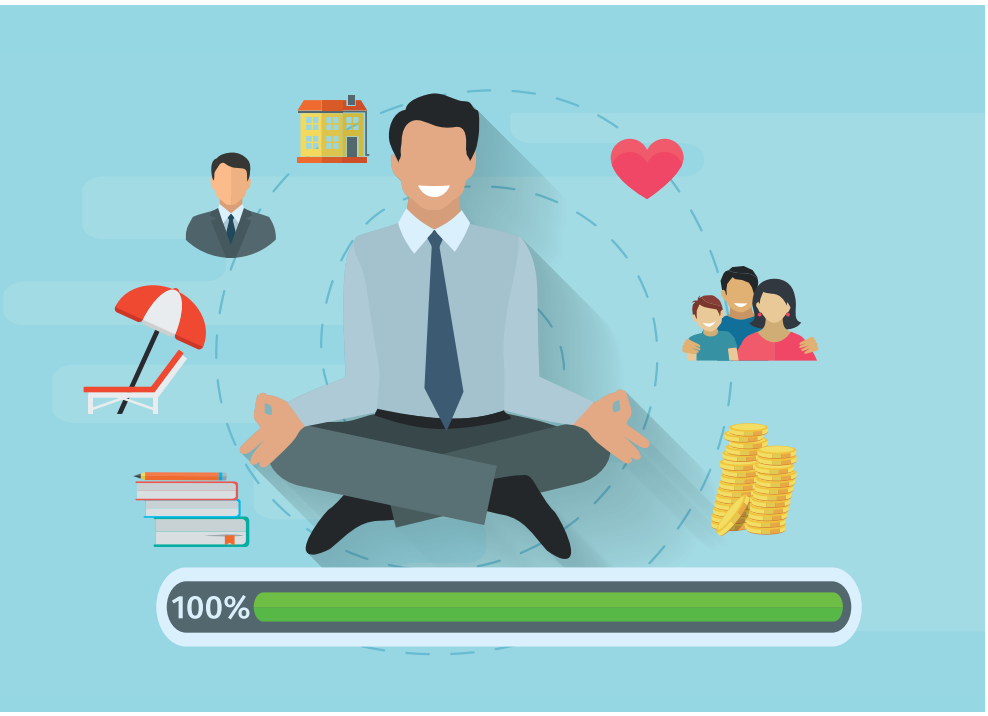
A client with depression can display avoidance behaviour which includes inactivity and withdrawal. In CBT, the counsellor would refer to the negative side of these behaviours by asking the depressed client such questions as: "Will you feel worse if you do not do anything?" or "What would be lost by trying?" A major theme of CBT is for the depressed client to understand that doing something is more likely to lead to feeling better than doing nothing (Corey 2001, pp 311:316). Cognitive Behavioural therapy has been criticised for focusing too much on positive thinking, as being too technique orientated and neglecting the role of feelings (Freeman & Dattilio 1992 as cited in Corey 2001, p. 331). Furthermore, this therapy does not appear to benefit people with melancholic or psychotic depression (Parker 2004, p. 117). Despite these criticisms, CBT is considered by

many to be a superior strategy for treating depression. Parker (2004, pp. 116-117) disagrees with this evaluation, suggesting that there is no universal treatment for depression but each method has specific benefits in certain circumstances.

Interpersonal Therapy (IPT) is another therapy recommended by the Black Dog Institute (Healey 2005, p. 25). The premise of this therapy is that depression and interpersonal relationships are interrelated and for the client to understand how these factors are contributing to their depression (Black Dog Institute, 2005). Interpersonal psychotherapy is a brief therapy which is based in the present rather than the past. In contrast to CBT, this therapy focuses less on changing irrational and self-defeating thoughts instead focusing on existing issues such as unresolved grief or anger and difficult relationships (Prendergast 2006, p. 48). Problems are discussed in the context of the personal relationships that are involved (Prendergast 2006, p. 47). The therapy has three major goals. The first goal is to identify the causes and triggers of the depression. Then, the counsellor and the client provide strategies for dealing with the depression. The final goal is to acknowledge what has been learnt and develop strategies for countering depression in the future. The four areas where IPT can be helpful are with unresolved grief, disputes, life transitions, and interpersonal shortfalls, such as lack of assertiveness (Parker 2004, p. 119). Similar to CBT, this therapy appears more useful to clients with non-melancholic disorders.

To summarise, treatments for depression include physical therapies, such as medications and 'talking' therapies. Continuing research evaluates the success of these treatments and new ideas appear on a regular basis (Healey 2005, p. 24). According to Beyond Blue (2007) there appears to be no conclusive evidence to prove whether antidepressants or therapy are more effective in the treatment of depression. Similarly, Prendergast (2006, p. 35) observes that there continues to be an ongoing debate about the preferred methods of treatment for depression. On the other hand, Parker (2004, pp. 132-137) believes that the more severe types of depression seem more likely to respond to medication whilst a client with mild depression may do well with counselling as the prominent treatment. It would seem, therefore, that there is no 'one size fits all' model, rather, treatments should be selected according to the type of depression the individual has (Parker 2004, pp. 132). Moreover, Corey (2001, p. 459) believes no single therapy is sufficient to account for the complexities of human behaviour and therefore counselling for depression needs to draw from a number of different approaches. In brief, it is apparent that there is not enough evidence as yet to recommend any form of treatment as the optimal treatment for depression but rather an integrated approach may be most effective.

In addition to therapy, the counsellor can also look at the client's general lifestyle. There is evidence that people with depression experience changes in their sleep patterns and eating habits (Parker 2004, p. 2) and may require more exercise (Prendergast 2006). The client can be encouraged to look at what can be



In order to achieve a trusting relationship with the client, it is important for the counsellor to gain an understanding of the client's cultural background.

done in terms of their general health and well-being. Moreover, by taking an active role in their recovery the client can gain a stronger sense of control (Prendergast 2006, p. 56). In order to achieve a trusting relationship with the client, it is important for the counsellor to gain an understanding of the client's cultural background. For example, clients from some cultures may consider direct questions to be discourteous (Geldard & Geldard 2001, p.p. 336-348). In addition, it is vital for the counsellor to familiarise themselves with the client's family; their attitude towards the illness; and whether the family can be relied upon to support the client throughout the counselling. Lastly, the counsellor will also need to be aware of services or resources in the community which may be useful to the client, such as self-help groups, gyms and community centres (Corney 2000, p. 171).

Finally, a client with depression may be undertaking different types of treatment simultaneously and as a result, the counsellor may find themselves working as a member of a case management team (Falvo 2005, pp 192-193). Among other duties, the counsellor may be required to consult with medical professionals, refer clients to appropriate specialists, write case notes for others to understand the case and generally collaborate with others on the team so that services are coordinated appropriately and timely (Leahy, Matrone & Chan 2005, p. 41). To work effectively as a member of a team, the counsellor needs to have a clear understanding of the roles and value of others in the team (Corney 2000, p. 170), good organisation and time management skills and efficient case recording systems (Hawkins 2006, p. 73). In addition, there are likely to be cost and resource factors that will need to be accommodated by the counsellor (Corney 2000, pp. 170-171). Finally, it is important that clients are kept informed and motivated and that there is a seamless progression of services during their treatment program.

In conclusion, it is apparent that there are varied causes of depression and multiple methods of treatment in counselling. Factors which a counsellor should be aware of are; the impact of any medication, the client's lifestyle, resources and services which may be useful and the impact of other service providers both within the organisation and outside. The current evidence, therefore, concludes that an integrated approach, which takes ideas and strategies from several therapies and incorporates practical strategies, may be the most effective method.

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Mijin Seo-Kim	DOWNER	02 6255 4597	Upon Enquiry	FTF
Hun Kim	DOWNER	02 6255 4597	Upon Enquiry	
Brenda Searle	CANBERRA REGION	0406 376 302	$100 to $130	FTF/PH/GRP/WEB
NEW SOUTH WALES				
Gwenyth Lavis	ALBURY	0428 440 677	Upon Enquiry	FTF/PH
Jennifer Blundell	AUSTINMER	0416 291 760	Upon Enquiry	FTF/PH/GRP/WEB
Sandra Bowden	BATEAU BAY/CENTRAL COAST	0438 291 874	$70	FTF
Rod McClure	BONDI JUNCTION	0412 777 303	Upon Enquiry	FTF
Heide McConke	BONDI JUNCTION	02 9386 5656	Upon Enquiry	FTF
Carol Stuart	BONDI JUNCTION	0293 877 752	$80 pp - % rate $ 50 for early graduates	FTF/GRP/PH/WEB
Aaron Elliott	CARDIFF	0408 615 155	Upon Enquiry (flexible)	FTF/PH/WEB
Nastaran Tofigh	CASTLE HILL	02 8872 4641	Upon Enquiry	FTF
Maarit Mirjami Rivers	CHURCH POINT	0417 462 115	Upon Enquiry	FTF
Dr Dawn Macintyre	CLUNES	0417 633 977	Upon Enquiry	FTF/PH/WEB
John Harradine	CREMONE	0419 953 389	$160; GRP $120	FTF/GRP/WEB
Penny Bell	CUMBI UMBI	0416 043 884	Upon Enquiry	FTF/GRP/PH/WEB
Shane Warren	DARLINGHURST	0418 726 880	Upon Enquiry	FTF
Trudi Fehrenbach	EAST BALLINA	0427 678 275	Upon Enquiry	FTF
Vicki Johnston	EASTLAKES	02 9667 4664	Upon Enquiry	FTF
David Robert Watkins	ELANORA HEIGHTS	0404 084 706	Upon Enquiry	FTF
Josephine Byrnes-Luna	ELDERSLIE	0412 263 088	Upon Enquiry	FTF
Brian Edwards	FORRESTERS BEACH	0412 912 288	Upon Enquiry	FTF
Danny D. Lewis	FORRESTERS BEACH	0412 468 867	Upon Enquiry	FTF
Moira McCabe	HAMILTON	0416 038 026	Upon Enquiry	FTF
Leonie Frances Raffan	HAMILTON	0402 327 712	$120	FTF /PH/ Skype
Kathryn Jane Quayle	HORNSBY	0414 322 428	$95	FTF/WEB/PH
Patricia Cheetham	KENSINGTON	1300 552 659	Upon Enquiry	FTF
Lyndall Briggs	KINGSGROVE	02 9024 5182	Upon Enquiry	FTF
Wendy Gibson	KOOLEWONG	02 4342 6746 or 0422 374 906	Upon Enquiry	FTF
Michella Wherrett	LAKE MACQUARIE/NEWCASTLE	0414 624 513	$80	FTF/PH
Leon Cowen	LINDFIELD	02 9415 6500	Upon Enquiry	FTF/GRP/PH/WEB
Hanna Salib	LUDDENHAM	0401 171 506	Upon Enquiry	FTF
Lorraine Dailey	MAROOTA	0416 081 882	Upon Enquiry	FTF/PH/GRP/WEB
Patriciah Catley	NARELLAN	02 9606 4390	Upon Enquiry	FTF
Karen Morris	NEWCASTLE/HUNTER VALLEY	0417 233 752	$100	FTF/GRP/PH/WEB
Brian Lamb	NEWCASTLE/LAKE MACQUARIE	0412 736 240	$120 (contact for sliding scales)	FTF/GRP/PH
Kirilly Smitheram	NEWTOWN	0411 550 980	Upon Enquiry	FTF
Katrina Christou	NEWTOWN	0412 246 416	Upon Enquiry	FTF
Michael Morris Cohn	NORTH BONDI	0413 947 582	$120	FTF/GRP/PH/WEB

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NEW SOUTH WALES *CONTINUED*				
Joy Ruth Kenned	OAKDALE	0437 571 424	Available upon enquiry	FTF/PH/GRP/SKYPE
David Edwin Warner	PEAKHURST	0418 283 519	Upon Enquiry	FTF/PH/GRP
Jacky Gerald	POTTS POINT	0406 915 379	Upon Enquiry	FTF
Kim Michelle Hansen	PUTNEY	2 9809 5989 or 0412 606 727	Upon Enquiry	FTF
Elizabeth Allmand	QUEANBEYAN	0488 363 129	$120	FTF/WEB/PH
Grahame Smith	SINGLETON	0428 218 808	$66	FTF/GRP/PH/WEB
Judith Reader	STOCKTON	02 4928 4880	Upon Enquiry	FTF
Deborah Rollings	SUTHERLAND	0427 584 554	Upon Enquiry	FTF/PH
Matti Ngai Lee	SYDNEY	0400 272 940	Upon Enquiry	FTF
David Gotlieb	SYDNEY/BOWRAL	0421 762 236	$40 Grp, $80 Indiv	$40 Grp, $80 Indiv
Angela Malone	TOMERONG	0438 822 284		
Karen Daniel	TURRAMURRA	02 9449 7121 Or 0403 773 757	$125 1hr; $145 1.5hr	FTF/WEB
Linda Elsey	WYEE	02 4359 1976	Upon Enquiry	FTF/GRP/PH/WEB
Margaret Hutchings	YAMBA GRAFTON	0417 046 562	Upon Enquiry	FTF/PH/GRP/WEB
NORTHERN TERRITORY				
Judy Eckermann	Alice Springs	0427 551 145	Upon Enquiry	FTF
Margaret Lambert	DARWIN	08 8945 9588 or 0414 459 585	Upon Enquiry	FTF/GRP/PH/WEB
Rian Rombouts	MILLNER	0439 768 648	Upon Enquiry	FTF
QUEENSLAND				
Christine Castro	ALGESTER	0478 507 991	Upon Enquiry	FTF
Patrick Michael Glancy	AROONA	450977171	$95	FTF/SKYPE
Tracey Milson	ARUNDEL	0408 614 062	Upon Enquiry	FTF
Iain Bowman	ASHGROVE	0402 446 947	Upon Enquiry	FTF/PH/GRP/WEB
Erin Annie Delaney	BEENLEIGH	0477 431 173	Upon Enquiry	FTF
David Hamilton	BEENLEIGH	07 3807 7355 or 0430 512 060	Indiv $80, Students $60	FTF/PH/GRP/WEB
Laura Banks	BROADBEACH	0431 713 732	Upon Enquiry	FTF
Lyn Patman	BROWNS PLAINS	0415 385 064	Upon Enquiry	FTF
Steven Josef Novak	BUDERIM	0431 925 771	N/A	FTF
Anne-Marie Houston	BUNDABERG	0467 900 224	Upon Enquiry	FTF
Christine Perry	BUNDABERG	0412 604 701	$70	FTF/SKYPE
Diane Newman	BUNDABERG WEST	0410 397 816	Upon Enquiry	FTF/PH
Pamela Thiel-Paul	BUNDALL/GOLD COAST	0401 205 536	$90	FTF
Sharron Mackison	CABOOLTURE	07 5497 4610	Upon Enquiry	FTF/PH/GRP/WEB
Penelope Richards	CHAPEL HILL	0409 284 904	Upon Enquiry	FTF
Christine Boulter	COOLUM BEACH	0417 602 448	Upon Enquiry	FTF
Rev Peter Gee	EASTERN HEIGHTS/IPSWICH	0403 563 467	$65	FTF/GRP/PH/WEB
Ligia Emmel Barnet	EMERALD	0419 954 984	Upon Enquiry	FTF/PH/SKYPE
Patricia Fernandes	EMERALD/SUNSHINE COAST	0421 545 994	$30-$60	FTF/PH
Catherine Dodemont	GRANGE	0413 623 162	$40 Grp; $100 indiv	FTF/GRP/PH/WEB
Heidi Edwards	GYMPIE	0466 267 509	$99	FTF/WEB
Kaye Laemmle	HELENSVALE	0410 618 330	Upon Enquiry	FTF
Jodie Logovik	HERVEY BAY	0434 060 877	Upon Enquiry	FTF/PH
Colin Palmer	KALLANGUR	0423 928 955	Upon Enquiry	FTF
Deborah Stevens	KINGAROY	0411 661 098	Upon Enquiry	FTF

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QUEENSLAND *CONTINUED*				
Menny Monahan	KIPPA-RING	0419 750 539	$100.00	FTF/PH/WEB
Ronald Davis	LABRADOR	0434 576 218	Upon Enquiry	FTF
William James Sidney	LOGANHOLME	0411 821 755 Or 07 3388 0197	Upon Enquiry	FTF/PH/GRP
Gary Noble	LOGANHOLME DC	0439 909 434	Upon Enquiry	FTF
Aisling Fry	LOTA	0412 460 104	N/A	FTF
Lynette Baird	MAROOCHYDORE/SUNSHINE COAST	07 5451 0555	Grp $30 or Indiv $90	FTF/GRP
Bruce Hansen	Moorooka	07 3848 3965/ 0400 058 001	F/F $80,Group $40, Stud $50	FTF/PH/GRP/SKYPE
Jenny Endicott	Mt Gravatt East	0407 411 562	Upon Enquiry	FTF
Kirsten Greenwood	MUDGEERABA	0421 904 340	Upon Enquiry	FTF
Sherrie Brook	MURRUMBA DOWNS	0476 268 165	Upon Enquiry	FTF
Yvette Marion Johnstone	MURRUMBA DOWNS	07 3496 2861	$70	FTF/GRP/SKYPE
Robyn Brownlee	NANANGO	0457 633 770	Upon Enquiry	FTF
Beverley Howarth	PADDINGTON	0420 403 102	Upon Enquiry	FTF/PH/WEB
Neil Roger Mellor	PELICAN WATERS	0409 338 427	Upon Enquiry	FTF
Valerie Holden	PEREGIAN SPRINGS	0403 292 885	Upon Enquiry	FTF
Frances Taylor	REDLAND BAY	0415 959 267 or 07 3206 7855	Upon Enquiry	FTF
Margaret Newport	SARINA	0414 562 455	Upon Enquiry	FTF/GRP/SKYPE
Ann Moir-Bussy	SIPPY DOWNS	07 5476 9625 or 0400 474 425	Upon Enquiry	FTF/GRP/PH/WEB
David Kliese	SIPPY DOWNS/SUNSHINE COAST	07 5476 8122	Indiv $80, Grp $40 (2 hours)	FTF/GRP/PH
Julianne Cutcliffe	SPRINGFIELD	0425 623 400	$50 Students $60 professionals	FTF/PH/SKYPE
Judy Boyland	SPRINGWOOD	0413 358 234	$100	FTF/GRP/PH/WEB
Nancy Grand	SURFERS PARADISE	0408 450 045	Upon Enquiry	FTF
Pamela M Blamey	TARINGA	0401 881 490	$100 f/t therapists $75 (p/t or students $60 group	FTF/GRP
Natalie Scott	TARRAGINDI	0410 417 527	0410 417 527	FTF
Judith Morgan	TOOWOOMBA	07 4635 1303 or 0412 372 431	$100	FTF/PH
Brian Ruhle	URANGAN	0401 602 601	Upon Enquiry	FTF
Jennifer Bye	VICTORIA POINT	0418 880 460	Upon Enquiry	FTF
Maartje (Boyo) Barter	WAKERLEY	0421 575 446	Upon Enquiry	FTF
Yildiz Sethi	WAKERLEY	07 3390 8039	Indiv $90, Grp $45	FTF/GRP/PH/WEB
Maggie Maylin	WEST END	0434 575 610	Upon Enquiry	FTF/PH/GRP/WEB
Tanya-Lee M Barich	WONDUNNA	0458 567 861	Upon Enquiry	FTF
Kim King	YEPPOON	0434 889 946	Upon Enquiry	FTF
SOUTH AUSTRALIA				
Laura Wardleworth	ANGASTON	0417 087 696	Upon Enquiry	FTF
Anthony Gray	ATHELSTONE	08 8336 6770/ 0437 817 370	Upon Enquiry	FTF
Susan Turrell	BLAKEVIEW	0404 066 433	$55	FTF/GRP/SKYPE
Maxine Litchfield	GAWLER WEST	0438 500 307	Upon Enquiry	FTF
Ellen Turner	HACKHAM WEST	0411 556 593	Upon Enquiry	FTF
Carol Moore	OLD REYNELLA	08 8297 5111 bus Or SMS 0419 859 844	Grp $35, Indiv $99	FTF/PH/GRP/WEB
Barry White	PORT ADELAIDE	0488 777 459	Upon Enquiry	FTF/PH
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon Enquiry	FTF

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SOUTH AUSTRALIA				
Adrienne Jeffries	STONYFELL	08 8332 5407	Upon Enquiry	FTF/PH/WEB
Kerry Turvey	TANUNDA	0423 329 823	Upon Enquiry	FTF
Rachael Cassell	TORRENSVILLE	0434 570 992	$80 1 hour : $120 1.5 hours	FTF
Pamela Mitchell	WATERFALL GULLY	0418 835 767	Upon Enquiry	FTF
Richard Hughes	WILLUNGA	0409 282 211	Negotiable	FTF/PH/SKYPE
TASMANIA				
Jane Oakley-Lohm	BLACKSTONE HEIGHTS	0438 681 390	$110 GST inclusive, $80 for new students	FTF/PH/GRP/SKYPE
Benjamin Donald Turale	HOBART	0409 777 026	Upon Enquiry	FTF/PH/WEB
David Hayden	HOWRAH NORTH	0417 581 699	Upon Enquiry	FTF
Pauline Mary Enright	Sandy Bay	0409 191 342	$65 per session	GRP/FTF/PH/SKYPE
VICTORIA				
Deborah Cameron	BRIGHTON	0447 262 130	Upon Enquiry	FTF/GRP/WEB
Joan Wray	MOBILE SERVICE	0418 574 098	Upon Enquiry	FTF
Jacquie Wise	ALBERT PARK	03 9690 8159	Upon Enquiry	FTF
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon Enquiry	FTF
Marie Bajada	BALLARAT	0409 954 703	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
Lynne Rolfe	BERWICK	03 9768 9902	Upon Enquiry	FTF
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF
Stephen O'Kane	BLACKBURN	0433 143 211	To be discussed with client	FTF/GRP
Jo-Ellen White	BLACKBURN SOUTH	0414 487 509	$100 ind. $50 Group. Student Discount $80	FTF/PH/GRP/ SKYPE Specialising is Autism Spectrum Disorder
Natalie Wild	BORONIA	0415 544 325	Upon Enquir	FTF
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF/SKYPE
Kenneth Robert Scott	BUNYIP	03 5629 5775	Upon Enquiry	FTF
Lisa Derham	CAMBERWELL	0402 759 286	Upon Enquiry	FTF/WEB
Claire Sargent	CANTERBURY	0409 438 514	Upon Enquiry	FTF
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Individual $80	FTF/GRP/PH/WEB
Sheryl Brosnan	CARLTON NORTH/MELBOURNE	03 8319 0975 Or 0419 884 793	Upon Enquiry	FTF/GRP/PH/WEB
Anna Atkin	CHETLENHAM	0403 174 390	Upon Enquiry	FTF
Matt Glover	CROYDON HILLS, EAST DONCASTER	0478 651 951	Conc: $70, Full: $90 Group: $30/hour	FTF/GRP/PH/SKYPE
Sara Edwards	DINGLEY	0407 774 663	Upon Enquiry	FTF/WEB
Lynda M Carlyle	EAST MELBOURNE, SPRINGVALE SOUTH, RIPPON LEA	0425 728 676	$135 per hour	FTF/PH/SKYPE
Nyrelle Bade	EAST MELBOURNE/POINT COOK	0402 423 532	Upon Enquiry	FTF/GRP/WEB
Gabrielle Skelsey	ELSTERNWICK	03 9018 9356	Upon Enquiry	FTF/PH/WEB
Maurice Grant-Drew	ELWOOD	0412 331 301	Upon Enquiry	FTF
Tabitha Veness	FERNTREE GULLY	0400 924 891	Upon Enquiry	FTF
Sandra Brown	FRANKSTON/MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Graeme John Riley	GLADSTONE PARK	03 9338 6271 or 0423 194 985	$85	FTF/WEB

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VICTORIA *CONTINUED*				
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon Enquiry	FTF
Lehi CernaH	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF
Molly Carlile	INVERLOCH	0419 579 960	Upon Enquiry	FTF
Rosslyn Wilson	KNOXFIELD	03 9763 0772 Or 03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
Sandra Robinson	MANSFIELD/BENALLA	0403 175 555	$110 individual 1 hour session. $50 - group per hr	FTF/SKYPE
Batul Fatima Gulani	MELBOURNE	0422 851 536	Upon Enquiry	FTF
Barbara Matheson	MELBOURNE	03 9703 2920 or 0412 977 553	Upon Enquiry	FTF
Andrew Reay	MOORABBIN	0433 273 799	Upon Enquiry	FTF
Judith Beaumont	MORNINGTON	0412 925 700	Upon Enquiry	FTF/PH/GRP/WEB
Patricia Reilly	MOUNT MARTHA/GARDENVALE	0401 963 099	Upon Enquiry	FTF
Kathleen (Kathy) Brennan	NARRE WARREN	0417 038 983	$35 Grp, $60 Individual	FTF/GRP/PH/WEB
Beverley Kuster	NARRE WARREN	0488 477 566	Upon Enquiry	FTF
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Marguerite Middling	NORTH BALARAT	0438 744 217	Upon Enquiry	FTF
Karen Efron	NORTHCOTE	0432 391 887	Upon Enquiry	FTF
Melissa Harte	PAKENHAM/SOUTH YARRA	0407 427 172	$132 to $143	FTF
Graham Hocking	PARK ORCHARDS	0419 572 023	Upon Enquiry	FTF
Joanne Ablett	PHILLIP ISLAND/MELBOURNE	0417 078 792	$120	FTF/GRP/PH/WEB
Tra-ill Dowie	PORT FAIRY	0439 494 633	Upon Enquiry	FTF
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon Enquiry	FTF
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260 Or 03 9786 8006	Upon Enquiry	FTF
Danielle Aitken	SOUTH GIPPSLAND/MELBOURNE	0409 332 052	Upon Enquiry	FTF/GRP/PH/WEB
Zohar Berchik	SOUTH YARRA	0425 851 188	Upon Enquiry	FTF
Helen Wayland	ST KILDA	0412 443 899	$75 Individual	FTF/PH/GRP/WEB
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Paul Montalto	THORNBURY	0415 315 431	Upon Enquiry	FTF
Sandra Clough	TRARALGON	0412 230 181	Upon Enquiry	FTF/PH/GRP/SKYPE
Belinda Hulstrom	WILLIAMSTOWN	04714 331 457	Upon Enquiry	FTF
Cas Willow	WILLIAMSTOWN	03 9397 0010 Or 0428 655 270	Upon Enquiry	FTF/PH/WEB/GRP
Karen Seinor	WODONGA	0409 777 116	Upon Enquiry	FTF
John Dunn	COLAC SW AREA/MT GAMBIER	03 5232 2918	By Negotiation	FTF/GRP/WEB
Brian Whiter	CARLTON, MOORABBIN	0411 308 078	By Negotiation	FTF/GRP/WEB
Sophie Lea	MORNINGTON PENINSULA	0437 704 611	Individual $100/hour	FTF/PH/SKYPE
WESTERN AUSTRALIA				
Marie-Josee Boulianne	BEACONSFIELD	0407 315 240	Upon Enquiry	FTF
Karen Heather Civello	BRIDGETOWN	0419 493 649	Upon Enquiry	FTF
Merrilyn Hughes	CANNING VALE	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB

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WESTERN AUSTRALIA *CONTINUED*				
Lynette Cannon	CAREY PARK	0429 876 525	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
Cindy Cranswick	Fremantle	0408 656 300	Upon Enquiry	FTF
John Dallimore	FREMANTLE	0437 087 119	Upon Enquiry	FTF
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
Dr. Patricia Sherwood	PERTH/BUNBURY	0417 977 085 or 08 9731 5022	$120	FTF/PH/WEB
Eva Lenz	SOUTH FREMANTLE/COOGEE	0417 977 085 or 08 9731 502	$120	FTF/PH/WEB
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
Alan Furlong	WINTHROP	0457 324 464	Upon Enquiry	FTF
Julie Hall	YANCHEP/BUTLER/JINDALEE/ JOONDALUP	0416 898 034	$100	FTF/PH/SKYPE
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
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
Deborah Cameron	Hong Kong	+65 9186 8952	Upon Enquiry	FTF/GRP/WEB
Eugene Chong	Singapore	+65 6397 1547	Upon Enquiry	FTF
David Kan Kum Fatt	Singapore	+65 9770 3568	Upon Enquiry	FTF
Su Keng Gan	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