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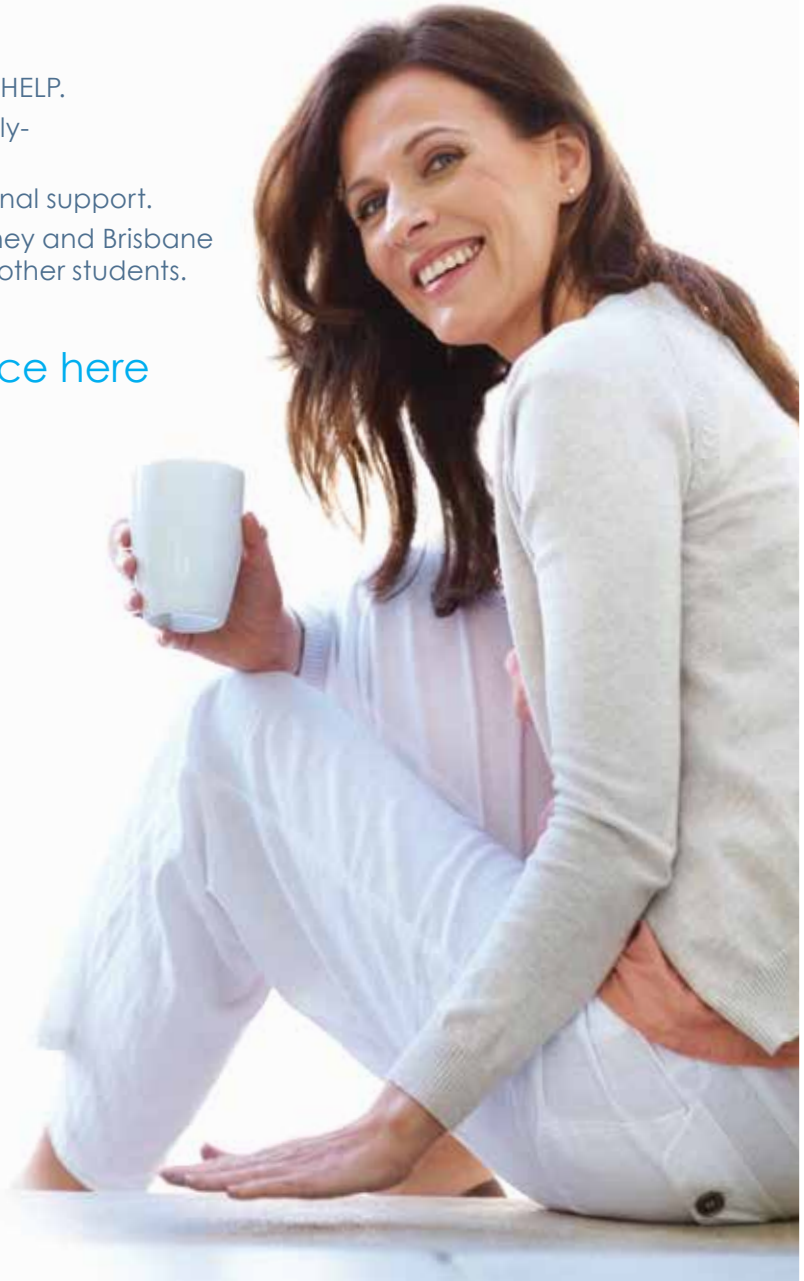

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The Editor
Australian Counselling Association
P.O Box 88
GRANGE QLD 4051

aca@theaca.com.au
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ACA Scope of Practice for Registered Counsellors

By Philip Armstrong FACA

ACA has released its long awaited for Scope of Practice for Registered Counsellors.

Registered counsellors provide many social and economic benefits to the Australian Mental Health System, from improved consumers treatment engagement, increased independent living, reduced homelessness, lower levels of substance abuse, improved employment participation, and a reduction in suicidal ideation and homicide risk. Providing counselling services within the mental health commissioning landscape enables consumers access to a wider range of efficient and appropriate services, which are safe and responsive to consumers presenting and emerging mental health needs.

Registered counsellors are trained professionals working in a variety of settings, from low needs such as early intervention services, through to moderate and high needs in primary, secondary and tertiary care. The registered counsellor supports consumers with behavioral change through psychological interventions.

Like other Allied Health Professionals, registered counsellors are required to maintain their registration obligations and further develop their practice by participating in Clinical Supervision and Ongoing Professional Development.

Registered counsellors train in assessment procedures and the use of assessment tools to communicate clinical outcomes with other Allied Health Professionals such as General Practitioners and Psychiatrists. Counselling provides consumers who would not normally benefit from standard treatment options provided by their General Practitioner or Psychiatrist access to cost-effective complementary psychological interventions, which are responsive to the consumer's mental health needs.

The Australian Counselling Association Inc. has developed an evidence-based Scope of Practice for Counsellors, which provide a clear understanding and consistent interpretation of a registered counsellors role and capabilities. In developing the Scope of Practice for Counsellors, Australian Counselling Association Inc. has reviewed and evaluated the registration and practice requirements of their members, the type of services and programs they operate in, the therapeutic perspectives they provide, and their professional development activities.

The Scope of Practice for Counsellors defines four domains for identifying and measuring the practice of counselling for each level of attainment. These include the registered counsellor's relevant professional practice, their critical thinking and analysis skills, their communication responsibilities when providing Support Facilitation/Case management, and their ability to provide supervision and function in a leadership/management role.

Additionally, the Scope of Practice for Counsellors defines nine Standards and eight Guidelines to assist mental health professionals, managers, and health system administrators integrate and evaluate registered counsellors into existing and emerging mental health services and programs.

This Scope of Practice for Counsellors is the outcome of Australian Counselling Association Inc. consultation with strategic stakeholder groups; from private enterprise, Non-Government Sector, State and Federal Governments. The Scope of Practice for Counsellors demonstrates how registered counsellors can respond to the sustainability demands of the mental health sector.

As a mental health workforce, registered counsellors can comprehensively integrate into existing and emerging programs and services to provide targeted evidence-based psychological interventions. Registered counsellors currently work with other Allied Health Professions to deliver psychological interventions in clinical settings, and within broader service stepped care environments, to provide consumers with a choice of high-quality, evidence-based Person-Centred psychological interventions that are responsive to the needs of consumers and the wider health system. This scoping document is intended to help service program designers, bureaucrats, employers, government Ministers and the consumer to understand the Scope of Practice of Registered Counsellors.

The Scope has been developed in response to the National Mental Health Commission's Review of Mental Health Programs and Services, commissioned by the Australian Commonwealth Government.

The Scope provides a framework for counsellors to operate in existing and emerging mental health programs/services as identified in the review. The Minister for Health and Aging's response to the review stated the need for effective early intervention strategies across a consumers lifespan and the care

continuum - shifting the balance to provide the right care when it is needed (Minister for Health and Ageing, 2015).

Registered counsellors under the Scope can provide key workforce personnel to current service providers and add to the mental health field force shortages with core professional practitioners:

- Provide a more comprehensive and integrated mental health workforce integrating into Non-Government Organisations (NGO)s and other service providers.
- Improve service equity for rural and remote communities through place-based models of care.
- Provide targeted evidence-based psychological interventions such as person-centred or cognitive behavioral therapies aimed at building resilience and interventions for the families of children with emerging behavioral issues, distress, and mental health difficulties.
- Support evidence-based mental health programs/services that reduce stigma and build capacity and respond to the diversity of needs of different population groups.
- Support mental health, social and emotional wellbeing teams in Indigenous Primary Health Care Organisations.
- Assist in providing sustainable, comprehensive; Whole-of-community approaches to suicide prevention.
- Improve research capacity and support strategic research that responds to policy directions and community needs.
- Improve education and training of evidence-based mental health treatments.
- Support emergency access to telephone and internet-based crisis support programs and services.
- Support families and communities in the prevention of trauma from maltreatment during infancy and early childhood, and to support those impacted by childhood trauma.

The Scope describes the full spectrum of roles, functions, responsibilities, activities and decision-making capabilities of a registered counsellor. Registered counsellor (Armstrong, 2014) under this Scope is an individual who meets the requirements for registration. The Australian Counselling Association Inc. (ACA) and the Psychotherapy and Counselling Federation of Australia (PACFA) both list their registered counsellors under the Australian Register of Counsellors and Psychotherapists (ARCAP). There is a clear distinction between a registered counsellor under the Scope and those who may use counselling skills as an adjunct to their primary role.

Additionally, the Scope defines a registered counsellors level of education and competencies, providing a sound risk management and professional framework that enables registered counsellors to operate to their full potential, and know when to delegate activities to others. There are overlaps in regards the functions and skills utilized by other professions similar to counsellors, as there is with nurses and physicians. However, this document specifically relates to registered counsellors who work within the sphere of Allied Health Professionals. The Scope framework addresses the issue of unplanned responses that can result in a wide variation in practice between counsellors of similar background and experience and between similar mental health programs and services.

The Scope will enable consumers, health systems administrators, and program/service providers to identify clearly how counsellors;

- Integrate into existing and emerging mental health programs and services.
- Work with other Allied Health Professions to provide psychological interventions and interventions in clinical settings and broader service environments.
- Provide private practice services to the community and contract work to service providers.

Registered counsellors consistently demonstrate skills, knowledge, responsibilities and accountabilities commensurate with their level of attainment. The Scope demonstrates how registered counsellors can contribute widely within their service/program environment; as therapeutic providers, case managers, team leaders, and strategic thinkers. Registered counsellors are a critical component of service delivery able to meet the needs of the national mental health workforce strategy that promotes diversity, flexibility, and responsiveness in the mental health workforce.

If you would like a copy of the full 78 page document email philip@theaca.net.au for a free electronic copy.

Interpersonal Psychotherapy and the Importance of Theoretical Frameworks for Counsellors

By Dr Genevieve Armson

Purpose Of This Paper

The aim of this paper is to critically evaluate the modality of interpersonal psychotherapy (IPT), its importance and use in the counselling process and its application to multicultural counselling, and to contrast it to alternative psychotherapy modalities. Finally, the paper will briefly appraise the significance of counsellors being cognisant of the theoretical framework(s) in which they are working.

The Modality Of Interpersonal Psychotherapy –Theory And Processes

THE ORIGINS OF IPT.

Interpersonal psychotherapy, in contrast to other therapies, is unique in its origins. While the majority of therapies have been developed from clinical observations, IPT (initially referred to as 'high contact') was originally developed, during the 1970s, as a manualised placebo for psychopharmacologic trials for the treatment of depression (Markowitz & Weissman, 2012; Stuart & Robertson, 2003). Serendipitously, IPT was subsequently demonstrated to be beneficial to clients, especially those individuals with social adjustment and interpersonal relationship problems (Klerman, Dimascio, Weissman, Prusoff, & Paykel, 1974; M.M. Weissman, Klerman, Prusoff, Sholomskas, & Padian, 1981).

In the 1970s, the predominant treatment for depression was based on the medical model, hence, as IPT was developed, it was codified into a detailed manual, which describes the procedures and techniques that were to be used to counsel clients (Stuart & Robertson, 2003). The manual is a standardised tome, aimed at incorporating what are considered to be 'best' elements of psychotherapy, that can then be reproduced in subsequent trials and treatments (Robertson, Rushton, & Wurm, 2008).

The focus of IPT as a therapy.

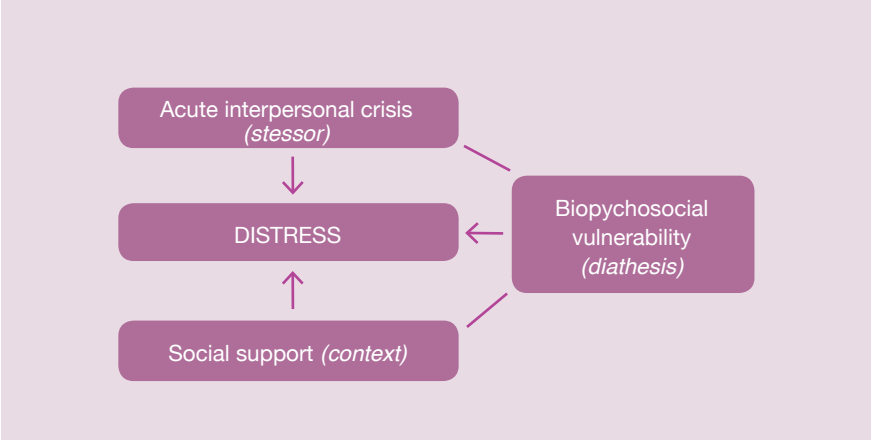
IPT is a time-limited (12 to 16 sessions), dynamically-informed, diagnosis-targeted, empirically-tested, biopsychosocial therapy (Freeman & Power, 2007), the goals of which are to relieve symptoms and improve interpersonal functioning (Jensen, 1994; Robertson et al., 2008). The focal point in IPT is the attention on the individual's interpersonal relationships, change occurring either within the actual relationships or within the client's perceptions of these relationships (Robertson et al., 2008). Concurrently, IPT aims to enhance the social support of clients in an effort to alleviate their present interpersonal distress (Sloan, Hobson, Leighton, McFarlane, & Law, 2009). That is to say, "IPT is concerned with the 'interpersonal context' – the relational factors that predispose, precipitate and perpetuate the patient's distress" (Robertson et al., 2008, p. 47). This 'interpersonal triad' is illustrated in figure 1.

Theoretical underpinnings of IPT.

IPT is predominantly influenced by three major theories: attachment, communication and social theories, and informed by the interpersonal school of psychiatry (Sloan et al., 2009). It borrows from the 1950s psychobiological work on mental illnesses by Adolph Meyer and the interpersonal work of Harry Sullivan, the latter having popularised the term 'interpersonal'. The focus on 'interpersonal' and especially the influence of experiences in adult life was a divergent view at that time as the predominant therapy was psychoanalysis, which emphasised the childhood experiences of the client (Freeman & Power, 2007). According to Sullivan, "personality is made manifest in interpersonal situations, and not otherwise" (2000, p. 113, orig. 1938).

Attachment theory. Bowlby, and later Ainsworth, were instrumental in

Figure 1 The interpersonal triad – the development of psychological distress. (Adapted from the International Society for Interpersonal Psychotherapy, 2012, p. about IPT)



developing attachment theory in the 1960s and 1970s (Bretherton, 1992; Teyber & McClure, 2011). Bowlby held that human beings have an innate need to form attachments, the denial of which can lead to emotional distress, sadness and even depression (Corsini & Wedding, 2011). Ainsworth (1994), in her famous "Strange Situation" study, identified three major attachment styles: ambivalent-insecure attachment, avoidant-insecure attachment and secure attachment. A fourth style, disorganised-insecure attachment, was later added by Main and Solomon (Corsini & Wedding, 2011). The nature of adult attachment has been further refined and elucidated by conceptualising it within a two-dimensional model: one dimension representing anxiety about rejection and abandonment; the other dimension representing uneasiness with closeness and intimacy (C. McBride, Atkinson, Quilty, & Bagby, 2006). IPT thus hypothesises that psychological distress occurs when an individual's attachment needs remain unfilled (Sloan et al., 2009). It is, therefore, the aim of IPT to explore the ways in which the client communicates his/her attachment needs and to encourage the client to build an effective social network to support this aim (Sloan et al., 2009). IPT does not seek to necessarily alter the client's existing attachment style (Stuart & Robertson, 2003).

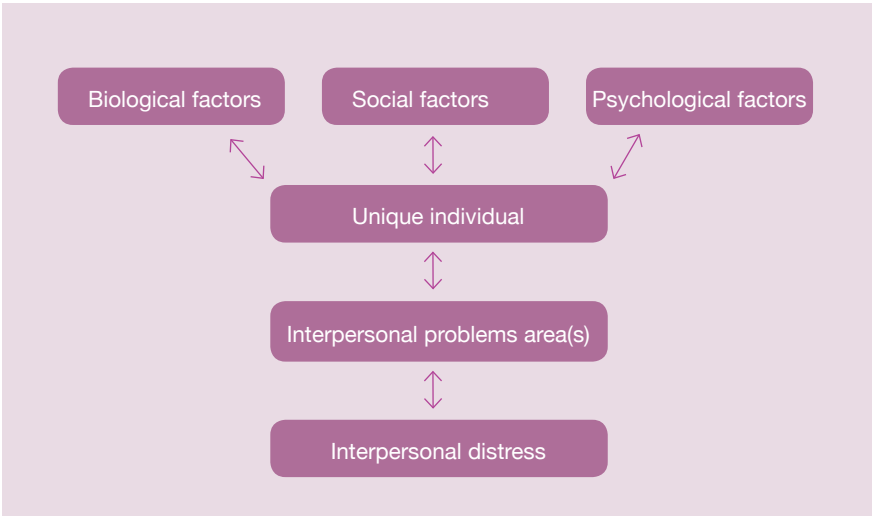
Communication theory. Kiesler (1979, p. 305) proposed that people experience negative interpersonal relationships as a result of utilising unhelpful communication patterns, "abnormal behaviour [being] defined as inappropriate or inadequate interpersonal communication". In this approach, relationships can be viewed along three dimensions: affiliation, ranging from high positive to low negative attachment to others; control, ranging from dominance to submissiveness; and inclusion, representing the degree of importance of the relationship to the individual (Van Denburg & Kiesler, 2002). It is thus the role of the IPT therapist to guide the client in the exploration of how she/he communicates with others and with what subsequent reactions (Sloan et al., 2009).

Social theory. This theory posits that the likelihood of psychological difficulties and distress are increased for those clients who experience a deficiency in their social relationships (Stuart & Robertson, 2003). When faced with change or significant psychosocial stressors, those clients who lack strong support through a social network will have a greater propensity for psychological distress (Stuart & Robertson, 2003). Moreover, an individual's early interpersonal relationships, especially those contained in the family of origin, are often mirrored in their responses to changing and stressful events in their environment (Sloan et al., 2009). During IPT, therefore, the therapist aims to assist the client with appropriate interventions in her/his social relationships, leading to improved social functioning and networking, and reduced psychosocial distress (Markowitz & Weissman, 2012).

Table 1 The Phases of IPT

Phase	Characteristics
Assessment	Determination of whether the client is suitable for IPT
Initial sessions	Development of an interpersonal formulation/ hypothesis of the client's interpersonal difficulties and assessment of the client's social network
Middle sessions	Addressing of the one or two major problem areas for the client
Termination sessions	Fostering of the client's independent functioning and competence; review of progress achieved
Maintenance sessions	A new contract for maintenance session can be negotiated

Figure 2 The interpersonal inventory as used in IPT.



Processes involved in the use of IPT. Interpersonal psychotherapy consists of five distinct phases (Robertson et al., 2008). These phases and their key characteristics are summarised in table 1. IPT focuses on four major problem areas: grief, representing a significant loss and a complicated bereavement in the client's life; interpersonal disputes, including conflicts, betrayals, disappointments and inhibited conflicts; role transitions, including situational role transitions, illness-related and relationship role transitions; and interpersonal sensitivity, representing difficulties in forming and maintaining relationships (Robertson et al., 2008).

The IPT therapist utilises, as the main technique, the interpersonal inventory. This represents a register of the major relationships in the client's life, classifying them into biological, social and psychological factors (Sloan et al., 2009). The use of this interpersonal inventory, aiding the therapist in forming a diagnosis, is illustrated in figure 2.

From the interpersonal inventory, IPT utilises a range of techniques, the most important of which is the establishment of an effective therapeutic alliance (Constantino et al., 2010; Corsini & Wedding, 2011). Techniques utilised in IPT include: clarification, communication →

analysis, interpersonal incidents, use of affect, role playing, problem solving and homework (Stuart & Robertson, 2003). While these techniques are common to other therapies, IPT is unique in focusing specifically on interpersonal issues (Corsini & Wedding, 2011). Use of the appropriate technique(s) is informed by the therapist's diagnosis of the major problem area for the client.

IPT – Evaluation, Application and Importance

IPT AS AN EVIDENCE-BASED THERAPY.

IPT began as a manualised placebo treatment during an 8-month clinical drug trial in the treatment of major depressive disorder (Markowitz & Weissman, 2012; Stuart & Robertson, 2003). These beginnings, and the resultant manualised format of the therapy, have resulted in two unique characteristics of IPT. Firstly, IPT embodies regular assessments of the client's symptoms and functioning throughout the progress of the therapeutic treatment (Corsini & Wedding, 2011). This latter characteristic assists in providing the therapist and the client with a measure of the client's progress and can thereby aid in the assessment of the efficacy of treatment (Corsini & Wedding, 2011). Secondly, due to its strongly systematised processes, IPT has been tested and stands as one of the most evidence-based current therapies, its efficacy having been demonstrated in over 150 studies (Sloan et al., 2009; Myrna M. Weissman, Markowitz, & Klerman, 2000). The best known of these trials is the National Institute of Mental Health Treatment of Depression Collaborative Research Program (NIMH-TDCRP). This research project established that IPT was superior to placebo treatment, and equivalent to the antidepressant (imipramine) and cognitive behaviour therapy (CBT) for mild to moderate depression (Elkin et al., 1989).

Since the landmark NIHM project, IPT has continued to grow, with research focussing on different cultures and a range of disorders (Markowitz & Weissman, 2012). Due to the success of IPT in the treatment of major depression and bulimia, professional and national treatment guidelines have been established, treatment manuals have been translated into multiple languages and an international professional body, the International Society of Interpersonal Psychotherapy (ISIPT), has been formed (2012). IPT continues to gain increased acceptance in North and South America, Europe, New Zealand and Australia, and was utilised in the first psychotherapy research studies undertaken in Africa (Bolton et al., 2003).

Clinical applications of IPT.

Since its beginnings, as a placebo in the treatment trials involving clients with non-bipolar, non-psychotic major depression, IPT has been adapted to other depressed groups of people including older adults (Hinrichsen, 2008), adolescents, adults with chronic depression, depressed adults experiencing marital issues, and depressed adults in primary-care environments (Snyder & Ingram, 2000). Moreover, the extant research on IPT has demonstrated that not only is it efficacious for depression (Timulak, 2011), but also for mood and eating disorders (Markowitz & Weissman, 2012); for bipolar affective disorder, in combination with pharmacotherapy (Frank et al., 2005); for sudden gains in unipolar depressed clients (Kelly, Cyranowski, & Frank, 2007); for suicide ideation in older adults (Heisel, Duberstein, Talbot, King, & Tu, 2009), and for anxiety disorders, including posttraumatic stress disorder (Bleiberg & Markowitz, 2005). Further research suggests tentative efficacy in the treatment of borderline personality disorder (Markowitz, Bleiberg, Pessin, & Skodol, 2007). Recent studies have also begun to examine the way in which IPT assists clients, taking particular note of attachment theory and contemporary interpersonal theory (Ravitz, Maunder, & McBride, 2008). Despite the extensive research undertaken into the efficacy of IPT, further studies are now required into the use of IPT for different subgroups of individuals, differentiated by their initial degree of interpersonal competency (Snyder & Ingram, 2000).

Contrasting IPT with other therapies – strengths and weaknesses.

Over the past three or more decades of extensive research, the strengths of IPT in clinical settings have been shown to be its focus on: the client's interpersonal relationships, how these are expressed by the client in the present, and the development of supportive social networks (Myrna M. Weissman, 2007). While the primary focus for attention and change within IPT is the interpersonal processes, the majority of traditional therapies focus on the intrapersonal aspects of the client (Snyder & Ingram, 2000). Additional strengths (Robertson et al., 2008; Timulak, 2011) and limitations (Chen, Jordan, & Thompson, 2006; Corsini & Wedding, 2011; Robertson et al., 2008) of IPT are shown in table 2. In displaying this classification of

Table 2 Strengths and Limitations of IPT

Strengths	Limitations
Evidence-based	Infrequently taught in universities thus leading to insufficient knowledge of its proper use as a therapy
Minimal use of jargon; simple principles for clients to grasp	Limited opportunities for competency training, especially in Australia
Manualised format assists speed of competence by therapist…	Technical requirements may be challenging for some therapists
Effective with a range of issues, especially grief and relationships	Not as effective for some problem areas eg client presenting with cognitive distortions as fundamental issue, severe and complex trauma, psychotic disorders, profound disturbances in personality functioning
Focus on interpersonal relationships which are frequently at the source of client issues	IPT can work indirectly with distorted thinking patterns through their impact on current interpersonal relationship problems
Time-limited	Not applicable to understanding the contributions of earlier life experiences to the client's current issues
Shown to be effective for interpersonal-based issues	Can be difficult for the therapist to stay focused on the problem areas
In the treatment of bulimia, CBT seems to have an earlier response rate whereas IPT has better retention	The etiology of the illness (eg depression) is not part of the treatment

'strengths' and 'limitations' it must be noted that such taxonomy may, in some cases, be misleading as a therapeutic strength for one client may be a limitation or even a frustration for another. The overriding determinate for the therapist in the use of an appropriate therapy is the specific needs of the client (as well as the therapist's competency), as each therapy "has its own vital place in helping patients to overcome their psychological distress" (Stuart & Robertson, 2003, p. 43).

The Use Of IPT In Multicultural Counselling

Even in the 21st century, there remains a paucity of evidence-based research on the efficacy of psychotherapies for ethnic groups, with the vast majority of research having been directed towards white, middle-class, English-speaking populations (Snyder & Ingram, 2000). The limited research that has involved multicultural populations has demonstrated that psychotherapy programs can be equally effective for Asian-American and Caucasian clients when assessed by the therapist's view of outcomes, however there is still the need for cultural sensitivity on the part of the therapist (Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Zane, Enomoto, & Chun, 1994). Further, Sue et al (1991) in their large African scale study found that therapist-client matching in terms of ethnicity and language can be beneficial to clients, lending partial support to the cultural responsiveness hypothesis. Regardless of whether this matching occurs or is even feasible in the clinical setting, it is imperative that therapists possess well-developed metacognitive abilities to monitor their own cultural biases, values and assumptions, in an effort to utilise the most appropriate therapy and to establish a strong and supportive therapeutic alliance (Palmer, 1997; Roysircar, 2009).

In contrast to the above-mentioned dearth of research, IPT has been successfully utilised in multicultural populations in over 30 countries (Corsini & Wedding, 2011), the most well-known study having been conducted in southwest Uganda and involving clients suffering from depression (Bolton et al., 2003). This study found that group IPT was well accepted by the local community, had excellent attendance, and was highly successful in reducing depression. The success of this study in a developing country relied on several factors that demonstrated multicultural awareness (M. Weissman, Markowitz, & Klerman, 2007). These included: an understanding of the mental and physical health needs of the local community; modification of the IPT manual to reflect the needs of the local community through discussions with trainees and the local people; the choice and training of local lay people as health providers; development of collaborative arrangements, locally, nationally and internationally, and timely withdrawal of the international experts, allowing local autonomy (Corsini & Wedding, 2011). Furthermore, the project was able to demonstrate that the four problem areas used in IPT "are intrinsic and universal elements of the human condition" and suggests that "the depressogenic effects of these universal conditions, as well as the efficacy of IPT, extend beyond the confines of Western culture" (Verdeli et al., 2003, p. 119).

Importance Of A Theoretical Framework For Counsellors

As counselling becomes increasingly recognised as a profession worldwide, the acknowledged use of theoretical frameworks by counsellors intensifies in importance. Theories inform the →

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counsellor as to the dynamics of human behaviour and support the profession as a legitimate and well-researched occupation (Drapela, 1990). They provide the opportunity for the therapist to confidently develop a conceptual framework of the presenting issues, thus enabling the selection of the most appropriate methodology for the client and his/her specific and unique situation and goals (Teyber & McClure, 2011) Use of the appropriate counselling theory, usually underpinned by a corresponding philosophical perspective, thus strengthens the work of the counsellor with the client, defining the role of the counsellor and the skills and techniques that are most appropriate in the therapeutic relationship (Drapela, 1990). Knowledge of, and the apposite use of, theoretical frameworks by counsellors ensure theoretically consistent practices (M. C. McBride & Martin, 1990); raise the standard of the profession (Robbins & Jolkovski, 1987); aid in the design and conduct of valid and reliable research in and away from clinical settings; provide a professional view to those outside the profession (Drapela, 1990), and inform and enhance the quality of health promotions in society (Green, 2000). A theoretical framework creates the platform for research and the appropriate use of a particular therapy, the results of which can assist the counsellor and the counselling profession in the appropriate application and/or modification of a therapeutic modality and, in turn, provide vital information and direction for continued counsellor development (Skovholt & Ronnestad, 1992). Further, a theoretical counselling framework assists counsellors to comprehend their limitations and to ensure ethical practices continue to be utilised in the counselling setting (Drapela, 1990).

The importance of theoretical frameworks notwithstanding, it is incumbent on the counsellor and the profession to fully comprehend what is meant by a *theoretical framework or theory*: theories "may be useful and thus true in some way [yet] we cannot think of them as Truth in the ultimate sense" (Robinson, 2012, p. 2). That is to say, a theoretical framework guides, informs, challenges, provides meaning, understanding and linkages yet needs to be, itself, challenged, reviewed, refined, researched and questioned as our knowledge of human development and interactions continues to expand.

REFERENCES

Ainsworth, M. D. S., & Marvin, R. S. (1994). On the shaping of attachment theory and research: An interview wiht Mary D.S. Ainsworth. *Society for Research in Child Development*, *60*(2/3), 2-21.

Bleiberg, K. L., & Markowitz, J. C. (2005). A pilot study of interpersonal psychotherapy for posttraumatic stress disorder. *The American Journal of Psychiatry*, *162*(1), 181.

Bolton, P., Bass, J., Neugebauer, R., Verdeli, H., Clougherty, K. F., Wickramaratne, P., . . . Weissman, M. (2003). Group interpersonal psychotherapy for depression in rural Uganda. *Journal of the American Medical Association*, *289*(3), 3117-3124.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, *28*(3), 759-775.

Chen, S.-Y., Jordan, C., & Thompson, S. (2006). The effect of cognitive behavioral therapy (CBT) on depression: The role of problem-solving appraisal. *Research on Social Work Practice*, *16*(5), 500-510.

Constantino, M. J., Schwaiger, E. M., Smith, J. Z., DeGeorge, J., McBride, C., Ravitz, P., & Zuroff, D. C. (2010). Patient interpersonal impacts and the early therapeutic alliance in interpersonal therapy for depression. *Psychotherapy Theory, Research, Practice, Training*, *47*(3), 418-424.

Corsini, R. J., & Wedding, D. (2011). *Current psychotherapies* (9th ed.). Belmont, CA, USA: Brooks/Cole.

Drapela, V. J. (1990). The value of theories for counseling practitioners. *International Journal for the Advancement of Counselling*, *13*(1), 19-26.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S. D., Sotsky, S. M., Collins, J. F., . . . Docherty, J. P. (1989). National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Archives of General Psychiatry*, *46*(11), 971-982.

Frank, E., Kupfer, D., Thase, M. E., Mallinger, A. G., Swartz, H. A., Fagiolini, A. M., . . . Monk, T. (2005). Two-year outcomes for interpersonal and social rhythm therapy in individuals with bipolar I disorder. *Archives of General Psychiatry*, *62*(9), 996-999.

Freeman, C., & Power, M. (Eds.). (2007). *Handbook of evidence-based psychotherapies: A guide for research and practice*. West Sussex, UK: John Wiley & Sons.

Green, J. (2000). The role of theory in evidence-based health promotion practice. *Health Education Research, 15*(2), 125-129.

Heisel, M. J., Duberstein, P. R., Talbot, N. L., King, D. A., & Tu, X. M. (2009). Adapting interpersonal psychotherapy for older adults at risk for suicide: Preliminary findings. *Professional Psychology: Research and Practice*, *40*(2), 156-164.

Hinrichsen, G. A. (2008). Interpersonal psychotherapy as a treatment for depression in later life. *Professional Psychology: Research and Practice*, *39*(3), 306-312.

International Society for Interpersonal Psychotherapy. (2012). About IPT. Retrieved from www.interpersonalpsychotherapy.org/about-ipt/

Jensen, C. (1994). Psychosocial treatment of depression in women: Nine single-subject evaluations. *Research on Social Work Practice*, *4*(3), 267-282.

Kelly, M. A. R., Cyranowski, J. M., & Frank, E. (2007). Sudden gains in interpersonal psychotherapy for depression. *Behaviour Research and Therapy*, *45*(1), 2563-2572.

Kiesler, D. J. (1979). An interpersonal communication analysis of relationship in psychotherapy. *Psychiatry*, *42*(4), 299-311.

Klerman, G., Dimascio, A., Weissman, M., Prusoff, B., & Paykel, E. (1974). Treatment of depression by drugs and psychotherapy. *American Journal of Psychiatry*, *131*(2), 186-191.

Markowitz, J. C., Bleiberg, K. L., Pessin, H., & Skodol, A. E. (2007). Adapting interpersonal psychotherapy for borderline personality disorder. *Journal of Mental Health*, *16(*1), 103-116.

Markowitz, J. C., & Weissman, M. M. (2012). Interpersonal psychotheapy: Past, present and future. *Clinical Psychology and Psychotherapy*, *special issue*

McBride, C., Atkinson, L., Quilty, L., & Bagby, R. M. (2006). Attachment as moderator of treatment outcome in major depression: A randomized control trial of interpersonal psychotherapy versus cognitive behavior therapy. *Journal of Consulting and Clinical Psychology*, *74*(6), 1041-1054.

McBride, M. C., & Martin, G. E. (1990). A framework for eclecticism: The importance of theory to mental health counseling. *Journal of Mental Health Counseling*, *12*(4), 495-505.

Palmer, S. (Ed.). (1997). *Handbook of counselling*. (2nd ed.) New York, USA: Routledge.

Ravitz, P., Maunder, R., & McBride, C. (2008). Attachment, contemporary interpersonal theory and IPT: An integration of theoretical, clinical, and empirical perspectives. *Journal of Contemporary Psychotherapy*, *38*(1), 11-21.

Robbins, S. B., & Jolkovski, M. P. (1987). Managing countertransference feelings:

An interactional model using awareness of feeling and theoretical framework. *Journal of Counseling Psychology*, *34*(3), 276-282.

Robertson, M., Rushton, P., & Wurm, C. (2008). Interpersonal psychotherapy: *An overview. Psychotherapy in Australia*, *14*(3), 46-53.

Robinson, M. D. (2012). Theory or bust: A doctoral student's insight on the role of theory in education and research. Retrieved from http://www.socialworker.com./home/feature_articles/general

Roysircar, G. (2009). Evidence-based practice and its implications for culturally sensitive treatment. *Journal of Multicultural Counseling and Development*, *37*(2), 66-82.

Skovholt, T. M., & Ronnestad, M. H. (1992). *The evolving professional self*. West Sussex, England: John Wiley and Sons.

Sloan, G., Hobson, J., Leighton, J., McFarlane, B., & Law, R. (2009). An overview and history of interpersonal psychotherapy. *Nursing Standard*, *23*(26), 44-49.

Snyder, C. R., & Ingram, R. E. (Eds.). (2000). *Handbook of psychological change*. NY, USA: John Wiley & Sons.

Stuart, S., & Robertson, M. (2003). *Interpersonal psychotherapy: A clinician's guide*. London, UK: Hodder Arnold.

Sue, S., Fujino, D. C., Hu, L. T., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology*, *59*(4), 533-540.

Sullivan, H. S. (2000). Psychiatry: Introduction to the study of interpersonal relations. *Psychiatry*, *63*(2), 113-126.

Teyber, E., & McClure, F. H. (2011). *Interpersonal process in therapy: An intergrative model*. Belmont, CA: Brooks/Cole.

Timulak, L. (2011). *Developing your counselling and psychotherapy skills and practice.* London, UK: Sage.

Van Denburg, T. F., & Kiesler, D. J. (2002). An interpersonal communication perspective on resistance in psychotherapy. *Journal of Clinical Psychology*, *58*(2), 195-205.

Verdeli, H., Clougherty, K., Bolton, P., Speelman, L., Ndogoni, L., Bass, J., . . . Weissman, M. M. (2003). Adapting group interpersonal psychotherapy for a developing country: Experience in rural Uganda. *World Psychiatry*, *2*(2), 114-120.

Weissman, M., Markowitz, J. C., & Klerman, G. L. (2007). *Clinician's quick guide to interpersonal psychotherapy*. New York, N.Y.: Oxford University Press.

Weissman, M. M. (2007). Cognitive therapy and interpersonal psychotherapy: 30 years later. *The American Journal of Psychiatry*, 164(5), 693-696.

Weissman, M. M., Klerman, G. L., Prusoff, B. A., Sholomskas, D., & Padian, N. (1981). Depressed outpatients: Results one year after treatment with drugs and/or interpersonal psychotherapy. *Archives of General Psychiatry*, *38*(1), 51-55.

Weissman, M. M., Markowitz, J. C., & Klerman, G. L. (2000). *Comprehensive guide to interpersonal psychotherapy*. New York, N.Y.: Basic Books.

Zane, N., Enomoto, K., & Chun, C. (1994). Treatment outcomes of Asian- and White-American clients in outpatient therapy. *Journal of Community Psychology*, *22*(2), 177-191.

As a counsellor, Dr Genevieve Armson provides supportive, confidential and client-centered sessions. She has a passion for assisting her clients to realise their full inner potential through strength-based counselling. She has been working with organisations for over 20 years as a coach and corporate educator, has established a strong client base and a reputation for well-paced and relevant strategies that successfully assist her clients to reach their stated personal and professional goals.

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The Effects of Violence on Children with Disabilities

By Roshni Sachdev

Introduction

It is widely documented across the literature that for all types of violence, children with disabilities are significantly more vulnerable than their peers without disabilities (Hershkowitz, Lamb, & Horowitz, 2007; Hibbard & Desch, 2007; Jones et al., 2012; Okasha, 2007; Pinheiro, 2006). This includes several forms of violence including physical and sexual assault, emotional and psychological abuse, neglect, and bullying (Alriksson-Schmidt, Armour, & Thibadeau, 2009; Flynt & Morton, 2004; Jones et al., 2012). Violence against children and adolescents with disabilities results in enduring and detrimental health effects across their physical, psychological, and emotional wellbeing (Alriksson-Schmidt et al., 2009). While the prevention of violence against this population should be a priority given its far-reaching and adverse consequences, children with disabilities continue to be severely overlooked as victims of violence (Alriksson-Schmidt et al., 2009; Marge, 2003). Moreover, the terms "disability" and "abuse" are often poorly defined within the literature with considerable variations across studies (Westcott & Jones, 1999).

Accordingly, this paper seeks to highlight the key issues associated with the literature surrounding violence against children with disabilities. A comprehensive critical review of the contemporary literature will be provided, and two theoretical interventions for children with disabilities who have experienced violence will be offered. In addition, the implications of these interventions for policy and counselling practice will be discussed.

Critical Literature Review

Prevalence of children with disabilities that experience violence

Children with disabilities are at significantly greater risk of experiencing violence and maltreatment when compared to their nondisabled peers (Hershkowitz et al., 2007; Hibbard & Desch, 2007). A study by Jones and colleagues (2012) reveals that up to a quarter of children with disabilities will be maltreated and are three or four times more likely to be victimized than their peers without disabilities. Children with disabilities are also frequently victims of physical and psychological bullying and social exclusion within schools (Sullivan, 2009).

There is large amount of inconsistency within the research regarding the type of disability that makes children most vulnerable to abuse. While Sullivan and Knutson (2000) found children with behavioural disorders to be more vulnerable to of all forms of abuse, Jones and colleagues (2012) argue that children with intellectual difficulties have a higher risk of experiencing violence than children with other impairments. Despite this debate, children with disabilities, regardless of impairment, often experience violence at earlier ages than their normally developing peers and are often victimized before the age of five (Sullivan & Knutson, 2000). In addition, Sullivan (2009) argues that children with visible disabilities in special education programs are more likely to be bullied and excluded than children with less noticeable deficits such as learning difficulties.

Problems within the research literature

While all the prevalence studies point to the increased vulnerability of children with disabilities, there are several problems within the research literature. Varying operational definitions of violence and disability are employed across studies, making it increasingly difficult to ascertain incidence and prevalence rates (Hibbard & Desch, 2007). For example, while several researchers include any type of undesired touch in their definition of sexual abuse, Alriksson-Schmidt and colleagues (2009) only include forced intercourse (Jones et al., 2012). Similarly, with definitions of disability, Jones and colleagues (2012) and Sullivan and Knutson (2000) both include a wide variety of disabilities while Alriksson and colleagues focus exclusively on physical impairments. This creates an inconsistency within the research and makes it difficult to generalize the findings surrounding the effects of violence to all children with disabilities. For the purposes of this paper, Rosen's (2006) definition of disability will be adopted as it offers a broad all-encompassing definition to include physical, psychological, emotional and intellectual disabilities. More specifically, Rosen (2006) defines disability as "a chronic physical, affective, and/or cognitive condition(s) that, to a significant extent, precludes normal activities of daily functioning" (p. 171).

Another substantial problem within the research is caused by the bi-directionality of violence and disability (Sobsey, 2002). Child mistreatment can result in the development of impairments and disability, which can perpetuate further

abuse (Hibbard & Desch, 2007). Studies have therefore been unable to clearly and accurately distinguish whether certain disabilities were present before the abuse or were the immediate consequence of violence (Hibbard & Desch, 2007).

An additional issue that is present among the research is rooted in the reporting difficulties that exist for children with disabilities. Prevalence rates may be significantly underestimated as communication deficits common amongst children with intellectual deficits may create challenges for disclosure (Hibbard & Desch, 2007). Additionally, children are often not believed and actions that may signify abuse such as self-harm and repetitive behaviours may be erroneously ascribed to their disability (Westcott & Jones, 1999). Exacerbating the possibility of underestimated prevalence rates, most of the studies available within the literature have been conducted in developed Western countries. Consequently, prevalence rates are absent for developing lower-income countries, which typically have elevated rates of disability and violence and scarce support systems (Jones et al., 2012; World Health Organization, 2011). Data from these countries must therefore be considered to provide a more accurate estimate of the prevalence of violence against children with disabilities.

Vulnerability of children with disabilities

Several hypotheses have been offered to explain why children with disabilities are at an increased risk of experiencing violence. Firstly, children with disabilities continue to experience societal stigma and discrimination (Groce & Paeglow, 2005). Despite our movement towards inclusion, negative traditional beliefs and ignorance towards children with disabilities continue to exist. Moreover, children with disabilities might be targeted as their intellectual and communication deficits may prevent them from recognizing the incident as abuse and reporting its occurrence (Hibbard & Desch, 2007). This significantly increases their vulnerability, as perpetrators are more likely to abuse individuals when they believe they will not be identified (Jones et al., 2012; Rosen, 2006).

Children with disabilities may also have a compromised ability to flee or fight off a perpetrator (Marge, 2003). Environmental barriers such as inaccessibility and a lack of adaptive aids may also further prevent children with physical disabilities from escaping potentially dangerous situations (Alriksson-Schmidt et al., 2009). These risks are exacerbated by the limited access children with disabilities have to information about their personal safety (Rosen, 2006). Sex education is commonly denied to people with intellectual disabilities and as a result children with disabilities often do not understand what sexual assault entails (Rosen, 2006).

Children with disabilities are also often dependent on a variety of others including parents, carers, and doctors (Hibbard & Desch, 2007). Their reliance on others significantly increases their vulnerability, as people who commit violence are commonly trusted individuals who are familiar to the child and in a caregiving role (Marge, 2003). Improper intimate activities may be obscured during personal care routines and medical examinations may also be carried out in an unethical →

A lack of social support for parents and carers has also been hypothesized to increase the prevalence of violence and neglect against children with disabilities

and insensitive manner (Westcott & Jones, 1999).

A significant number of children with disabilities continue to be placed in institutions, a place with an enduring reputation of maltreatment (Sullivan, 2009). According to Sullivan (2009), children living in institutions are six times more likely to experience violence than those residing in foster care. In general, children with disabilities are more likely to be living in foster care, group homes, and large institutions all of which characteristically hold higher levels of risk (Sobsey, 2002).

A lack of social support for parents and carers has also been hypothesized to increase the prevalence of violence and neglect against children with disabilities (Jones et al., 2012). Parents with limited support may feel fatigued or incapable of managing the responsibilities of having a child with additional needs. A lack of respite opportunities for parents and carers may therefore heighten the risk of child maltreatment (Hibbard & Desch, 2007).

The effects of abuse on children with disabilities

The effects of violence on children with disabilities can be both devastating and long lasting. Violence can have a multitude of destructive impacts across a child's physical, psychological, emotional, and behavioural functioning. According to Mansell and Sobsey (2001), children with disabilities who experience maltreatment are highly likely to experience enduring health problems and somatic complaints (Mansell & Sobsey, 2001). These adverse health effects can lead to exacerbated impairment as well as mortality (Alriksson-Schmidt et al., 2009).

There are a wide variety of psychological and emotional impacts that children with disabilities may face as a result of violence. These include self-blame, anger, depression, immense fear, and post traumatic stress disorder (Kennedy, 1990; Marge, 2003). Some children with disabilities may judge every contact as violent after the traumatic incident, whilst others may not understand the magnitude of their victimization (Sullivan, 2002; Marge, 2003). Similarly, school bullying significantly contributes to heightened negative emotions among children with disabilities and hinders their ability to learn from special education (Sullivan, 2006).

Children with disabilities who have experienced violence may become socially isolated and withdrawn (Marge, 2003). Those who have been sexually abused may verbalize inappropriate sexual remarks, practice self-harm, and appear dishevelled (Mansell & Sobsey, 2001). Like other nondisabled children, children with disabilities may also develop aggressive or delinquent behaviour in later life (Bross, 2002). They are at an increased risk of substance abuse and perpetrating violence upon others (Marge, 2003). Children with disabilities who have been victimized have also been found to attend less school, aggravating their learning difficulties (Sobsey, 2002). When compared to their non-maltreated peers with disabilities, they achieved significantly lower math and reading scores (Sullivan & Knutson, 2000).

The families of children with disabilities who are victimized are often overlooked (Marge, 2003). However, it is critical to acknowledge that children with disabilities who experience violence are not the only victims. Parents, siblings, and other caregivers of the child may become secondary victims, experiencing considerable distress, anxiety, and concern for the safety of the child (Marge, 2003). They may experience secondary trauma, exhibiting symptoms of posttraumatic stress disorder, including but not limited to depression, anxiety, rage, denial, and reliving the incident based on their knowledge of it (Marge, 2003).

Theoretical Interventions

There is a considerable gap in the literature surrounding how to respond to children with disabilities who have been maltreated (Hibbard & Desch, 2007). Whilst most of the research focuses on normally developing children who have experienced violence, there is some evidence in the literature for the therapeutic effects of music, art, and play therapy for children with disabilities (Sullivan, 2009). Despite this, Peckham (2007) argues that children with disabilities are likely to experience corresponding impacts and symptoms as their nondisabled peers (Sequeira, Howlin, & Hollins, 2003). Like children with disabilities, normally developing children often experience trauma, anger, depression, withdrawal, anger, anxiety, self-harm, and sexualized behaviours as a consequence of experiencing violence (O'Callaghan & Murphy, 2003; Peckham 2007). Thus, several therapy modalities used for typically developing children may also be modified to treat children with disabilities following experiences of abuse.

According to Clayton (2005), children who have experienced maltreatment, with or without disabilities, are highly likely to experience attachment-related problems (Clayton, 2005). These distressing attachment experiences significantly affect the development of their right cortical brain areas involved in affect regulation (Clayton, 2005). Changes to their hippocampus were also observed, leading to a distortion and fragmentation of memories

(Bremner, 2001; Wethington et al., 2008).

Highlighting the neurobiological consequences of trauma is essential for evaluating the efficacy of therapeutic modalities for children with disabilities who have experienced maltreatment. As traumatic memories are stored in the right cortical regions of the brain, a part of the brain that is nonverbal, it is simultaneously appropriate to utilize nonverbal methods of treatment such as art therapy, sandplay therapy, dance therapy, touch therapy, eye movement therapy, or nondirective play therapy (Clayton, 2005). By employing expressive therapies such as the ones listed, practitioners can attempt to integrate left and right hemisphere functioning (Schiffer, 2000). These nonverbal therapy modalities are highly effective interventions for children with trauma symptoms who often cannot verbally communicate their experiences (Clayton, 2005; Pifalo, 2007). Furthermore, they may be especially suitable for children with disabilities that have communication deficits.

Based on the neurobiological evidence, this section will introduce art therapy and

eye movement desensitization reprocessing (EMDR) as theoretical interventions for treating children with disabilities who have experienced violence. Art therapy is a therapeutic intervention rooted in psychoanalytic theory (Eaton, Doherty, & Widrick, 2007). It utilizes the child's right brain to explore their experiences of maltreatment whilst considering their cognitive, developmental, and emotional functioning (Clayton, 2005). It is important that the procedure of art therapy is modified and adapted to suit the characteristics and needs of each child (Eaton et al., 2007). In the early sessions of art therapy, a piece of art is produced often with pencil drawing, colouring, painting or clay (Eaton et al., 2007). During this phase, the therapist supports the child through their creative process by providing a variety of tools and resources (Eaton et al., 2007). The therapist within this modality is nondirective. Rather, they must attempt to foster an optimal creative environment for the child to explore their own feelings (Clayton, 2005). As the session progresses, the therapist may ask the child to share a story about their piece of art while attempting to facilitate an understanding of the story (Eaton et al., 2007). In doing so, the therapist seeks to help the child cope with the reality of the trauma and their thoughts and feelings surrounding it (St. Thomas & Johnson, 2002).

Eye Movement Desensitization and Reprocessing (EMDR) is another treatment intervention that can be used with children with disabilities experiencing trauma symptoms as a consequence of maltreatment (Wethington et al., 2008). Embedded in cognitive behavioural therapy, EMDR strives to diminish the negative emotional and behavioural responses of the child who has been abused and alter the maladaptive cognitions associated with the traumatic experience (Pifalo, 2007). Typically, EMDR can be divided into an eight stage psychotherapeutic process (Shapiro, 2001). While the first and second phase involve case formulation and preparing the client for trauma work, phase three till eight consist of reprocessing the traumatic memory (Mevissen, Lievegoed, Suebert, & De Jongh, 2011). In this phase, the client is asked to introduce the traumatic memory and concentrate on its multifaceted aspects, the most salient image, and the dysfunctional cognitions of oneself associated with it (Mevissen et al., 2011). Clients are asked to do this whilst following the back and forth hand movements of the therapist with their eyes (Shapiro, 2001; Wethington et al., 2008). Furthermore, the client is continually asked to reveal the emotional, cognitive, and bodily experiences experienced until these internal disturbances are reduced to a zero on the Subjective Unit of Disturbances scale (Mevissen et al., 2011). Additionally, their adaptive positive beliefs must be rated highly on the Validity of Cognition scale (Mevissen et al., 2011).

Like art therapy, it is essential to make appropriate modifications to the processes of EMDR to suit the individual needs of children with disabilities. According to Mevissen and colleagues (2011), therapists can apply stickers on their fingers to assist tracking or buzzers that vibrate alternately between the left and right hand when working with children. Alternatively, therapists can also tap the child's hands and knees (Mevissen et al., 2011). Furthermore, the means of activating the trauma should be adjusted to the child's →

mental age and consider the characteristics of the child's impairment (Adler-Tapia & Settle, 2008). For clients between the mental age of four till eight, Mevissen and colleagues (2011) recommend that children be instructed to draw the story instead of expressing it verbally. When applying EMDR to children younger than three years of age, the Story Telling Method may be employed. In this method, parents or caregivers articulate the traumatic incident, which begins positively and gradually incorporates more distressing facts surrounding what was experienced, observed, heard, felt, and thought (Mevissen et al., 2011). The story also includes the response of the client and must have an optimistic ending (Mevissen et al., 2011). As described above, this story is repeated until the child responds to it without a stress reaction, yielding a zero on the Subjective Unit of Disturbances scale (Mevissen et al., 2011).

Both art therapy and EMDR show strong empirical support across the literature, and can be employed for individuals of varying ages, symptoms, and experiences of traumatic events (Cloitre, 2009; Reynolds, Nabors, & Quinlan, 2000; Rodenburg, Benjamin, De Roos, Meijer, & Stams, 2009). Whilst they involve different processes, both art therapy and EMDR seek to gain access to traumatic memories and bring them into consciousness where they can be interpreted (Pifalo, 2007). The use of art as a medium in both modalities allows children to express their conflicted feelings in a less intimidating manner (Pifalo, 2007). As children may be fearful of their perpetrators, communicating their feelings and experiences through art may appeal to them as a safer communication medium (Pifalo, 2007). Art therapy and EMDR have been found to be effective in reducing symptoms of posttraumatic stress disorder and reducing the impact of the distressing imagery (Mevissen et al., 2011; Withington et al., 2008). Other positive changes have also been noted such as decreased anxiety, improved mood, acquisition of new skills, and increased autonomy (Mevissen et al., 2011; Pifalo, 2007).

Implications for Policy and Practice

The research on violence against people with disabilities should be utilized to inform and guide public policy and practice (Sullivan, 2009).

Implications for Policy

The prevention of violence against children with disabilities is indispensable given its harmful costs (Alrikssson-Schmidt et al., 2009). To begin with, it is essential to educate the community about the problem of disability and violence (Marge, 2003). In addition, it is widely agreed upon across the literature that children with disabilities should be provided with sex education and specifically learn what abuse entails and how to report it (Edwards, 2016; Marge, 2003; Peckham, 2007). The provision of sex education improves each child's personal capacity for safe participation in their communities and should prevent both the occurrence and recurrence of abuse (Hogan, 2014). However, to meet the diverse needs of children with disabilities, it is imperative that accessible and flexible formats of teaching are available in schools (Marge, 2003).

Additionally, healthcare professionals and educators should be trained in identifying and reporting cases of

Both art therapy and EMDR show strong empirical support across the literature, and can be employed for individuals of varying ages, symptoms, and experiences of traumatic events

child maltreatment (Hibbard & Desch, 2007). According to the Queensland Government (2016), individuals in the disability services sector such as schools and health services must be aware of the polices and procedures for responding to abuse. Practitioners must ascertain safety for the child, remove the potential source of harm, and immediately report the offence (Queensland Government, 2016). Disability services will then further provide support services and counselling for clients and their family to enhance security and wellbeing (Queensland, 2016). To further minimize barriers to reporting for children with disabilities, multidisciplinary arrangements can also be made between child services and those with expertise in particular impairments (Marge, 2003; Westcott & Jones, 1999). Effective systems such as these are necessary for identifying abuse and enabling prompt and suitable responses to incidents (Hogan, 2014). Violence prevention training should also be provided to all caregivers, and background checks should be carried out routinely for all employees (Marge, 2003).

As practitioners, we need to advocate for state and local policies to further improve in preventing, identifying, and treating children with disabilities who have been maltreated (Hibbard & Desch, 2007). It is critical that service providers use the most effective and efficient evidence-based methods to deliver quality treatment to victimized children and their families (Hogan, 2014; Pifalo, 2007). To ensure this can happen successfully, researchers should continue to address the sizeable gap within the literature surrounding treatment modalities that are most effective for this population and how they can be provided with the appropriate modifications.

Implications of the theoretical interventions for counseling practice

As practitioners, it is essential that we advocate for the provision of effective therapy modalities for survivors of abuse with a disability (Peckham, 2007). While art therapy and EMDR both demonstrate efficacy for children and adolescents who have experienced abuse, it is important to acknowledge that in both approaches, the safety of the child and the development of a positive therapeutic relationship is paramount (Clayton, 2005; Peckham, 2007; Pifalo, 2007). Moreover, encouraging disclosure is vital in the early stages of treatment to create a safety plan. However, after this is done, forcing the child to share further details about their traumatic experience may be injurious (Clayton, 2005).

While art therapy is employed in a variety of contexts for children experiencing trauma, researchers often fail to provide adequate information regarding the specific methodology employed and the number of sessions provided to clients (Eaton et al., 2007). This lack of procedural thoroughness may limit the utility and applicability of these studies for informing practice (Eaton et al., 2007). However, it is also plausible that this information is omitted as the duration of art therapy may vary across clients and is very much dependent on an individual's characteristics (Eaton et al., 2007). Thus, despite these limitations, Eaton and colleagues (2007) reveal art therapy as a valuable tool for establishing a positive therapeutic alliance and an effective method of treatment for the negative consequences of child maltreatment (Eaton et al., 2007).

EMDR has also been reported as an effective treatment method for people with mild, moderate, and severe intellectual difficulties that suffer from trauma symptoms (Baro & Seubert, 2010). Within a maximum of 17 sessions, Mevissen and colleagues (2011) noted positive improvements and found that these changes were maintained at the two-year follow up.

Regardless of the treatment modality employed, Peckham (2007) provides a number of recommendations for practitioners providing therapy to children with disabilities. Firstly, Peckham (2007) emphasises the importance of permitting time for positive change to occur when delivering treatment. Practitioners should be aware that children with disabilities might need substantial time to understand, reprocess, and work through their experiences of maltreatment (Peckham, 2007). Practitioners should also acknowledge that symptoms of trauma might get worse before they get better amongst survivors with disabilities (Peckham, 2007). Furthermore, as parents and caregivers may be severely affected by the maltreatment, practitioners may need to consider providing them with psychoeducation or treatment alongside the victim (Mevissen et al., 2011; Peckham, 2007). The use of different gender therapists should also be considered to explore the client's attitudes towards males and females and model a healthy relationship (Peckham, 2007). Lastly, practitioners should demonstrate relentless creativity, using modelling, repetition, art, and pictures to support understanding and skill acquisition (Frankish & Terry, 2003). To ensure the efficacy of EMDR, art therapy or other treatment modalities, adapting the instructions and processes of therapy to accommodate a child's cognitive and emotional level is absolutely vital (Mevissen et al., 2011).

Conclusion

The prevalence statistics on violence against children with disabilities are incredibly distressing and unacceptable. It is essential now that we use this knowledge to decrease the occurrence of violence and its harmful effects on this vulnerable population. Research has the capacity to inform public policy, which in turn has the power to influence practice. Thus, as practitioners, it is essential that we commit to empowering change and optimizing the safety of children with disabilities by continuously engaging in research and sharing with our community, the knowledge products that it creates.

REFERENCES

Adler-Tapia, R., & Settle, C. (2008). *EMDR and the art of psychotherapy with children*. New York, NY: Springer Publishing Company.

Alriksson-Schmidt, A.I., Armour, B.S., & Thibadeau, J.K. (2009). Are adolescent girls with a physical disability at increased risk for sexual violence? *Journal of School Health*, *80*(7), 361-367. doi: 10.1111/j.1746-1561.2010.00514.x

Bremner, J.D. (2001). A biological model for delayed recall of childhood abuse. *Journal*

of Aggression, Maltreatment and Trauma, *4*(2), 165-183. Retrieved from http://www.tandfonline.com/doi/abs/10.1300/J146v04n02_08#.V187TGY-I4A

Clayton, G.K. (2005). Expressive therapy with severely maltreated children: Neuroscience contributions. *Art Therapy: Journal of the American Art Therapy Association*, *22*(4), 213-220. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/07421656.2005.10129523

Cloitre, M. (2009). Effective psychotherapies for posttraumatic stress disorder: A review and critique. *CNS Spectrums*, *14*(1), 32-43. Retrieved from http://www.inimh.org/libdocuments/PTSD_Psychological_Tx.pdf

Eaton, L.G., Doherty, K.L., & Widrick, R.M. (2007). A review of research and methods used to establish art therapy as an effective treatment method for traumatized children. *The Arts in Psychotherapy*, *34*, 256-262. Retrieved from http://www.sciencedirect.com/science/article/pii/S0197455607000287

Edwards, M. (2016). *Inquiry into abuse in disability services: Final report*. Melbourne, Vic: Victorian Government.

Flynt, S.W. & Morton, R.C. (2004). Bullying and children with disabilities. *Journal of Instructional Psychology*, *31*(4), 330-333. Retrieved from http://search.proquest.com.ezproxy.library.uq.edu.au/docview/213907917?accountid =14723

Frankish, P., & Terry, S. (2003). Modern therapeutic approaches in learning disability services. *Tizard Learning Disability Review*, *8*(3), 3-10. Retrieved from http://www.emeraldinsight.com/doi/abs/10.1108/13595474200300022

Groce, N.E., & Paeglow, C. (2005). Violence against disabled children: *UN Secretary General's report on violence against children thematic group on violence against disabled children*. *Summary Report*. New York, NY: UNICEF.

Hershkowitz, I., Lamb, M.E., & Horowitz, D. (2007). Victimization of children with disabilities. *American Journal of Orthopsychiatry*, *77*(4), 629-635. Retrieved from http://psycnet.apa.org/journals/ort/77/4/629/

Hibbard, R.A. & Desch, L.W. (2007). Maltreatment of children with disabilities. *American Academy of Paediatrics*, *119*(5), 1018-1025. Retrieved from http://pediatrics.aappublications.org/content/119/5/1018.short

Hogan, M. (2014). *Preventing and responding to the abuse, neglect, and exploitation of people with disability*. Brisbane, QLD: Department of Communities, Child Safety and Disability Services

Jones, L., Bellis, M.A., Wood, S., Hughes, K., McCoy, E., Eckley, L., Bates, G., Mikton, C., Shakespeare, T., & Officer, A (2012). Prevalence and risk of violence against children with disabilities: A systematic review and meta-analysis of observational studies. *The Lancet*, *380*(9845). 899-907. http://dx.doi.org/10.1016/S0140-6736(12)60692-8

Kennedy, M. (1990). The deaf child who is sexually abused. *Child Abuse Review*, 3(1), 3-7.

Mansell, S. L., & Sobsey, R. (2001). *Counselling people with developmental disabilities who have been sexually abused*. London, UK: Nadd Press.

Marge, D.K. (2003). *A call to action: Ending crimes of violence against children and adults with disabilities. A report to the nation*. Syracuse, NY: State University of New York.

Mevissen, L., Lievegoed, R., Seubert, A., & De Jongh, A. (2011). Treatment of PTSD in people with severe intellectual disabilities: A case series. *Developmental Neurorehabilitation*, *15*(3), 223-232. Retrieved from http://www.tandfonline.com/doi/abs/10.3109/17518423.2011.654283

O'Callaghan, A.C., Murphy, G., & Clare, I.C. (2003). The impact of abuse on men and women with severe learning disabilities and their families. *British Journal of Learning Disabilities*, *31*(4), 175-180. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3156.2003.00254.x/abstract

Okasha, A. (2007). Mental health and violence: WPA Cairo declaration. International perspectives for intervention. *International Review of Psychiatry*, *19*(3), 193-200. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/09540260701349449

Peckham, N.G. (2007). The vulnerability and sexual abuse of people with learning disabilities. *British Journal of Learning Disabilities*, *35*(2), 131-137. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1468-3156.2006.00428.x/abstract

Pifalo, T. (2007). Jogging the cogs: Trauma-focused art therapy and cognitive behavioural therapy with sexually abused children. *Art Therapy: Journal of the American Art Therapy Association*, *24*(4), 170-175. Retrieved from http://files.eric.ed.gov/fulltext/EJ791441.pdf

Pinheiro, P. S. (2006). *World report on violence against children, United Nations Secretary General's study on violence against children*. Geneva, CH: United Nations.

Queensland Government. (2016). Department of communities, child safety and disability services: Responding to abuse, neglect and exploitation. Upper Mt Gravatt, Qld: Queensland Government.

Reynolds, M. W., Nabors, L., & Quinlan, A. (2000). The effectiveness of art therapy: Does it work? *Art Therapy*, *17*(3), 207–213. Retrieved from http://www.tandfonline.com/doi/abs/10.1080/07421656.2000.10129706

Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A.M., & Stams, G.J. (2009). Efficacy of EMDR in children: A meta-analysis. *Clinical Psychology Review*, *29*(7), 599-606. Retrieved from http://www.emdrkindenadolescent.nl/folders/Efficacy%20of%20EMDR%20in%20children%20A%20meta-analysis1.pdf

Rosen, D.B. (2006). Violence and exploitation against women and girls with disability. *Annals of the New York Academy of Sciences*, 1087(1), 170-177. doi: 10.1196/annals.1385.002

Schiffer, F. (2000). Can the different cerebral hemispheres have distinct personalities? Evidence and its implications for theory and treatment of PTSD and other disorders. *Journal of Trauma and Dissociation*, *1*(2), 83-104. Retrieved from http://www.tandfonline.com/doi/abs/10.1300/J229v01n02_06

Sequeira H., Howlin P. & Hollins S. (2003) Psychological disturbance associated with sexual abuse in people with learning disabilities: Case control study. *The British Journal of Psychiatry*, *183*(5), 451–456. Retrieved from http://bjp.rcpsych.org/content/183/5/451.short

Shapiro, F. (2001). *Eye movement desensitization and reprocessing*: Basic principles, protocols, and procedures (2nd ed.). New York, NY: Guilford Press.

Sobsey, D. (2002). Exceptionality, education, and maltreatment. *Exceptionality*, *10*(1), 29-46. doi: 10.1207/S15327035EX1001_3

St. Thomas, B., & Johnson, P. (2002). In their own voices: Play activities and art with traumatized children. *Groupwork*, *13*(2), 34-38. Retrieved from http://www.scie socialcareonline.org.uk/in-their-own-voices-play-activities-and-art-with-traumatised-children/r/a1CG0000000GMqSMAW

Sullivan, P.M. (2002). Violence against children with disabilities: Prevention, public policy and research implications: *Paper commissioned for the National Conference on Preventing and Intervening in Violence Against Children with Disabilities*. New York, NY: SUNY Upstate Medical University.

Sullivan, P. M. (2006). Children with disabilities exposed to violence: Legal and public policy issues. In M. M. Feerick & G. B. Silverman (Eds.), Children exposed to violence: Current status, gaps, and research priorities (pp. 213–237). Baltimore, MD: Brookes Publishing.

Sullivan, P.M. (2009). Violence exposure among children with disabilities. *Clinical Child Family Psychology Review*, *12*(2), 196-216. Retrieved from http://link.springer.com/article/10.1007/s10567-009-0056-1

Sullivan, P.M., & Knutson, J.F. (2000). Maltreatment and disabilities: A population-based epidemiological study. *Child Abuse and Neglect*, 24, 1257–1274. doi:10.1016/S0145 2134(00)00190-3.

Westcott, H.L. & Jones, D.P.H. (1999). Annotation: The abuse of disabled children. *Journal of Child Psychology and Psychiatry*, *40*(4), 497-506. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/1469-7610.00468/abstract

Wethington, H.R., Hahn, R.A., Fuqua-Whitley, D.S. Sipe, T.A., Crosby, A.E., Johnson, R.L., Liberman, A.M., Moscicki, E., Price, L.N., Tuma, F.K., Kalra, G., & Chattopadhyay, S.K. (2008). The effectiveness of interventions to reduce psychological harm from traumatic events among children and adolescents: A systematic review. *American Journal of Preventive Medicine*, *35*(3), 287-313. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/18692745

World Health Organisation [WHO] (2011). *World report on disability*. Geneva, CH: World Health Organization.

Roshni Sachdev has recently completed her Masters of Counselling program at the University of Queensland

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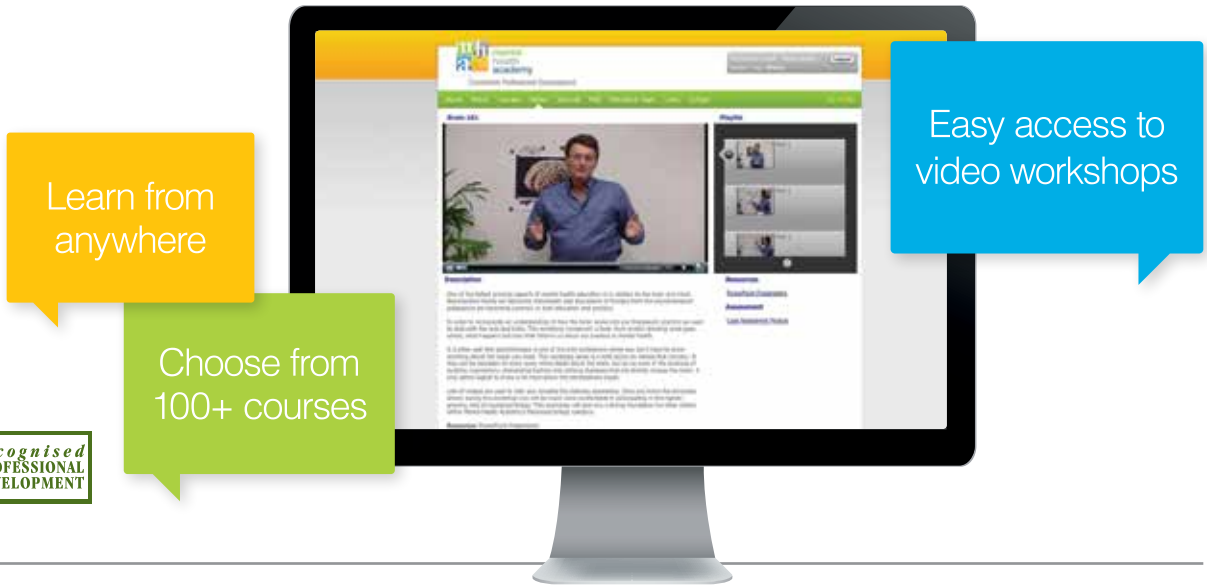

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PEER REVIEWED ARTICLE

The Experience of Illness

By Loren Soeiro, PhD, ABPP

Introduction

Within the realm of healthcare practice and research, there has been a growing emphasis on the concept of patient experience (Wolf, Niederhauser, Marshburn, & LaVela, 2014). The inclusion of patient experience is critical to understanding how health challenges and treatment impacts a person's subjective wellbeing and how practitioners and policy makers can enhance the quality of healthcare (LaVela & Gallan, 2014; Lee et al., 2013; Wolf et al., 2014). Despite this increased attention on patient experience, there continues to be a lack of a shared definition across the literature in regards to what patient experience encompasses and how it should be measured (La Vela & Gallan, 2014; Wolf et al., 2014). However, various theories can be considered to explore the means by which people internalize their illness or capacity challenge to be uniquely their own. Furthermore, the biopsychosocial-spiritual model offers a comprehensive representation of the factors that may influence each individual's lived experience.

This essay will discuss the available definitions of patient experience and further explore theories concerning how a person constructs their internal experience of illness. Drawing on the biopsychosocial-spiritual model, this essay also seeks to highlight factors that may influence the lived experience of a client. Subsequently, a discussion of how counsellors can gain access and achieve a better understanding of their client's lived experience will be provided.

Exploring the definitions of patient experience

A wide variety of definitions exist for the concept of patient experience within the healthcare literature (Wolf et al., 2014). Current dialogues centre around whether organisations and researchers should focus on expectations, patient-centeredness, individualized care, satisfaction, or other concepts (LaVela & Gallan, 2014; Staniszewska & Bullock, 2012). For example, in their study, Bowling and colleagues (2012) determined patient experience by considering whether expectations were met. Therefore, it is clear that although the concept of patient experience is strongly advocated within healthcare settings, there continues to be a vague conceptualization of how to define and measure its constituents (LaVela & Gallan, 2014; Wiig et al., 2013; Wolf et al., 2014).

While there continues to be complexities surrounding which operational definitions to recognize, there is a general consensus that the patient experience encompasses the individual's holistic experience of the illness (LaVela & Gallan, 2014; Manary, Boulding, Staelin, & Glickman, 2013). Furthermore, to some extent, each of these concepts aspires to include individual perceptions about their healthcare and enhance the patient experience (LaVela & Gallan, 2014). Thus, while numerous definitions exist to convey the concept of patient experience, Wolf and colleagues (2014) argue that there is some agreement around the themes integral to patient experience. Overlapping concepts found across 18 articles include the physiological and affective lived experience, the quality of all interactions across the entire care experience, the influence of the organization and culture, the importance of collaboration, and the person's involvement in decision-making (Wolf et al., 2014). To further overcome the varied views of patient experience, The Beryl Institute (2016) defines the concept as "the sum of all interactions, shaped by an organization's culture, that influence patient perceptions across the continuum of care" (LaVela & Gallan, 2014; Wolf et al., 2014). Comprehensive approaches to measurement should therefore be employed to ensure an accurate encapsulation of a patient's whole experience (LaVela & Gallan, 2014).

After reviewing the literature, it is apparent that there is a need for a standardized operational definition to improve the experiences of individuals accessing and utilizing healthcare services through both research and practice (LaVela & Gallan, 2014; Wolf et al., 2014). The development of a shared definition of patient experience will help identify essential components of the construct and place confines for what it includes and excludes (LaVela & Gallan, 2014; Wolf et al., 2014).

Drawing upon theories to explain the formation of the lived experience

A wide variety of theories can be drawn upon to explain how an individual may construct their internal lived experience of an illness or capacity challenge. It is critical to acknowledge that while

It is critical to acknowledge that while the physiology of an illness may be similar for some people with an identical diagnosis, their lived experience will be distinct.

the physiology of an illness may be similar for some people with an identical diagnosis, their lived experience will be distinct. Neurobiological, attachment, and cognitive-behavioural models offer divergent perspectives on how an individual may form their lived experience of an illness. Through the mechanisms described within each theory, it is apparent that individuals receive and interpret the input from their health challenges differently and internalize it to be uniquely their own.

The neurobiological approach

The neurobiological approach sheds light on the organismic and biological construction of illness, which asserts the importance of neural circuitry in shaping behaviour (Viamontes & Beitman, 2006). Within this theoretical perspective, the prefrontal cortex plays a significant role in constructing the lived experience of illness for an individual.

There are three circuits in the prefrontal cortex that are responsible for these intricate processes. The first contains the cingulate gyrus, which enables the body to focus on both physiological and environmental demands to prepare for appropriate action (Viamontes & Beitman, 2006). It generates emotional states that correspond to cognitive input and adjusts arousal, motivation, and attention accordingly to activate behavioural responses (Viamontes & Beitman, 2006). The orbito-frontal circuit, connected to the amygdala, adds considerations of context and potential consequences to maximize reward and minimize risk (Viamontes & Beitman, 2006). Lastly, the dorsolateral prefrontal circuit controls executive functions such as memory, organisation, problem solving, and language (Mega & Cummings, 2001). Thus, as a person experiences an illness or incapacity, the circuits in the prefrontal cortex respond by coordinating goal-directed behaviour that initiate the appropriate emotional and behavioural responses based on a consideration of the internal and external circumstances, memory, context, and possible consequences (Viamontes & Beitman, 2006). Accordingly, chronic stress and intense emotional states, which lead to a simplification of these processes, can result in maladaptive emotional and behavioural responses that do not consider as many variables (Sapolsky, 2002).

Attachment theory

The attachment theory pioneered by Bowlby (1980) can be employed to explain the lived experience of illness through a developmental approach. The attachment style a child forms as a result of their caregiver's responses significantly affects their succeeding social and emotional development (Bowlby, 1980; Feeney, →

As we outline the relationship between cognition and behaviour, it is important to acknowledge the strong relationship between beliefs and health behaviours

2000). Attachment styles often manifest when a child is in an unfamiliar or fear-provoking situation. Thus, according to Feeney (2000), illness is very likely to activate the attachment system.

Individual differences in attachment styles reflect the rules and tactics the child has internalized to manage their distress. The rules that were initially learned through experiences of attachment-related distress are further generalized to subsequent threatening situations (Feeney, 2000). For example, while secure children who encountered responsive caregivers are able to recognize their distress and request assistance from others, insecure children react with maladaptive responses (Feeney, 2000). As a result, individuals with different attachment styles will inevitably manifest varied responses to illness or incapacity (Feeney, 2000). The formation of the illness experience is therefore distinctive for each individual as the source of threat activates a set of unique attachment behaviours steered by the person's existing schemas (Feeney, 2000).

A cognitive-behavioural lens

The cognitive-behavioural model is based upon the assumption that cognitions, which consist of thoughts and beliefs, affect behaviour, emotions and physiology (Taylor, 2006). Beck's (1996) cognitive model consists of three levels of cognition, which include core beliefs, intermediate beliefs, and automatic thoughts. While core beliefs drive intermediate beliefs or one's implicit assumptions, they are both expressed as automatic thoughts articulated within a particular situation (Taylor, 2006). Core beliefs and intermediate beliefs are therefore the means by which people endeavour to understand their experiences and environment. According to Taylor (2006), these interpretations largely depend on the cognitive schemas developed early in development.

As we outline the relationship between cognition and behaviour, it is important to acknowledge the strong relationship between beliefs and health behaviours (Miller & O'Leary, 1993). Cognitive appraisals or beliefs about one's illness affect all facets of the illness experience as well as coping (Miller & O'Leary, 1993). According to Leventhal, Meyer, and Nerenz (1980), people with chronic conditions interpret their illness experience along five dimensions, which include identity, timeline, cause, consequences and control. Three types of appraisals are prescribed to each of these dimensions, ranging from irrelevant, benign-to-positive, and stressful (Leventhal et al., 1980). Through this view it is evident that different cognitive appraisals of one's illness experience will inescapably lead to variations in the manifestation of stress responses, self-care behaviours, psychological functioning, and the experience and severity of the illness (Murphy et al., 1999; Taylor, 2006).

Factors that affect the lived experience: The biopsychosocial-spiritual model

There are a wide variety of factors that may affect the lived experience of an individual. In recognition of these factors, the biopsychosocial model offers a comprehensive framework that emphasises the importance of biological, psychological, and social factors for understanding illness (Fava & Sonino, 2008; Sarafino, 2006).

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Across the research literature, spirituality is correlated with several positive effects on health through biological pathways, social support, health behaviours, and finding a purpose or deeper meaning

According to Turk and Monarch (2002), illness is the subjective experience of a having a disease or capacity challenge. In this regard, illness refers to how an individual lives with their symptoms (Gatchel, 2004). The experience of illness is therefore significantly influenced by a person's genetic composition, psychological state, and sociocultural context (Gatchel, 2004). These factors influence the expression of illness for each individual and uniquely determine its course, severity, and consequences (Gatchel, 2004). To understand a patient's experience and response to illness, interactions among physiological changes, psychological functioning, and social context must be considered (Adler, 2009; Gatchel, 2004). Consequently, models such as the biomedical model that focus solely on one of these main dimensions will provide a limited and incomplete insight of the person's lived experience (Gatchel, 2004; Hatala, 2013).

The relationship between psychological and physical health is highly researched across the literature (Gatchel, 2004). Kroenke, Spitzer and Williams (1994) found that patients with anxiety or depression often display more physical symptoms, and as physical symptoms increase individuals are increasingly susceptible to developing anxiety or depression. Other psychological factors that should also be considered in influencing a patient's experience of illness include their knowledge of the disease, daily functioning, emotional stability, and intellectual capability (Fava & Sonino, 2008). A broad range of social factors should also be considered spanning economic constraints, social support, family environment, interpersonal relationships, and culture (Gatchel, 2004).

While the biopsychosocial model provides a comprehensive inspection of the factors that may affect an individual's experience of illness, the absence of a spiritual dimension is a noteworthy limitation (Hatala, 2013). It is essential that researchers and practitioners acknowledge the relationship between spirituality and health, as a large majority of people believe in a higher power or faith system (Hatala, 2013).

Across the research literature, spirituality is correlated with several positive effects on health through biological pathways, social support, health behaviours, and finding a purpose or deeper meaning (Hatala, 2013). Bussing, Ostermann and Matthiessen (2005) found that patients who participated in spiritual thinking and behaviour such as looking for positive aspects or praying, experienced an increased ability to cope with their illness when compared to their nonspiritual counterparts. In addition to operating through biological mechanisms, spirituality also influences illness through increased social support (Hatala, 2013). Spiritually inclined individuals have greater access to other like-minded individuals, and an enhanced sense of community and social support are strongly correlated with positive health effects (Idler, 2010). Spirituality has also been found to promote positive health behaviours (Hatala, 2013). Idler (2010) found that highly observant sectarian groups had significantly reduced rates of cancer and cardiovascular disease. Spirituality can also offer a source of comfort, strengthen hope, and assist individuals in overcoming feelings of helplessness (Kaye & Raghavan, 2002).

While there are several positive health effects of spirituality, Idler (2010) outlines the propensity for some spiritual individuals to make less use of health services, engage in fewer constructive behaviours, interact negatively with other members, and hold discriminatory attitudes towards minority groups. Thus, the literature offers contradictory findings, which suggest that spirituality and religion can also impair health (Sloan & Bagiaella, 2002). This significantly strengthens the argument for the inclusion of spirituality into the biopsychosocial model as it further portrays the relationship between spirituality and health (Hatala, 2013). The biopsychosocial-spiritual model provides a foundation for treating patients holistically and moves away from the reductionist biomedical perspective that focuses solely on somatic pathology (Sulmasy, 2002). From a biopsychosocial perspective, it is plausible to understand that individuals can find meaning and solace with a serious biological condition which allows them to lead healthy lives despite their interrupted biological functioning (Hatala, 2013; Sulmasy, 2002). Health, therefore, is more than the absence of a somatic pathology, and includes psychological, social, and spiritual factors (Hatala, 2013). To access the internal lived experience of an individual, it is essential that counsellors focus on the interaction between these four domains rather than addressing them independently (Hatala, 2013).

Accessing the lived experience of illness

There are various means by which a counsellor or researcher can access the lived experience of a client ranging from individual counselling to formal research methodologies. According to Wiig and colleagues (2013), several organisations have attempted to measure patient experience using surveys, interviews, focus groups, forums, informal feedback, and formal complaints. Thus, measuring patient experience can be performed by means of quantitative or qualitative approaches (LaVela & Gallan, 2014).

For counsellors seeking to access the lived experience of a client through individual therapy, a variety of qualitative methods can be used to gather information about patient experiences. Clandinin (2006) offers narrative inquiry as an approach where clients have the opportunity to interpret their experiences as they share their story. Bearing resemblance to the biopsychosocial-spiritual model, narrative inquirers seek to understand individuals in relation to their sociocultural context by observing, listening, living together with, or through interpreting texts (Clandinin, 2006). The McGill Illness Narrative Interview (MINI) developed by Groleau, Young and Kirimayer (2006), is a semistructured qualitative interview technique that allows researchers to systematically look for and carefully listen to what is being conveyed whilst giving participants a chance to articulate their story in their own way.

Other innovative qualitative observational and ethnographic approaches can also be utilized to better understand patient perspectives (LaVela & Gallan, 2014). Shadowing and mystery shopping

are both ethnographic approaches that allow researchers or counsellors to embed themselves within their client's setting and observe their lived experience (LaVela & Gallan, 2014). Photovoice is another ethnographic approach that can be used by encouraging the client or participant to take pictures of personally meaningful stimuli and/or events within their environment (Baker and Wang, 2006). Subsequently, in-depth interviews are conducted to allow participants to explain the visual imagery in detail and share their unique narratives, which may be largely influenced by their cognitions and sociocultural context (LaVela & Gallan, 2014). Baker and Wang (2006) argue that the photovoice technique is extremely valuable in providing a wealth of information concerning an individual's perceptions. Thus, through these qualitative approaches, researchers and counsellors can access a better understanding of an individual's experience and how they construct meaning (LaVela & Gallan, 2014).

To obtain a well-rounded depiction of a person's lived experience, counsellors can also engage in triangulation by utilizing a quantitative instrument (LaVela & Gallan, 2014). The Picker Patient Experience Questionnaire can be employed to learn about the patient's perception of the process and outcomes of care, and other factors that may have influenced their care experience (Jenkinson, Coulter, & Bruster, 2002; LaVela & Gallan, 2014). Thus, mixed methods approaches that utilize both quantitative and qualitative research will significantly assist counsellors and researchers in acquiring a more honest and holistic perspective than using a single method (LaVela & Gallan, 2014).

Moving towards patient-centred care

The factors that influence a patient's lived experience such as those highlighted in the biopsychosocial-spiritual model are often overlooked in healthcare settings. To overcome these constraints, the experience of illness can be consistently considered through patient-centred care, which strongly considers a patient's needs, individual perspectives, and sociocultural context (Epstein, Fiscella, Lesser & Stange, 2010). Patient-centred care prioritises the values and interests of patients and offers respect and autonomy through providing choice and forming collaborative partnerships (Epstein et al., 2010). According to Abma, Nierse, and Widdershoven (2009), patient-centred care demonstrates considerable improvements on disease-related outcomes and quality of life. Policymakers and health practitioners should therefore move towards cultivating a patient-centric environment that is responsive to individual needs (Epstein et al., 2010). This way of providing care holistically considers the factors represented within the biopsychosocial-spiritual model.

REFERENCES

Abma, A., Nierse, C.J. & Widdershoven, G.A.M. (2009). Patients as partners in responsive research: Methodological notions for collaborations in mixed research teams. *Qualitative Health Research*, 19(3), 401-415. Retrieved from http://qhr.sagepub.com/content/19/3/401.short

Adler, R. (2009). Engel's biopsychosocial model is still relevant today. *Journal of Psychosomatic Research*, *67*, 607–611. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/19913665

Baker, T.A., & Wang, C.C. (2006). Photovoice: Use of a participatory action research method to explore the chronic pain experience in older adults. *Qualitative Health Research*, *16*(10), 1405-1413. Retrieved from http://qhr.sagepub.com/content/16/10/1405.short

Beck, A.T. (1996). Beyond belief: A theory of modes, personality, and psychopathology. In P. Salkovskis (Ed.), *Frontiers of Cognitive Therapy* (pp. 1-25). New York, NY: Guilford.

Bowlby, J. (1980). *Attachment and Loss* (Vol.3). New York, NY: Basic books.

Bowling, A., Rowe, G., Lambert, N., Waddington, M., Mahtani, K.R., Kenten, C., Howe, A., & Francis, S.A. (2012). The measurement of patients' expectations for health care: A review and psychometric testing of a measure of patients' expectations. *Health Technology Assessment*, *16*(3), 1-8. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK99051/

Büssing A., Ostermann T., & Matthiessen P. F. (2005). The role of religion and spirituality in medical patients in Germany. *Journal of Religion and Health*, *44*(3), 321-340. Retrieved from http://link.springer.com/article/10.1007/s10943-005-5468-8

Clandinin, D.J. (2006). Narrative inquiry: A methodology for studying lived experience. *Research Studies in Music Education*, *27*(1), 44-54. Retrieved from http://rsm.sagepub.com/content/27/1/44.abstract

Epstein, R.M., Fiscella, K., Lesser, C.S., & Stange, K.C. (2010). Why the nation needs a policy push on patient-centered healthcare. *Health Affairs*, *29*(8), 1489-1495. doi: 10.1377/hlthaff.2009.0888

Fava, G.A. & Sonino, N. (2008). The biopsychosocial model thirty years later. *Psychotherapy and Psychosomatics*, *77*(1), 1-2. doi: 10.1159/000110052

Feeney, J.A. (2000). Implications of attachment style for patterns of health and illness. *Child: Care, Health and Development*, *26*(4), 277-288. Retrieved from http://www.ncbi.nlm.nih.

gov/pubmed/10931068

Gatchel, R.J. (2004). Comorbidity of chronic pain and mental health disorders: The biopsychosocial perspective. *American Psychologist*, *59*(8), 795-805. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15554853

Groleau, D., Young, A. & Kirmayer, L.J. (2006). The McGill Illness Narrative Interview (MINI): An interview schedule to elicit meanings and modes of reasoning related to illness experience. *Transcultural Psychiatry*, *43*(4), 671-691. doi: 10.1177/1363461506070796

Hatala, A.R. (2013). Towards a biopsychosocial-spiritual approach in health psychology. Exploring theoretical orientations and future directions. *Journal of Spirituality in Mental Health*, *15*(4), 256-276. doi: 10.1080/19349637.2013.776448

Idler, E. (2010). Health & religion. In W. Cockerham (Eds.), *The New Blackwell Companion to Medical Sociology* (pp. 133–158). Malden, MA: Blackwell

Jenkinson, C., Coulter, A., & Bruster, S. (2002). The Picker Patient Experience Questionnaire: development and validation using data from in-patient surveys in five countries. *International Journal for Quality in Health Care*, *14*(5), 353-358. Retrieved from http://intqhc.oxfordjournals.org/content/14/5/353.short

Kaye, J., & Raghavan, S.K. (2002). Spirituality in disability and illness. *Journal of Religion and Health*, *41*(3), 231-242. Retrieved from http://link.springer.com/article/10.1023/A:1020284819593

Kroenke, K., Spitzer, R.L., & Williams, J.B. (1994). Physical symptoms in primary care. Predictors of psychiatric disorders and functional impairment. *Archives of Family Medicine*, *3*, 774–779. Retrieved from

LaVela, S.L. & Gallan, A.S. (2014). Evaluation and measurement of patient experience. *Patient Experience Journal*, *1*(1), 28-36. Retrieved from www.pxjournal.org

Lee, H., Vlaev, I., King, D., Mayer, E., Darzi, A., & Dolan, P. (2013). Subjective well-being and the measurement of quality in healthcare. *Social Science & Medicine*, *99*, 27-34. Retrieved from http://www.sciencedirect.com/science/article/pii/S0277953613005480

Leventhal, H., Meyer, D., & Nerenz, D. (1980). The common sense representation of illness danger. *Contributions to Medical Psychology*, *2*, 7-30. Retrieved from http://www.academia.edu/259452/The_Common_Sense_Representation_of_Illness Danger

Manary, M.P., Boulding, W., Staelin, R., & Glickman, S.W. (2013). The patient experience and health outcomes. *New England Journal of Medicine*, *368*(3), 201-203. doi:10.1056/NEJMp1211775.

Mega, M.S., & Cummings, J.L. (2001). Frontal subcortical circuits: anatomy and function. In S.P. Salloway., P.F. Malloy., & J.D. Duffy (Eds.), *The Frontal Lobes and Neuropsychiatric Illness*. Washington, DC: American Psychiatric Publishing.

Miller, S.M., & O'Leary, A. (1993). *Psychopathology and Cognition*. New York, NY: Academic Press.

Murphy, F.C., Sahakian, B.J., Rubinsztein, J.S., Michael, A., Rogers, R.D., Robbins, T.W., & Paykel, E.S. (1999). Emotional bias and inhibitory control processes in mania and depression. *Psychological Medicine*, *29*(6), 1307-1321. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/10616937

Sapolsky, R.M. (2002). *Stress, the aging brain, and the mechanisms of neuron death*. Cambridge, MA: MIT Press.

Sarafino, E. (2006). *Health Psychology: Biopsychosocial Interactions* (5th ed.). Hoboken, NJ: John Wiley & Sons

Sloan, R.P., & Bagiella, E. (2002). Claims about religious involvement and healthoutcomes. *Annals of Behavioral Medicine*, *24*(1), 14-21. Retrieved from http://link.springer.com/article/10.1207/S15324796ABM2401_03

Staniszewska, S., & Bullock, I. (2012). Can we help patients have a better experience? Implementing NICE guidance on patient experience. *Evidence Based Nursing*, *15*(4), 99. Retrieved from http://ebn.bmj.com/content/15/4/99.short

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist*, *42*(3), 24-33. Retrieved from http://gerontologist.oxfordjournals.org/content/42/suppl_3/24.short

Taylor, R.R. (2006). *Cognitive behavioural therapy for chronic illness and disability*. New York, NY: Springer.

The Beryl Institute. (2016). *Improving the patient experience*. Retrieved from http://www.theberylinstitute.org/.

Turk, D.C., & Monarch, E.S. (2002). Biopsychosocial perspective on chronic pain. In D.C. Turk & R.J. Gatchel (Eds.), *Psychological Approaches to Pain Management: A Practitioner's Handbook* (2nd ed.), (pp. 3–32). New York, NY: Guilford Press.

Viamontes, G.I., & Beitman, B.D. (2006). Neural substrates of psychotherapeutic change part II: Beyond default mode. *Psychiatric Annals*, *36*(4), 238-246. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/summary?doi=10.1.1.516.5781

Wiig, S., Storm, M., Aase, K., Gjestsen, M.T., Solheim, M., Harthug, S., Robert, G, & Fulop, N. (2013). Investigating the use of patient involvement and patient experience in quality improvement in Norway: Rhetoric or reality? *BMC Health Services Research*, *13*(1), 1-13. doi: 10.1186/1472-6963-13-206

Wolf, J.A., Niederhauser, V., Marshburn, D., & LaVela, S.L. (2014). Defining patient experience. *Patient Experience Journal*, *1*(1), 7-19. Retrieved from http://pxjournal.org/cgi/viewcontent.cgi?article=1004&context=journal

Loren Soeiro is a clinical psychologist, licensed in New York State and board-certified with the American Board of Professional Psychology.

Mental illness is more than 'worried wellness'

Mental illness is more than worried wellness

"So what kind of work do you do in your private practice?" asked a colleague.

"I specialize in depression, anxiety, relationship problems, work-life issues, and low self-esteem," I explained.

"Ah," he said with a knowing smile. "The worried well."

I cringed when I heard this. My patients would cringe, too, if they heard themselves referred to in this dismissive way. But it happens all too often. A close friend of mine — a physician — used the same phrase when I told her about my career trajectory. "Sure, sure," she said, as if I'd been hinting at a delicate truth that she understood intuitively. "The worried well. I treat plenty of those."

Every time I hear it, this phrase sticks in my craw. I feel irritated at the person I'm talking to, frustrated at the gap in understanding between us, and eager to speak up for my patients against this condescension — unwitting or not. This phrase trades upon a mistaken impression that a physician's patients — described as "medically ill" — are in more genuine need of professional attention than a psychologist's clients. In actuality, mental illness is no less real than physical illness. Calling someone "worried" but "well" is an insult to the people who suffer, and it cheats them of the real pain they feel.

Let's be clear. "Worry" doesn't accurately describe my patient population. Their problems, arising from the emotional realm, are no less real than the common cold. For example, imagine what it's like to struggle through feelings of deep grief — to feel nearly incapacitated by a sudden, wrenching loss of someone close to you. And what about the clinically depressed — people who could once live very comfortably in the moment, but who now can barely get out of bed in the morning and no longer enjoy the things that once made them smile? Basic human functions, relationships, and needs become the collateral damage of mental illness. The so-called "worried well" may be gritting their teeth merely to get through each day, not enjoying a minute of it, and falling into bed each night exhausted by the demands of normal living — only to face the same uphill battle the next morning. Why would a physician, trained to recognize and relieve suffering, dismiss or neglect so much quiet desperation?

And even if my patients were fully "well," if their psychological difficulties were invisible to them and to others, condescending to them as merely "worried" would shame them into silence. Many unhappy people have no one to talk to about their problems — no way to express or alleviate their pent-up distress, sadness, panic, or even simple worry. When a professional caregiver assumes a dismissive attitude, he or she bullies people who are hurting inside, forcing them to keep their problems inside where they won't be able to get better.

There's a dollars-and-cents argument for this as well. Common mental illnesses like anxiety and depression cost this country over $200 billion per year, including the costs of related illnesses and lost productivity (1). Depressed people also lose their jobs more frequently during times of economic retrenchment. Studies suggest that providing psychotherapeutic care to depressed workers can reduce these losses, by helping mentally ill workers become more productive (2); in contrast, stigmatizing mental illness with terms like "the worried well" makes it harder for people to get psychological help. Dismissing people who are genuinely suffering, and implying that they'd be fine if they'd simply stop worrying, is a costly error in judgment.

It's time to retire condescending stereotypes like "the worried well." Mental illness doesn't always take forms as dramatic as a broken leg or a harsh cough, but it deserves proper treatment as well as proper respect. In truth, the use of the phrase "worried well" obscures the very real, very serious nature of mental illness — even as it misses something very important about healing and humanity: that the body and mind often get sick, and get well again, together.

REFERENCES:

1. Greenberg, P. E. (2015). The growing economic burden of depression in the U.S. Scientific American, MIND Guest Blog (2/25/16), retrieved July 8, 2016, from http://blogs.scientificamerican.com/mind-guest-blog/the-growing-economic-burden-of-depression-in-the-u-s/.

2. Wang, P.S. et al., (2007). Telephone Screening, Outreach, and Care Management for Depressed Workers and Impact on Clinical and Work Productivity Outcomes: A randomized controlled trial. *JAMA*, *298*(12), 1401-1411. Retrieved August 8, 2016 from http://jama.jamanetwork.com/article.aspx?articleid=208957.

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Pamela Thiel-Paul	BUNDALL/GOLD COAST	0401 205 536	$90	FTF
Monika Wilson	MALENY	0413 962 899	$100 P/P	FTF, PH
David Hamilton	BEENLEIGH	07 3807 7355 or 0430 512 060	Indiv $80, Students $60	FTF/PH/GRP/WEB
SOUTH AUSTRALIA				
Rachael Cassell	TORRENSVILLE	0434 570 992	$80 1 hour : $120 1.5 hours	Face to face
Annie Cornish	HENLEY BEACH	0407 390 677	Upon Enquiry	FTF
Beverley Dales	GOLDEN GROVE	08 8289 0556 / 0413 303 576	$50	Face to Face
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon Enquiry	FTF
Anthony Gray	ATHELSTONE	08 8336 6770/ 0437 817 370	Upon Enquiry	FTF
Deborah Green	BLACKWOOD	0474 262 119	Indiv $75: Groups $45	Face to Face, Grou, Skype
Richard Hughes	WILLUNGA	0409 282 211	Negotiable	Face to Face, Phone, Skype
Adrienne Jeffries	STONYFELL	08 8332 5407	Upon Enquiry	FTF/PH/WEB
Carol Kerrigan	ENGLFIELD	0410 567 479	Upon Enquiry	FTF
Maxine Litchfield	GAWLER WEST	0438 500 307	Upon Enquiry	FTF
Pamela Mitchell	WATERFALL GULLY	0418 835 767	Upon Enquiry	FTF
Carol Moore	OLD REYNELLA	08 8297 5111 bus Or SMS 0419 859 844	Grp $35, Indiv $99	FTF/PH/GRP/WEB
Ellen Turner	HACKHAM WEST	0411 556 593	Upon Enquiry	FTF
Susan Turrell	BLAKEVIEW	0404 066 433	55	Face to face, Group, Skype
Kerry Turvey	TANUNDA	0423 329 823	Upon Enquiry	FTF
Laura Wardleworth	ANGASTON	0417 087 696	Upon Enquiry	FTF
Barry White	PORT ADELAIDE	0488 777 459	Upon Enquiry	Face to Face, Phone

ACA SUPERVISOR COLLEGE LIST		Medium key: FTF: Face to face I PH: Phone I GRP: Group I WEB: Skype		
Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
TASMANANIA				
Pauline Mary Enright	SANDY BAY	0409 191 342	$70 per session: Concession $60	FTF/PH/WEB
David Hayden	HOWRAH NORTH	0417 581 699	Upon Enquiry	FTF
Jane Oakley-Lohm	BLACKSTONE HEIGHTS, LAUNCESTON	0438 681 390	$110 GST inclusive, $80 for new students of one ye	FTF/GRP/PH/WEB
Benjamin Donald Turale	HOBART	0409 777 026	Upon Enquiry	FTF/PH/WEB
VICTORIA				
Joanne Ablett	PHILLIP ISLAND/ MELBOURNE METRO	0417 078 792	$120	FTF/GRP/PH/WEB
Danielle Aitken	SOUTH GIPPSLAND/ MELBOURNE METRO	0409 332 052	Upon Enquiry	FTF/GRP/PH/WEB
Anna Atkin	CHETLENHAM	0403 174 390	Upon Enquiry	FTF
Nyrelle Bade	EAST MELBOURNE/POINT COOK	0402 423 532	Upon Enquiry	FTF/GRP/WEB
Marie Bajada	BALLARAT	0409 954 703	Upon Enquiry	FTF
Rosie Barbara	SYDENHIAM/WYNDHAM	0433 277 771	Ind:$110/Grp:$50 each min of 4 hours	FTF/GRP/PH/WEB
Judith Beaumont	MORNINGTON	0412 925 700	Upon Enquiry	FTF/PH/GRP/WEB
Zohar Berchik	SOUTH YARRA	0425 851 188	Upon Enquiry	FTF
Kathleen (Kathy) Brennan	NARRE WARREN	0417 038 983	$35 Grp, $60 Indiv	FTF/GRP/PH/WEB
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Sheryl Brosnan	CARLTON NORTH/ MELBOURNE	03 8319 0975 Or 0419 884 793	Upon Enquiry	FTF/GRP/PH/WEB
Anne Meredith Brown	COLDSTREAM	0428 221 854	Upon enquiry	Face to Face, Phone, Group
Sandra Brown	FRANKSTON/MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Molly Carlile	INVERLOCH	0419 579 960	Upon Enquiry	FTF
Lynda M Carlyle	EAST MELBOURNE/ SPRINGVALE SOUTH/ RIPPON LEA	0425 728 676	$135 per hour	Face to Face, Phone, Skype
Lehi Cerna	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF,Skype
Sandra Clough	TRARALGON	0412 230 181	Upon Enquiry	Face to Face, Phone,Group, Skype
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Angeline Crossin	ASCOT VALE/ESSENDON	0451 010 750	$100 F/F, $90 Skye,$50 Group, $70 Students	Face to Face, Group, Skype
Debra Darbyshire	BERWICK	0437 735 807	Upon Enquiry	FTF
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
Petra de Kleijn	TATURA	0413 824 073	Upon Enquiry	Face to Face, Phone, Skype
Lisa Derham	CAMBERWELL	0402 759 286	Upon Enquiry	FTF/WEB
Tra-ill Dowie	PORT FAIRY	0439 494 633	Upon Enquiry	FTF

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Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
VICTORIA *CONTINUED*				
Dorothy Dullege	RINGWOOD NORTH	0433 246 848	Upon enquiry	Face to Face, Phone, Group,Skype
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon Enquiry	FTF, Skype, Groupwork
Sara Edwards	DINGLEY	0407 774 663	Upon Enquiry	FTF/WEB
Jenny Anne Field	UPPER FERNTREE GULLY	0404 492 011	On Request	FTF, PH, GRP, SKYP
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon Enquiry	FTF
Matt Glover	CROYDON HILLS, EAST DONCASTER	0478 651 951	Conc $70, Full $90, Group $30/hour	Face to Face, Phone, Group & Skype
Derek Goodlake	SANDRINGHAM	0403 045 800	$110	Face to Face, Phone & Skype
Maurice Grant-Drew	ELWOOD	0412 331 301	Upon Enquiry	FTF
Batul Fatima Gulani	MELBOURNE	0422 851 536	Upon Enquiry	FTF
Gaye Hart	BITTERN	0409 174 128	Upon Enquiry	FTF
Melissa Harte	PAKENHAM/SOUTH YARRA	0407 427 172	$132 to $143	FTF
Sandra Hatton	KEW	0425 722 311	Indiv: $80/hour, Small group $80/2 hours	Individual, face/face, Small group
Belinda Hulstrom	WILLIAMSTOWN	04714 331 457	Upon Enquiry	FTF
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Beverley Kuster	NARRE WARREN	0488 477 566	Upon Enquiry	FTF
Sophie Lea	MORNINGTON PENINSULA	0437 704 611	Individual $100/hour	Face to Face, Phone, Skype
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Marguerite Middling	NORTH BALLARAT	0438 744 217	Upon Enquiry	FTF
Paul Montalto	THORNBURY	0415 315 431	Upon Enquiry	FTF
Stephen O'Kane	BLACKBURN	0433 143 211	To be discussed with client	Face to Face, Group
Bridget Pannell	MELBOURNE	0423 040 718	Call to discuss	Face to Face, Phone, Group, Skype
Rosemary Petschack	DIAMOND CREEK	0407 530 636	80 p/h	Face to Face, Phone
Andrew Reay	MOORABBIN	0433 273 799	Upon Enquiry	FTF
Patricia Reilly	MOUNT MARTHA / GARDENVALE	0401 963 099	Upon Enquiry	FTF
Graeme John Riley	GLADSTONE PARK	03 9338 6271 or 0423 194 985	$85	FTF/WEB
Sandra Robinson	MANSFIELD/BENALLA	0403 175 555	$110 individual 1 hour session. $50 - group per he	Person to person/ Skype
Lynne Rolfe	BERWICK	03 9768 9902	Upon Enquiry	FTF
Paola Gina Salvagno	DONCASTER; TEMPLESTONE; BALWYN	(03) 9812 7520; 0430 157 857	$120 p/h $100 - students enroled in counseling	FTF, PH, WEB
Claire Sargent	CANTERBURY	0409 438 514	Upon Enquiry	FTF
Karen Seinor	WODONGA	0409 777 116	Upon Enquiry	FTF
Gabrielle Skelsey	ELSTERNWICK	03 9018 9356	Upon Enquiry	FTF/PH/WEB
Gayle Stapleton	BERWICK	0459 075 284	100 p/h Negotiable	FTF/PH/GRP/WEB
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon Enquiry	FTF
Tabitha Veness	Ferntree Gully	0400 924 891	Upon Enquiry	FTF

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Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
VICTORIA *CONTINUED*				
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Helen Wayland	ST KILDA	0412 443 899	$75 Indiv	FTF/PH/GRP/WEB
Jo-Ellen White	BLACKBURN SOUTH	0414 487 509	$100 ind/$50 Grp/Stu $80	FTF/PH/GRP/WEB
Brian Whiter	CARLTON, MOORABBIN	0411 308 078	$100	FTF
Natalie Wild	BORONIA	0415 544 325	Upon Enquiry	FTF
Cas Willow	WILLIAMSTOWN	03 9397 0010/0428 655 270	Upon Enquiry	FTF/PH/WEB/GRP
Rosslyn Wilson	KNOXFIELD	03 9763 0772/03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Jacquie Wise	ALBERT PARK	03 9690 8159/0439 969 081	By Negotiation	FTF/PH/GRP/WEB
Michelle Wood	MANSFIELD	0497 037 436	Upon Enquiry	FTF/PH/GRP/WEB
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260/03 9786 8006	Upon Enquiry	FTF
Joan Wray	(MOBILE SERVICE)	0418 574 098	Upon Enquiry	FTF
Deborah Cameron	BRIGHTON	0447 262 130	Upon Enquiry	FTF/GRP/WEB
Graham Hocking	PARK ORCHARDS	0419 572 023	Upon Enquiry	FTF
John Dunn	COLAC SW/MT GAMBIER	03 5232 2918	By Negotiation	FTF/GRP/WEB
WEST AUSTRALIA				
Genevieve Armson	CARLISLE	0412 292 999	Upon Enquiry	FTF, GRP, PH, WEB
Sharon Vivian Blake	FREMANTLE	0424 951 670	Indiv $100, Grp $60	FTF/PH/GRP/WEB
Marie-Josee Boulianne	BEACONSFIELD	0407 315 240	Upon Enquiry	FTF
Lynette Cannon	CAREY PARK	0429 876 525	Upon Enquiry	FTF
Karen Heather Civello	BRIDGETOWN	0419 493 649	Upon Enquiry	FTF
Cindy Cranswick	FREMANTLE	0408 656 300	Upon Enquiry	FTF
John Dallimore	FREMANTLE	0437 087 119	Upon Enquiry	FREMANTLE
Ligia Emmel Barnett	GERALDTON	0419 954 984	$80.00	Face to Face, Phone
David Fisk	NORTH LAKE	0412 781 865	$100 (neg) upon enquiry	F/F, Group, Skype
Alan Furlong	WINTHROP	0457 324 464	Upon enquiry	FTF
Julie Hall	YANCHEP/BUTLER/ JINDALEE/JOONDALUP	0416 898 034	$100	FTF/PH/WEB
Merrilyn Hughes	CANNING VALE	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB
Eva Lenz	SOUTH FREMANTLE /COOGEE	08 9418 1439/ 0409 405 585	$85, concession $65	FTF/PH/GRP/WEB
Allison Lord	CLARKSON	0403 357 656	Upon Enquiry	F/F, Phone, Group
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
Trudy McKenna	NEDLANDS	0438 551 210	Indiv $120/Grp $50/ Conc. $30	FTF/PH/GRP/WEB
Fiona McKenzie	GERALDTON	0427 928 505	Upon Enquiry	FTF
Carolyn Midwood	DUNCRAIG	08 9448 3210	Indiv $110, Grp $55	FTF/GRO/PH/WEB
Dr. Patricia Sherwood	PERTH/BUNBURY	0417 977 085/ 08 9731 5022	$120	FTF/PH/WEB
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
Jenna Trainor	BEDFORD	0431 817 807	Upon Enquiry	FTF, PH, GRP, SKP
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
Lillian Wolfinger	YOKINE	08 9345 0387/ 0401 555 140	Upon Enquiry	FTF/PH/WEB

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Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
INTERNATIONAL				
Frank King Wai Leung	HONG KONG	+852 3762 2255	Upon Enquiry	FTF
Deborah Cameron	HONG KONG	+65 9186 8952 Or 0447 262 130	Upon Enquiry	FTF/GRP/WEB
Yat Chor Wun	HONG KONG	+852 264 35347	Upon Enquiry	FTF
Barbara Whitehead	HONG KONG	+852 2813 4540	Upon Enquiry	FTF
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
Eugnice Yiu Sum Chiu	HONG KONG	+852 2116 3733	Upon Enquiry	FTF
Cary Hung	HONG KONG	+852 2176 1451	Upon Enquiry	FTF
Wing Wah Hui	HONG KONG	+852 6028 5833	Upon Enquiry	FTF
Giovanni Ka Wong Lam	HONG KONG	+852 9200 0075	Upon Enquiry	FTF
Su Keng Gan	SINGAPORE	+65 6289 6679	Upon Enquiry	FTF
David Kan Kum Fatt	SINGAPORE	+65 9770 3568	Upon Enquiry	FTF
Saik Hoong Tham	SINGAPORE	+65 8567 0508	Upon Enquiry	FTF
Jeffrey Gim Tee Po	SINGAPORE	+65 9618 8153	$100.00	FTF/GRP/PH/WEB
Eugene Chong	SINGAPORE	+65 6397 1547	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)

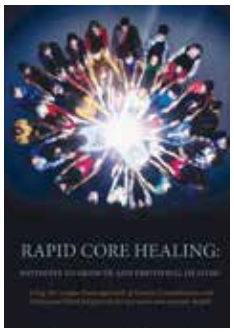
- Articles are to be submitted in MS Word format via email.
- Articles are to be single-spaced and with minimal formatting.
- Articles must be submitted with a covering page requesting a peer review.
- Attach a separate page noting your name experience, qualifications and contact details.
- The body 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.



Rapid Core Healing: Pathways to growth and emotional healing by Sethi Yildiz

Reviewed by Judith R Boyland

Introducing a dual approach to what the author describes as Rapid Core Healing (RCH), *Rapid Core Healing: Pathways to growth and emotional healing* defines and discusses a unique therapeutic modality using Family Constellations and Emotional Mind Integration (EMI) for discovering healing pathways to personal and systemic health. The approach is brief, solution focussed and experiential. It may be used to support a client in dealing with a wide range of issues and may take place in hypnotic trance or in general counselling.

Reviewing the powerful alliance between past and present knowledge and the theory and philosophy underpinning Family Constellations, it is suggested that RCH therapists have an integrated knowledge of systemic loyalties, dynamics and entanglement and the innate resources that human beings have in being able to find their own unique solutions. The author states that the RCH approach could become central to working with trauma and mental-health issues and a variety of Family Constellations and Emotional Mind Integration solutions are discussed. Referenced case studies focus on issues relating to depression, separation, weight management, shame, anger, carrying burdens, blame, phobias, fears, general anxiety, living with the trauma of violence, erectile dysfunction, addiction, parenting and personal development.

The author defines the purpose of *Rapid Core Healing: Pathways to growth and emotional healing* in terms of informing those in the helping professions about the nature of disturbances and dysfunctions and what is required for recovery

In the words of the author, "It's never too late to heal from the past and grow into the present with acceptance and love". *Rapid Core Healing: Pathways to growth and emotional healing* is considered by the reviewer to be an excellent read and a valuable resource in introducing the clinician to the modalities of Family Constellations and Emotional Mind Integration.

Available at: http://yildizsethi.com

Gain Entry Into An ACA Professional College

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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.

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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

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- 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.

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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