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Addiction
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Why do we do what we do?
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A qualitative study of motivation to quit of prisoners with gambling problem in Australia

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Standards for ACA Registered Counsellors

By Philip Armstrong FACA

A common question I am asked at ACA is what standards does ACA apply when defining practice standards for ACA members. The following sets out the nine standards as defined in the ACA Scope of Practice.

These nine standards have been developed to define how ACA registered counsellors undertake their practice. These standards reflect the various settings a registered counsellor may operate in, from an individual counselling practitioner to a mental health services/programs.

Standard 1

Registered counsellors have the appropriate qualifications, knowledge, and skills to operate within the prescribed roles defined in the Scope.

Rational - A registered counsellor has the qualifications, knowledge, and skills appropriate to their level of attainment.

Practice Outcomes - A registered counsellor is recognised as having the required proficiency to provide therapeutic interventions to consumers with a wide range of complex mental health issues in line with this scope.

Standard 2

All registered counsellors are encouraged to access appropriate Ongoing Professional Development (OPD) opportunities and supervision.

Rational - ACA recommends that: post qualification, counsellors will undertake the required activities each year that contribute to their professional development. The professional development will be documented with the counsellor's supervisor.

Practice Outcomes -Ongoing Professional Development can take a variety of forms. Counsellors will be able to discuss with their supervisor the need for appropriate further training (e.g. in specialist areas of counselling). OPD will be appropriate to the registered counsellor's requirements and available on a pro rata basis.

Standard 3

A registered counsellor must identify time for supervision.

Rational - Counselling supervision is concerned with monitoring, developing and supporting individuals in their counselling role to ensure that the needs of the consumer are being addressed. Supervision is different from personal therapy or in-line management.

Practice Outcomes - A supervisor for a registered counsellor will have the knowledge base, experience, and skills to support the registered counsellor in their specialist field of practice.

Standard 4

Supervision should be delivered by an ACA accredited supervisor with an understanding of the registered counsellor's therapeutic practice. Evidence of supervision should be kept.

Rational – The supervision of a registered counsellor is a formalized relationship between a counsellor and their supervisor(s). Where appropriate, the supervisor will have professional experience and a knowledge base that equips the supervisor to work in the counsellor's specialist field.

Practice Outcomes - Supervisors, will have a formal contract with; and accountability to, the registered counsellor. Additionally, there shall be clear procedures in place between the supervisor and the registered counsellor, should consumers be at risk.

Standard 5

Services or programs that utilise registered counsellors are to provide both an identified operational line manager and access to professional support. Counsellors are to operate within the ACA code of ethics and are accountable for their clinical practice including confidentiality.

Rational - Registered counsellors within mental health programs/services must have an operational line manager who is responsible for the counsellor's usual line management functions.

Practice Outcomes - Line management procedures for engage registered counsellors shall be consistent with those of other professional staff within mental health programs/services.

A counsellor operating within a programs/service will have a line manager who can facilitate professional links with other allied health professionals for all registered counsellors.

These standards reflect the various settings a registered counsellor may operate in, from an individual counselling practitioner to a mental health services/programs.

Standard 6

The Scope defines a structured professional development and career progression for registered counsellors. Rational - Registered counsellors have a recognised career path in line with the levels of registration as outlined by Scope.

Practice Outcomes - Counsellors can identify a clear career path in line with the levels of registration within their chosen field of specialty.

Standard 7

A registered counsellor can maintain consumer records with associated access privileges, in accordance with the program/service setting. Consumer records maintenance and privileges will be similar to other allied health professionals.

Rational - Regardless of the source of referral (including self-referral), all registered counsellors will record an assessment that notes;

a) a presenting problem,
b) confirms the appropriateness of counselling,
c) ensures the consumer has been appraised of any appropriate alternatives,
d) confirms the consumer's agreement to counselling, and
e) records the anticipated health outcomes including anticipated benefits to the consumer's well-being.

Practice Outcomes - A registered counsellor has the relevant access to relevant consumer records and the ability to meet the standards for record keeping.

Standard 8

Registered counsellors employed in a program/service are to have a structured and standardised approach to placements, including clear accountabilities.

Rational - Employers are to provide structure and standardise placements for registered counsellors within the mental health programs and services.

Practice Outcomes - To standardise responsibilities and accountabilities for counsellors placed within programs/ services.

Standard 9

Registered counsellors will provide consistent information about counselling competencies defined under the ACA 2016 Scope.

Rational - All consumers can expect to receive a similar standard of service, regardless of the setting and the area in which they live.

Practice Outcomes - Consumers have access to consistent information about services standards provided by registered counsellors.

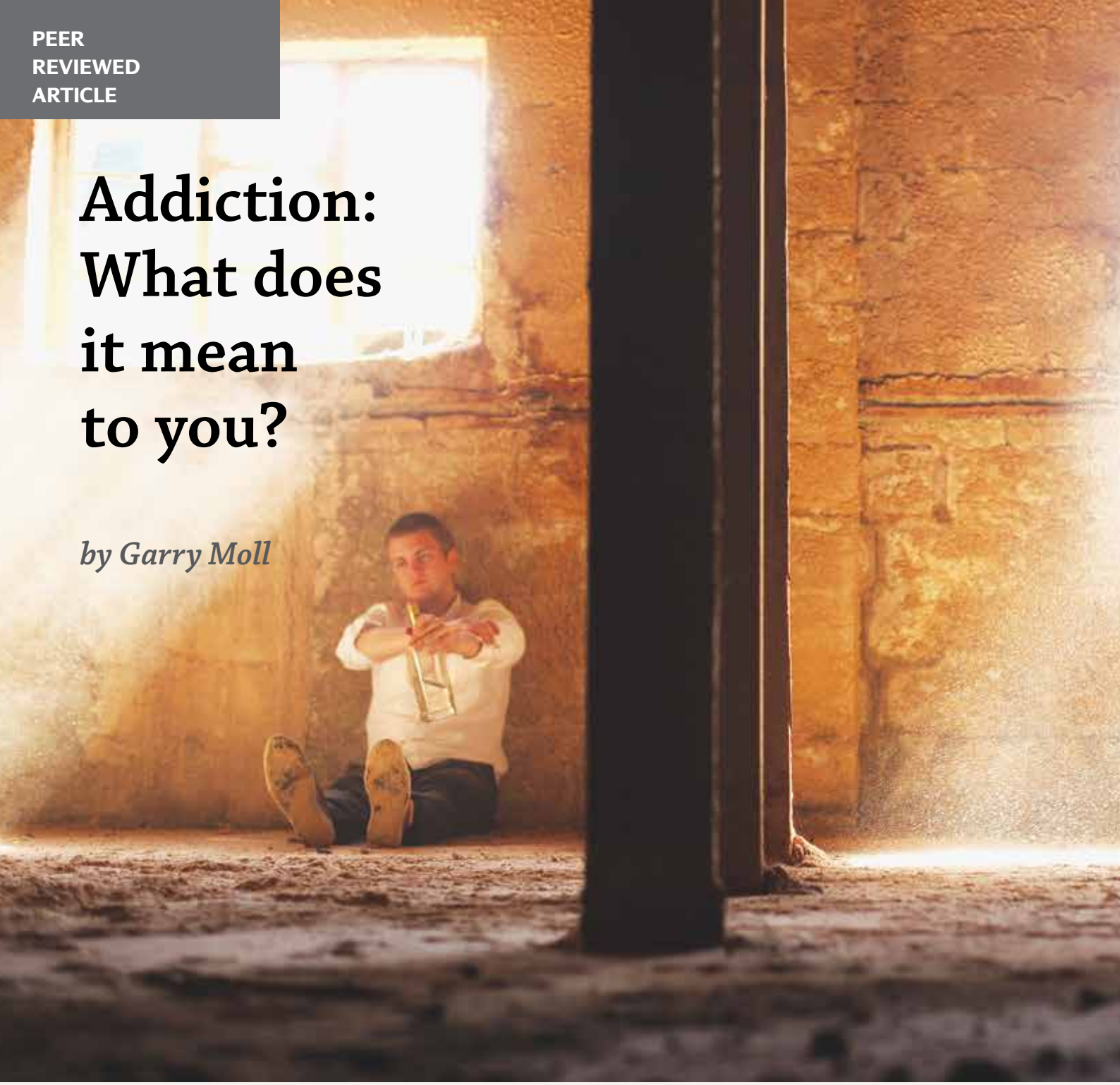
Until next time

Philip Armstrong FACA
CEO ACA Inc

PEER REVIEWED ARTICLE

Addiction: What does it mean to you?

by Garry Moll



Abstract

For many people the concept of addiction involves taking of drugs (Griffiths, M. (2005) cites Rachlin, (1990) and Walker, (1989)); thus most frequently, addiction discussions relate to drug addicts. We all are vulnerable to an addiction of some type overwhelming our heretofore inner emotional and wellbeing strengths.

Koob & Le Moal (1997), consistent with many other authorities, tell that addiction presents as a cycle of spiralling dysregulation of brain reward systems that progressively increases, resulting in compulsive use and a loss of control over the drug-taking. All addictions, to whatever essence, can be influenced by similar brain reward functions in a biopsychosocial effect on the person (Engel (1977)).

Addiction is a creeping social issue such that alcohol or other drugs are not necessarily the first essence of addiction for most people. Life conditions of 'predisposition, precipitation and perpetuation' can lead one to addiction. There is some societal expectation that being "Addicted" has connotations of a deleterious eventuation for the addict (Griffiths, (op.cit.)). Communities provide diverse help services for addicts. Whether or not a person can recover from their addiction is an issue for society as much as for them and their interpersonal relationships.

Introduction

Leshner (1997), as a director of National Institute of Drug Addiction (NIDA) in USA, tells us that 20 years of data affirms addiction as a "chronic medical brain disease". It continues today that we discover different ways for a person's behaviour to become addictive; ultimately, all addictions could become regarded as disease. The addicted person develops a dependence on the essence of their addiction. They can be physically or mentally addicted, or both concurrently. Clark (2016) discusses people with addiction, as being so intensely focussed on their addictive essence that it alters their life. Regardless of how one tries to not engage with that essence, predisposed

persons are always vulnerable to relapse. Overcoming any addiction is difficult as the human brain works to maintain a rewarded and gratified ego. McLellan et.al. (2000) inform that in order to overcome addiction an addict needs support of good family and friends. For drug addicts there are some help methods available; how to administer and deliver them, is a burning question politically and in general society (Cone (2012)). Societies' efforts are not equal for all cultures and within all communities, not all addicts get the same attention. Globally there are differing attitudes to addiction, particularly drug addiction. Some States or Countries utilise reward encouragement to desist the addiction others believe in and apply penalty to the addicted client. Kellogg et.al. (2005) discuss the methodology and terminology used by the diverse professionals who dedicate their lives to helping addicts recover. Help methods include mental awareness, physical adjustment medicine, and talk therapy counselling.

This paper will discuss addictions' diversity and the consequent inter-related issues confronting modern society, including possibility of recovery.

Discussion

How does addiction start?

Any behaviour or emotional sensation that personally effects to initiate release of the brain feel good chemical dopamine, may result in the person becoming addicted to the essence of that sensation. Personal addiction can start from a behaviour that for other people is simple human activity (Griffiths (op.cit.)); for example, a fitness exercise regime or, medication to reduce unbearable pain. Unable to resist belief that good feelings will repeat, the pre-addict person wants more (Erickson, C.K. (2007)). The essence of good feelings becomes something that can't be lived without; addiction can evolve in anticipation of the dopamine reward in the brain.

Are all addictions the same?

Is addiction to shopping or golf, betting on the races, the same as being hooked on drugs or alcohol? It is known that these things can affect your brain in many of the same ways; but experts don't yet agree about how far those similarities go ((Volkow et.al. (2004), (Satel & Lilienfeld (2013)). All addicts have same type of experiences. However, alcohol and drugs give more immediate reactions for dopamine (Volkow et.al. (op.cit.)) than shopping, or horse races, or poker machine gambling. Griffiths (op.cit.) has argued that many of the excessive behaviours which become addictions "seem to have many commonalties". Medical science is increasingly aware that addictive essence ingested to the human body can become very harmful to the person's brain, killing off brain cells (NIDA: 2003). It is not yet known that lifestyle behaviours like shopping or gambling can have such deadly impact on the brain.

Erickson C K (op.cit.) gives a concept of behaviour turning from being impulsive to compulsive to ultimately becoming a dependency. Nevertheless, addiction is not the same as Obsessive Compulsive Disorder (OCD); National Institute of Mental Health (NIMH) USA (2015) informs that OCD becomes an issue when the affected person "performs their rituals even though it interferes with their daily life and they find the repetition distressing". Whereas for the addict, performing the addiction is indicated as rewarding behaviour. Addiction with intrinsic resilient motivating features holds the addict from both sides of psychological reinforcement potential; addiction can be reinforced both positively and negatively (Griffiths (op.cit.)). Addiction is "a chronic relapsing disorder" (Griffiths (op.cit.)): Addicts use or do the essence of addiction for Positive reinforcement; if they stop using or doing the essence they get psychological negative reinforcement until they relapse and use or do again (Koob, G.F. & Buck, C.L. et.al. (2014)).

Psychosocial behaviour can initiate addiction when a person aims to impress their peers (Griffiths (op.cit.)). Whatever the behaviour activity one can become addicted under the influence of the adrenalin rush and dopamine derived sensation of excitement, together with satisfying the peer pressure. This outcome can occur in many socially driven actions.

Shanmugam (2015) references Ong (1989) when discussing the multifactorial complex of pharmacology, environment, social, genetic and psychology elements that, separately or variously combined, affect a person. Differing idiosyncratic impacts may result in some persons becoming addicted more quickly than others. Some people make it their business to initiate then provide ongoing thrills and excitement that another person craves; such as drug dealers. Parents of adolescents may see the influencing party simply as undesirable friend of their children, unfortunately such a 'friend' can become toxic. →

All people can be addicted to something.

Engel (op.cit.) identified the combined influence of biological and psychosocial states, discussed as biopsychosocial affect. Biopsychosocial affect occurs when the person's family cultural status is latterly affected by extrinsic social interactions. Engel (ibid.) discusses this condition to originate in the genetic cultural makeup of the addict. Familial biological predisposition combines with the living environment wherein the psychosocial elements contribute precipitating conditions. Living in a precipitating environment perpetuates the thought and behaviour processes occurring, resulting in addiction materialising and perpetuating (NIDA, (2003) McHugh, R.K., et.al. (2010)).

Another interpersonal precipitator to addiction can be as a consequence of a patient's interaction with medical and social services professionals; personal use of prescribed medications is not always astutely monitored by the primary carers or care givers (Engel, G.L., (op.cit.) Volkow, N.D. & McLellan, A.T. (2016)).

Alcohol and other drugs addicted person's lives are always inclusive of guilt, shame, and blame, including bad interpersonal relationships (NIDA: 2003). This condition may trigger otherwise restrained latent inappropriate or bad thoughts that progress to influence their behaviour as cognitive functions degrade (McHugh, et.al. (2010)).

Persons addicted to one form of sensation can be inclined to seek similar sensations elsewhere (Peele, S. (1985)). Every person is vulnerable to becoming engrossed by fulfilling pleasures of a single behaviour activity; after which autonomic vulnerability can lead to addiction. Published in Henningfield et.al. (Ed's), Peele, S. (2007.) argues that addiction is an outcome of environmental biopsychosocial conditions which initiate then perpetuate due to the individual's inherent predisposition.

Sabo, D.F. et.al. (2004) cite Johnston, O'Malley & Bachman. (2002) reporting that "one in three female college students have binge drunk in the past two weeks" in American student ages through eighth grade to twelfth grade; and predominantly amongst sporting team members. Volkow & McLellan, (op.cit.) discuss the increased risk for adolescents due to delicate cerebral neuroplasticity and, the immature prefrontal cortex. Satel & Lilienfeld (op. cit.) tell that addicts in early addiction stages are torn between the reasons to be addicted and reasons to not be addicted.

Alcohol or drug addiction related activities are regularly identifiable but, not always so the activities by people addicted to socially acceptable behaviours and personal beliefs. Gym junkies, sports or gambling addicts, can all become uncaring for their family and friends, if required to choose between their addiction and other people. Workaholics are seen to be increasingly prominent in ranks of addicts in the contemporary technological era, (Osterweil, N. (n.d.)).

What addiction does to a person

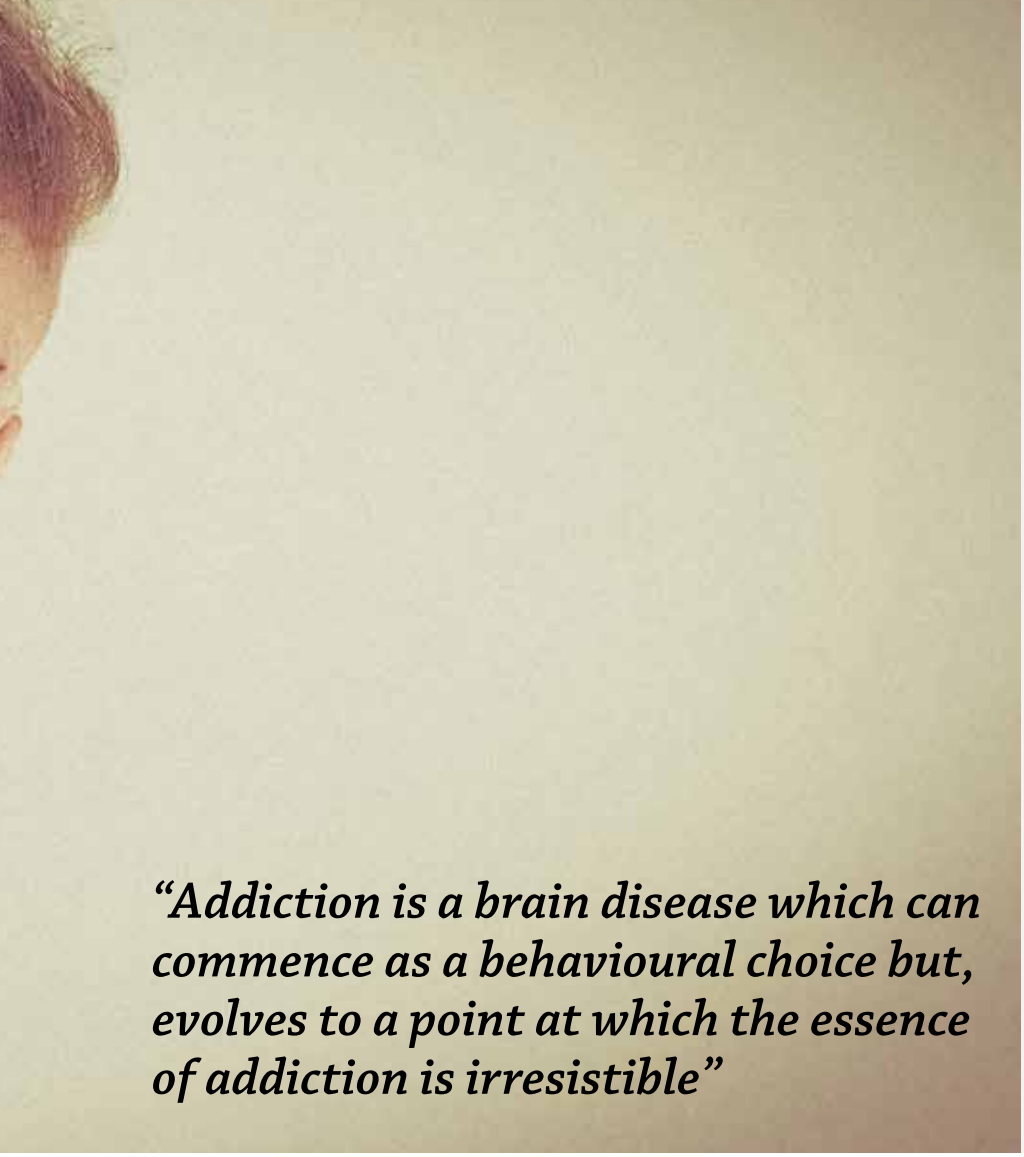
The addiction plants in the addict's brain, latently ready to manifest for purpose of dopaminergic positive rewarding or, response to negative reinforcement condition (Griffiths (op.cit.)).

American Psychiatry Association (APA) (2013) proposed that addiction damages spirituality; addicts lose their personal and moral values, self-esteem and morale are ultimately degraded by addiction. The brain is changed with dopamine bursts that initially displace the original psychological self of the addict (NIH. NIDA. (2011). When hooked on the dopamine burst addicts live with desire to increasingly get the euphoric affect; positive reinforcement is found. By smoking or drinking the essence of addiction, the drug effect goes more directly to the brain providing more immediate euphoria (NIDA (op.cit) Volkow & McLellan (op.cit.)).

Addiction is a brain disease which can commence as a behavioural choice but, evolves to a point at which the essence of addiction is irresistible (Erickson, C.K. (2009)). However, after Sabo et.al. (op. cit.) we may find argument that there can be peer pressure amongst adolescents, contingent upon their related psychosocial environment. When biopsycho element is involved there is increased certainty that a college teenager will become addicted to alcohol (Peele (2007)).

Maybe it is possible to foretell of addiction

Various synthetic drugs, and many natural elements, will modify brain chemistry



"Addiction is a brain disease which can commence as a behavioural choice but, evolves to a point at which the essence of addiction is irresistible"

strongly to induce the dopaminergic condition (Erickson, C.K. (op.cit.)). Alcohol, marijuana, many prescription medicines such as Valium, relieve the depression causing cytokines in brain cells (Parry, P. 2015). The user wants continuing relief so they use more of the drug type. Some drug user addicts start by using 'something' for their purpose of staying awake and active longer than normal; maybe to impress their 'friends' with social participation behaviour, and 'compliance' in a psychosocial way ((Parry op.cit.)). Dopaminergic adaptation can evolve after sufficient time of drug or medication use (Erickson, C.K. (op.cit.)).

As much as there are drugs and alcohols that damage brain functions, there are many foods that can damage brain cells to cause a person's self to feel bad. Parry (op.cit.) and Haas & Levin, (2006) tell that there are food elements which can be as damaging as regular drug elements that are often discussed; food becomes addictive in itself. Consumers ingesting too much Omega-6 can cause significant detriment to personal happiness and contentment (Brain (2000). Omega-6 triggers build-up of toxins, cytokines, within the brain cells causing inflammation; inflammation of brain cells is associated with human emotional depression (Parry (op.cit.) Brain (op.cit.) Haas (op.cit.)). Parry (op. cit.) collaborated with The Australian Counselling Association (ACA) to make submission on obesity to the National Mental Health Commission in 2014; citing addiction to food as a major cause of obesity. In the same report the ACA discusses the positive link between obesity and psychological disorders (Counselling Australia: V.14 (3)); particularly depression, often fostering excessive use of alcohol and smoking. Koob & Le Moal (op.cit.) discuss how a poor diet causes homeostasis disequilibrium which progresses to become a damaging state "the system is at the limit of its capability, and thus a small challenge can lead to breakdown. This is the beginning of spiralling distress and the addiction cycle."

Active addicts have "selfish" needs:

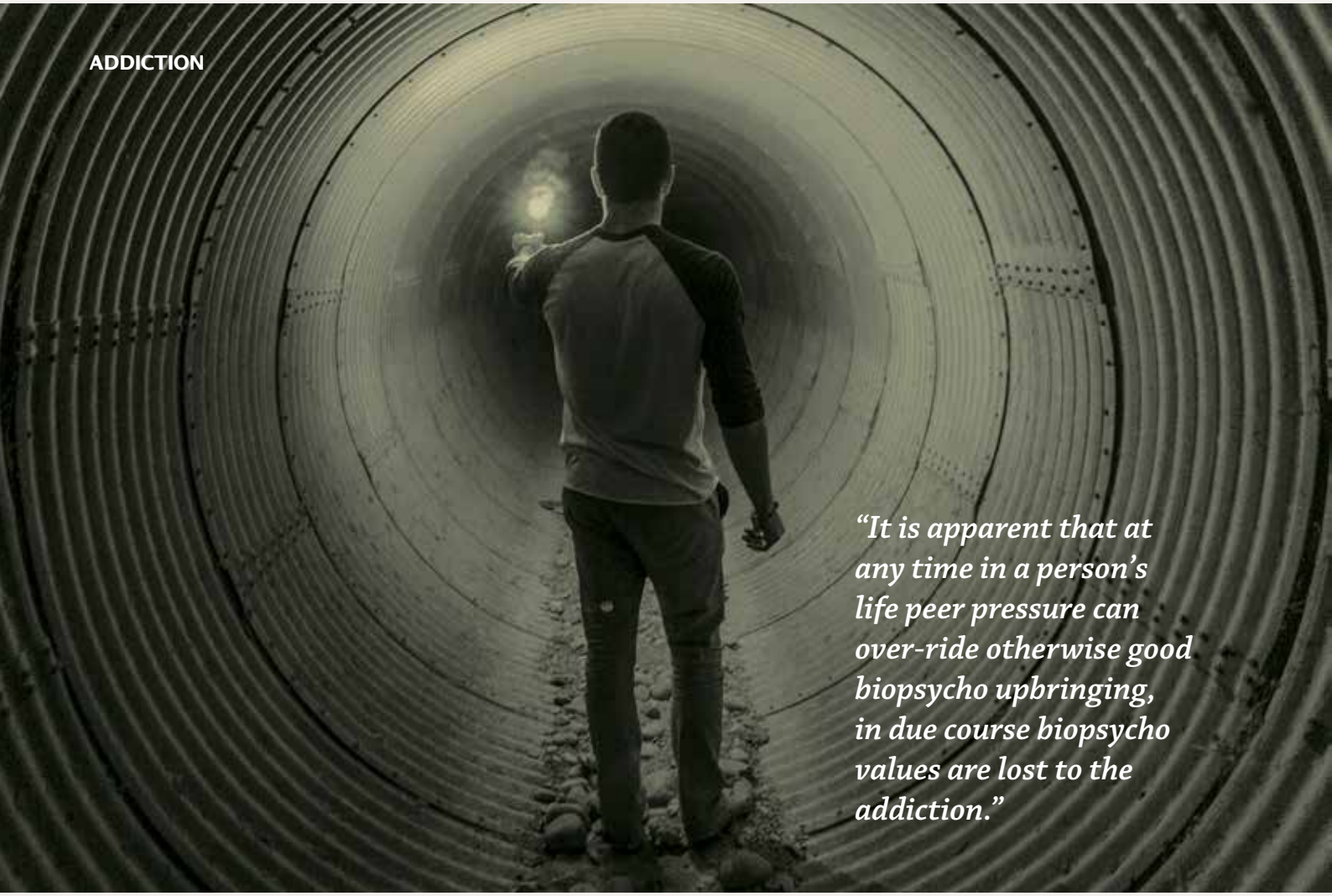
The early stage addict's life schema is negatively impacted as they adapt, to 'fit in', and assimilate with their social cohort (Sabo et.al. (2004)). At this time a person might be found to be vulnerable to engaging in an addiction learning process, and so a form of psychological adaptation; not in the positive behavioural way as Piaget (Atherton (2013)) described but, in an adverse adaptation. It is apparent that at any time in a person's life peer pressure can over-ride otherwise good biopsycho upbringing, in due course biopsycho values are lost to the addiction. Addiction will inevitably displace one's spirit for general life; the APA (2013) says that the individual becomes so engorged by addiction that they become spiritually bankrupt.

The biopsychosocial model confirms that we all are vulnerable. Everybody wants to be a part of society, to fit in; ego wants friends and to be liked by other people. A person needs to evolve through life's development processes as Mazlow reported in the 1950s era and is discussed by (McLeod (2014)); as well as learning to live within their societal environment as Piaget (Atherton (op.cit.)) theorised with evidence of the human capabilities of adaptation.

Parry (op.cit) infers that there are times when 'selfish' parts of our brain subjugate normal brain function and involuntary behaviour occurs. The 'selfish' brain accumulates change of behaviour and emotion over 'normal' brain function, therefrom, brain neural plasticity can result in displacement of good behaviours and emotions. 'Selfish' brain eventually makes a previously authentically good ego, maladaptively feel good; brain chemical imbalance is occurring (Erickson, C.K. (2009)). Positive reinforcement essence is subjugating previously well balanced life; addiction is evolving: The addict becomes selfish in demand of their addictive essence (Parry (op.cit.)). For an addict Piaget's adaptation displaces all of what Mazlow's familial tender caring and wellbeing had fostered into the person.

Damage done and losses of an addict

Wiens (2014) cites Leshner (2000) who discussed the matter of intense brain degradation when he wrote that methamphetamine ingestion augments apoptosis. Leshner emphasised that drug addiction causes brain conditioning to evolve to the point where apoptosis becomes malfunctional. Thereafter, apoptosis acts variably non-selectively →



and, can remove healthy brain cells. Thus illicit and overuse of drugs can cause users to become severely disabled. Heroin self-administration by inhalation has rendered some people near comatose with large brain lesions (Leshner 2000; NIDA Notes, Director's Column, 15 (4) Sept 2000), a permanently damaged brain becomes a dysfunctional human. Fowler, et. al. (2007) are cited in NIDA to discuss severe physical cerebral degradation caused by overuse of drugs, in particular for adolescents and young adults. Smoking and drinking provide more instantaneous uptake and drug dopaminergic impact in the user's brain, with "fast and high increase in dopamine" thus damaging the apoptosis process (Volkow et.al. (2004)). Volkow wrote that addicts using methamphetamine are vulnerable to ongoing brain inflammation damage (Volkow (2001)).

Landau & Garrett (2008), cite Nestler (2001) who discussed the damage that illicit drugs cause to a user's brain, particularly the pre-frontal cortex of frontal lobe. The executive function areas of immediacy, daily decision making, and general self-awareness are impacted severely. A drug user loses their inhibitions; they may do quite unusual things because their brain decision making malfunctions. Hyman (1994) tells of the loss of ability for a drug user to learn from their personal experiences due to diminished frontal lobe function. User's life becomes disorganised, they become bored, short tempered and argumentative. Younger aged drug users suffer more damaging effect to their brain due to enhanced cerebral neuroplasticity of the adolescent brain (Volkow & McLellan (op. cit.)).

The Costs of Addiction

There is societal evidence within most if not all communities of the price meted by addiction. The personal cost starts early in the time of addiction life, the cost impact on family and friends accumulates with the increasing duration of the addiction. Thus, the cost impact on the addict's community accumulates whilst addicted (Garrett (2012)). The price to break the addiction is another matter altogether. Under most circumstance an addict is not capable within them self to realise that they need some help. Consistent therewith, they reject the help proposed by loved ones, family and friends. Their salient addictive activity dominates life and their thinking (Griffiths, M. (2005)).

Garrett (op.cit.) informs how addicts' behaviours change detrimentally for themselves and society. Landau & Garrett (2008) confirm that addiction captures the addict's entire family as well as their social contacts and any other interpersonal relationships. The addict loses Society and flow on benefits of socialising within their community. Many addicts have abandoned family and friends and/or been abandoned by family and friends as they become physically demanding or threatening to other people, whether strangers or even fellow drug addicts. Leshner (op.cit.) Fowler et.al. (2007) discuss the socially unacceptable behaviour that can evolve for an addict, some resulting in fatal events.

The addict loses who and what they were in their community, their community loses the person. The person who is a drug addict can be so disconnected from reality, by the drugs they are using, that they are not capable of acknowledging any detriment or harm caused, to other persons or their community (Leshner (op. cit.) Fowler et.al. (op.cit.)). Of the physical trauma inflicted by addicts; Hyman (op. cit.) tells that quite often the addict does

not know or realise what they are doing at the time.

NIDA (2003) makes recommendations for schools to encourage students as they progress through formative years' ages to be helped with increased understanding of how their brain works. NIDA predicts positive outcomes from showing images and even models of drug damaged human brain and other organs. The reality of the condition is generally obscured from broad public observation. The study "Imaging the Addicted Human Brain" is explicit of drug addiction cerebral damage (Fowler et.al. (2007)); people must understand the fragility of their brain and drugs addiction impact on it.

Fan (2014) researched and reported the issue of gambling addicts and a range of treatment protocols in Australia. From Fan's work we read that gambling is a most broadly engaged addiction across many communities. Variable interval reinforcement together with issues of personal esteem and social interactivities often cause gambling persistence (Larimer, et. al. (2013)). The Australian Productivity Commission in 2010 estimated the cost of problem gambling at $4.7 billion in Australia at that time. Further, Fan reported a study, using NSW prisons as the population group, he found that 35% of women and 49% of men inmates had a recordable level gambling problem. Subsequently Fan found that 20% of women and 34% of men were in prison due in part to their gambling problems; the related matters included aggressive outburst behaviours, house breaking and entering as well as physical harm of other people, in the various ways that addicts use in pursuit of the money they need to gamble, or pay debts (Fan, (2014)).

Recovery

As attested to by the millions in recovery, this brain disease can be arrested and overcome. Recovery is real and is enjoyed by people with addiction, every day (Erickson, C.K. (2009)).

Identifying that a problem exists is the first step in helping to break the addict's addiction. Peele (1985) says that in order to properly treat the addict, we must recognise all interacting elements of their present lifestyle as well as their lifestyle history. The influencers include pharmacology, experiential, cultural, situational, and personality elements. Then we may be able to at least define the addict's motivation to addiction. And so by using CBT and talk therapy counselling there may be uncovered an appropriate alternative motivation to allow the addict's mind set to change, and a state of recovery to commence (Larimer, et.al. (2012), McHugh, et. al. (2010))

Many proposals for rehabilitation support, indicate an improved post addiction lifestyle for the participant (Ong, T H (1989)). There can be many options for an addict to be helped to break their addiction. Kellogg et. al. (2005) discusses drug addict treatment programmes in New York USA where the client is 'rewarded' with positive lifestyle help: For example, vocational training and gaining employment. Encouraging the addict to take up other socially acceptable virtuous activity, for example sport, a hobby, volunteering, can all offset a person's social needs and help to provide a mix of fulfilling activities, which give psychosocial contentment that diverts a person from ever becoming addicted, or, to break the progress of a bad addiction (Engel, (1977)). A good outcome is dependent on motivation; most people want to be the best person they can be by living in a manner which is →

acceptable to society in general (Kellogg et.al. (op.cit.)), addictions interfere with those natural human wants. The brain ultimately provides for management of the human body as necessary to satisfy the addict's want; good relationships to allow a contented brain mindset, divergent from the addiction essence, are basic to recovery. Satel & Lilienfeld (op.cit.) have argued that an addict can use medications to offset some addictions, but, physical and extrinsic emotional "support from family and friends to vault into sustained recovery" will ever be essential.

Nevertheless, there is much data showing how methadone treatment is accepted by heroin addicts: However, Cone (2011), reported by Satel & Lilienfeld, discusses that "half of the patients in methadone clinics were recorded to be still using heroin, cocaine and other opioid whilst participating in the methadone clinic". So it is confusing for scientists as they argue that there is no regular medicine to fix addiction in the same way as there is medicine to fix, for example, pneumonia. Leshner (op.cit.) discusses recognition that addiction is a disease of the brain but, then laments that there is no real answer for how to control the availability of illicit drugs; the essence of most addiction disease.

Satel & Lilienfeld (op.cit.) tell us that "addiction is a behaviour marked by repeated use despite destructive consequences, and, by difficulty quitting notwithstanding the user's resolution to do so." The daily work for an addict trying to recover requires an intense human approach from many people as helpers.

"Addictionis a behaviour marked by repeated use despite destructive consequences, and, by difficulty quitting notwithstanding the user's resolution to do so."

Landau & Garrett (op.cit.) tell of the importance to discourage children from using alcohol at an early age, and to be certain of using medications only as prescribed by a medical Doctor.

Managing the craving is one of the most difficult stages of user recovery; at such a time, family and friends' support is essential (McLellan, et. al (op.cit.)). Support helpers must endeavour to busily engage an addict at times when they are vulnerable to relapse and reusing. National Institute on Alcohol Abuse and Alcoholism (2001) discusses cognitive impairment from alcoholism. Alcohol and other drugs addicts will always cause themselves reduced mental capacity to think clearly for their personal behaviour (Garrett, F.P. (op.cit.). Such a state of mental health degradation causes reduced insight and motivation to stop using whatever is their addiction; Landau and Garrett (op.cit.) tell us quite clearly that the "denial of being addicted prevails". As McLellan et.al (op.cit) have discussed, some alcoholics believe they need to drink to stay alive: Helpers must replace that need for activity of drinking to start them on the track of recovery. Landau & Garret (op.cit.) make strong indication that the addict's life changes must include new physical functions in order to recover their self as a person. Simple behaviour changes, like not carrying cash money, are seen to be positive.

Satel & Lilienfeld (op.cit.) alert us to project HOPE (Hawaii's Opportunity Probation with Enforcement) in Hawaii. The project depends on sincere support from a household family perspective. Recovery support for the addict is not likely to be provided by previous friends; likewise, from other people in the family's

neighbourhood. Sometimes the family may be not safe with the addict as their mood can be extremely variable from pleasant and enjoyable, to fatally dangerous.

Dr. Prem Kumar Shanmugam (2015), Vice-president of Psychologists Counsellors Association of Singapore, tells of the importance of both identifying and developing a successful treatment plan for addicts enduring "relapsing compulsive behaviour". Dr. Prem works with Solace Prime, a programme developed to help addicts in Singapore; it derives in the biopsychosocial spiritual model, and aims to help people whether suffering substance or behavioural addiction. It uses inclusion processes which rely on the addict's spiritual emotions. Solace Prime aims to help addicts move past their addiction and reconnect with their self, both physically and emotionally, as well as reconnect socially and spiritually.

McLellan et.al. (op.cit.) discussed the issue of drugs use being treated as an acute disease. Health services bureaucracies, in some countries at least, have started to treat drug addiction as such; although facilities are not frequently evident they tend to be run by socially aware not for profit humanitarian organisations.

Conclusion

All people are vulnerable to becoming addicted to something in life. No addiction is found to be unquestionably good for the person or their society. All addictions will, by degrees, have negative more so than positive affect on the person's life and relationships. Furthermore, some addictions can wield greater harm than do others. People have varying and diverse vulnerabilities and so will participate at differing levels of engagement with family and friends. Some friends, good friends, can help break or displace an addiction; others, inappropriate friends, may well encourage participation in the addiction. On the other hand, there is the genetic biopsychosocial effect which can mean, in most such cases, that the addict needs more help than their family or friends alone can provide; professional emotional and behavioural counselling help must be sought.

That addiction is a brain disease does not mean the end of a good life, help towards recovery is available for most addicted persons. Notwithstanding, alcohol or drug addiction can cause physical loss of brain cells and degradation of brain function, resulting in incoherence and behavioural dysfunction. Being an addict can cause the family and friends to abandon the addicted person; or, the person may abandon their family and friends. Unfortunately, this may occur at a time when the addict would otherwise benefit from strong family and friendship support.

Addiction has become a community wide cause for concern and so it is community wide responsibility to help find ways of overcoming the initial causes whilst helping addicts to recover. It is the community's responsibility to ensure that all people of all cultures and generations have opportunity to find emotional and behavioural contentment in regular safe non-addictive activities.

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PEER REVIEWED ARTICLE

Why do we do what we do?

A critical review of Gottfredson's Theory of Circumscription and Compromise

by Gillian Taylor

Australians are spending more time at work and are expected to actively participate in the workforce for longer. In 2016, the Australian Bureau of Statistics (ABS) revealed that in the August quarter the national average fulltime worker spent 40.6 hours a week at work (ABS, 2016), not including time spent in commute, thinking about work matters, or engaging in other career related activities. The general population is working harder and longer, so it only makes sense that client's would come to counselling with questions and concerns around the role of work in their lives and how it contributes to their sense of purpose, expression of 'self', or even the 'pursuit of happiness'. 'Why are we here' and 'why do we do what we do?' are profound questions with often unclear answers that can vary from person to person. However, when it comes to understanding career development and the drivers behind career decisions, Linda Gottfredson's Theory of Circumscription and Compromise (1981) is considered a significant theory as it integrates a variety of theories with contemporary perspectives on things such as socioeconomic conditions, intelligence, and sex roles (Dorn & Schroer, 1983). The theory seeks to include non-psychological as well as psychological factors in its explanation of career development and incorporates concepts of child development and self-creation (Pryor, 1986). Nevertheless, various research studies on applications of Gottfredson's theory have been both supportive and inconclusive. It would appear that while elements of gender, prestige and interest play a role in the selection of occupations, career decision making is a complex and individual process. The following paper critically reviews Gottfredson's theory, and in particular applications of the theory in terms of self-concept, child development and gender, and social space and decision making, in an attempt to explore the underlying question of "why do we do what we do?".

Similar to Super's 'Life-Span, Life-Space' approach and Holland's theory regarding career choice and matching vocational personalities and work environments, Gottfredson's Theory of Circumscription and Compromise attempts to explain why people are attracted to particular occupations (Gottfredson, 1981). It differs from many career theories however, in that it is concerned with both the content of career aspirations and their course of development, whilst holding the concept of 'self' as a fundamental notion (Patton & McMahon, 2006). According to Gottfredson, self-concept refers to one's view of one self - of who one is and who one is not (Gottfredson, 1981). This theory holds that at different stages of cognitive development different elements are incorporated into one's developing self-concept and view of the world, including the vocationally relevant elements of gender, social class, intelligence, interests, competencies and values, all influencing the individual's perspectives as they become more differentiated and complex (Gottfredson, 1986). In this way, this theory represents a major contribution to the field of career development theory and understanding of what motivates career decisions as it moves beyond the dominant trait matching theories of the time and includes elements of non-psychological as well as psychological factors in its explanation of career aspirations (Pryor, 1986). In this model, the career decision-making process is focused more on the adjustment that individuals experience as they arrange options to correspond with their self concept (Dorn & Schroer, 1983).

It would appear that while elements of gender, prestige and interest play a role in the selection of occupations, career decision making is a complex and individual process.

The process of circumscription and compromise develops over four stages beginning in early childhood and ending in late adolescence (Patton & McMahon, 2006). As children progress through the four stages in the development of self-concept – Orientation to size and power, Orientation to sex roles, Orientation to social valuation, and Orientation to internal, unique self – they eliminate, or rather circumscribe, career possibilities and focus on occupational preferences (Dorn & Schroer, 1983). The self-concept therefore integrates expectations, →

hopes, beliefs, as well as how one perceives oneself (Pryor, 1986). Due to this, career options that are rejected are not usually reconsidered except under unusual circumstances, and are usually rejected because they do not fit into developing gender identity or because they hold low prestige (Dorn & Schroer, 1983). This is a point that has been supported by some evidence, however there is also some contradictory evidence as to the reasons for such decisions (Betz, 1994). Many of these differing findings surround child development and the second stage of circumscription - Orientation to sex roles.

According to this theory, the early stages of circumscription are quite basic and inaccurate, but also lasting. In the first stage of this model, Orientation to size and power, young children aged 3 to 5 years grasp the concept of being an adult. In the following stage, Orientation to sex roles, children aged 6 to 8 years, consolidate their gender self-concept (Gottfredson, 1981). In the third stage, Orientation to social valuation, children aged 9-13 years, the individual becomes more aware of social class and ability, whilst in the final stage, Orientation to internal, unique self, beginning around age 14 and onwards, the individual is concerned with weighing up acceptable alternatives in terms of personal preference and accessibility (Patton & McMahon, 2006). According to Gottfredson's, the young child has a fairly positive view of occupations that they are aware of but with age each of the developing self-concepts is used as an additional criterion to assess their job-self compatibility, therefore engaging in a successive circumscription of occupational alternatives considered acceptable (Gottfredson, 1981). Due to the order in which each self-concept is developed, Gottfredson hypothesised that the earlier developed the more entrenched, thus the model proposes that in a vocational decision, interest area is the first to be compromised, then status, and finally, gender appropriateness (Holt, 1989).

Gottfredson's theory does not suggest whether gender typing will differ between boys and girls, nor whether one sex is more likely than the other to nominate a wider range of occupational aspirations, however there is conflicting evidence concerning all of these issues (Care, Deans, & Brown, 2007). In a study conducted by Helwig (1998), Gottfredson's theory was tested by conducting a longitudinal study with 208 second graders (110 boys and 98 girls) across four elementary schools in Denver, USA. Helwig used a Survey of Interests and Plans during formal interviews with students at grade 2, 4 and 6 to investigate differences in aspirations and gender stereotyping. At first glance, Helwig found support for Gottfredson's theory with boys showing a tendency to select stereotypical occupations. However, girls in the study tended to choose more male or neutral occupations as they got older, rather than circumscribing based on gender appropriateness, and were more aware of different occupations as they got older then the boys were. Interestingly, Helwig also reported a trend for all children to report fewer traditional jobs for men and women as they got older. An explanation for these results were provided by Helwig whom suggested that these finding could have been due to the idea that as children got older they moved into the social orientation phase and many male occupations have higher social values. Thus the participants were more willing to compromise gender roles for prestige or status as they got older (Helwig, 1998).

An Australian study conducted by Care, Deans and Brown (2007), also found similar results to Helwig in their findings with younger children where three premises of Gottfredson's theory were tested: Most children between 3 and 5 years of age will come to recognize occupations as adult roles rather than fantasy; Children's occupational aspirations will be influenced by their perceptions of sex type; and, Preferences are typed at this stage through identification with same sex adults, rather than due to rejection of the opposite sex. Using short interviews and parents questionnaires, Care, Deans and Brown studied 84 children attending kindergarten (pre-school) in Melbourne. Care, Deans and Brown found support for Gottfredson's theory in that children had realistic job aspirations, however similar to Helwig's (1998) study, there was a definite gender difference with boys tending to identify stereotypical occupations and girls typically selecting more male or neutral occupations. Despite this, Care, Deans and Brown (2007) suggest these findings do support Gottfredson's theory as the children's job aspirations were based on identification with the same sex parent and in this sample the majority of mothers worked in neutral positions and were mainly university educated. Care, Deans and Brown (2007) suggest that these findings were more likely due to families creating a culture that encouraged girls to be open to all roles.

In a paper by Coogan and Chen (2007), the effects of gender stereotyping on women's career aspirations is explored further. According to Coogan and Chen (2007), women's career development is more complex than that of men's with research identifying internal and external barriers associated with women's career development that both complicate and restrict women's career choices and advancement including early gender-role orientation, employment inequities, and family responsibilities. The previous studies discussed suggest that there are gender differences in children's aspirations however provide different explanations unique to their studies. In an

The general population is working harder and longer, so it only makes sense that client's would come to counselling with questions and concerns around the role of work in their lives and how it contributes to their sense of purpose, expression of 'self'

article on life planning and elementary school, Magnuson and Starr (2000), suggest that career planning is a life skill which consists of the concepts of career awareness, career exploration, and skill development, which begin in early life and should be taught to all children. Through giving children the opportunity to develop skills for effective life career planning, they are empowered to reach their individual potential throughout their lives and in all aspects of life (Magnuson & Starr, 2000). This may include challenging children and adolescence to reconsider possible options that may have been previously eliminated and by encouraging more flexibility in their thinking (Dorn & Schroer, 1983).

According to Gottfredson's theory, social space refers to the set or range of occupations that an individual considers acceptable alternatives, although the person may prefer or consider some alternatives more than others (Gottfredson; 2002, 1981). This zone of acceptable alternatives is referred to as a perceived social space because these alternatives largely reflect the person's view of where he or she fits into society (Gottfredson; 2002, 1981). By circumscribing occupations under consideration, first, in terms of sex type, second, in terms of prestige, and third, in terms of vocational interests, a young person ends up with a range of tolerable occupational options - the social space (Hesketh, Pryor, & Gleitzman, 1989). Social space has persisted as a major problem for both the evaluation and the application of the theory, with even Gottfredson identifying the inability to measure ranges as the single biggest drawback to the proper evaluation of the theory (Gottfredson, 1981: Hesketh, Pryor, & Gleitzman, 1989). However research that has attempted to investigate social space has also found conflicting results regarding decision making processes.

The process of circumscription and compromise develops over four stages beginning in early childhood and ending in late adolescence

In a study conducted by Hesketh, Pryor, and Gleitzman (1989), fuzzy logic was applied to Gottfredson's concept of social space as a way to measure preferences for occupational prestige, sex-type, and interest dimensions, indicating not only the intensity of the attribute but also the tolerable ranges of the attribute. This study involved 30 participants, 15 men and 15 women, aged between 21 and 57 years, with occupations that reflected a spread of prestige, sex type, and occupational interest, with all six Holland personality types being represented (Hesketh, Pryor, & Gleitzman, 1989). Findings of this

study revealed that in decision-making, participants made some decisions to avoid the negative choice in comparison to obtaining the positive choice (Hesketh, Pryor, & Gleitzman, 1989). On the sex-type dimension, persons may be more certain of their preferred position but for the prestige scale state more reliably what they wish to avoid (Hesketh, Pryor, & Gleitzman, 1989). Hesketh, Pryor, and Gleitzman (1989) suggest that these findings demonstrate that decision-making is a complex and individual process however the measurement of ranges may provide a way of assessing flexibility and other personality-style variables.

The complexity of decision making was also highlighted in a study by Holt (1989). In this study, Holt (1989) directly tested Gottfredson's model by assessing the differential effect of status and interest area in the preference for various jobs of 42 undergraduate Engineering and Social Work students. Holt (1989) selected methods suggested by Gottfredson and conducted both a forced-choice test and a card sort with each participant. Results of this study indicated that on a forced-choice test, the university students were more likely to select jobs that were consistent with their university course majors and were also more likely to choose high-status jobs regardless of the major of the participant or area of interest (Holt, 1989). While in the card sort test, results varied greatly with status being more significant to Engineering students, and interest area more important to Social Work students (Holt 1989). These results support the complexity of decision making and indicate that the differential importance of status and interest levels when making a vocational choice may be a function characteristic of the Holland type (Holt, 1989).

In a much larger study, Leung (1993) conducted a similar examination of Gottfredson's theory with 149 undergraduate Asian-American students (52 male and 97 female students) at a major university on the west coast of America. Leung (1993) used the Occupations List to examine circumscription and the Occupational Choice Dilemma Inventory to examine compromise. Findings of the study indicated that the prestige levels of the Asian-American participants increased significantly from the second to the third stages of circumscription and that changes in the sex type boundary across the stages were moderated by gender (Leung, 1993). The study also found that the range and area of the zone of acceptable alternatives generally became bigger in the adolescent years instead of becoming smaller as predicted by Gottfredson's theory (Leung, 1993). These findings support the need to encourage adolescents to keep their career options open, so as not to prematurely eliminate choices based solely on prestige or sex type factors (Leung, 1993).

In conclusion, Gottfredson's theory encourages us to look beyond personality types and work environments, and consider the role of self-concept and the way occupations are circumscribed and compromised based on different elements in career decision. There is research to support that there are certain common elements by which individual's rule in or rule out different occupations, and there is also research to suggest that this process starts early in life when children

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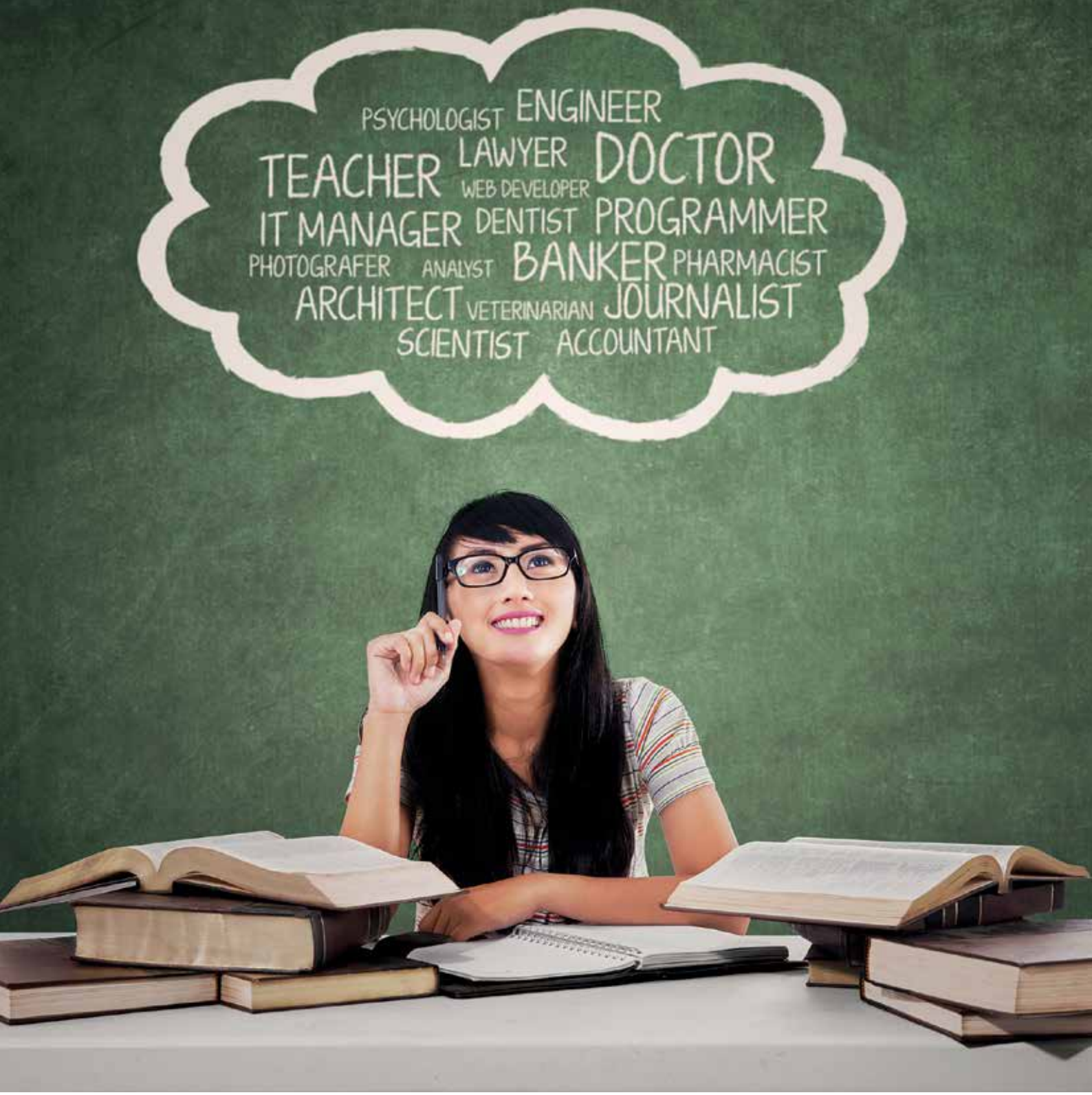

develop different vocationally relevant ideas around such things as gender and identifying occupations with the same sex parent. However, it is unclear as to why some individuals from the same circumstance circumscribe and compromise in particular ways, which suggests the factors or individuality and context cannot be overlooked (Gottfredson, 2002). These variables may also account for differences in the influence of gender stereotyping and children's aspirations, and could be reflective of changes to the world of work and attitudes towards equality such as the increase of female representation in previously male dominated or gender neutral industries and occupations, and supportive family cultures that encourage children, particularly girls, to be more open to opportunities (Care, Deans, & Brown, 2007; Helwig, 1998). Ideas that could be further explored in a future paper. Regardless, Gottfredson's theory and the research discussed in this paper highlight the need to dig deeper in our exploration of the role of psychological and non-psychological factors in our career decision making and the significance of self awareness in our explanations of why we are drawn to particular life paths.

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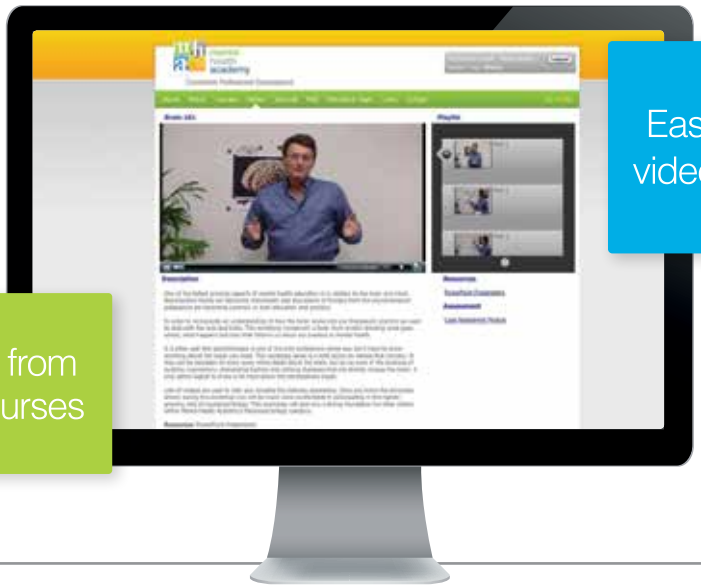

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PEER REVIEWED ARTICLE

A qualitative study of motivation to quit of prisoners with gambling problem in Australia

by Bernard W.S Fan

Abstract

The aim of this study was to explore the motivation for change of their gambling problem among the prisoners in Australia. It is a qualitative research using a phenomenological approach to analyse the data and to collate the themes and sub-themes of motivation of quitting or readiness for change. This study found four major themes of impact of gambling, family tie, individualistic needs, and restructuring of life as the main motivations for change their gambling addiction. This study also highlighted the importance of cultural value in determining motivations for change among prisoners.

Introduction

There is a strong link between problem gambling and crime. A number of surveys indicated a relationship between gambling and crime in Australia (Jones 1989, Lahn, 2000, Lahn & Grabosky 2003, Lahn 2005, Sakurai & Smith 2003). Productivity Commission (2010) reported that gambling was the most common motivation for fraud in Australia. Another study reported that 20% of women and 34% of men stated that gambling had contributed to their current imprisonment (Baron & Dickerson, 1999).

Leisure (1984) postulated a spiral options and involvement model in explaining the pathway of pathological gamblers involving in offences. As pathological gamblers attempt to chase their losses, they initially try legitimate sources, such as taking loan from financial institutions or borrowing from friends and families. Once the legitimate sources are exhausted, the urges to gamble and financial pressures will push gamblers to utilise any available means to obtain money to pay their gambling debts or to continue their gambling habit. Once the urges to gamble override their moral restraint, those pathological gamblers will resort to criminal activity and justify their action. For example, instead of considering their actions are stealing, employees think that they just borrow the money temporary and they will return it once they win. And their offenses were primarily nonviolent offenses against property, such as forgery, fraud, embezzlement, income tax evasion, employee theft, fencing stolen goods, selling drugs and hustling (Leisure 1984, Meyer & Fabrian 1992, Blaszczynski, McConaghy & Frankova 1989 Blaszczynski, A.P. 1994, Blaszczynski & McConaghy 1994).

In a survey, 25% of female gamblers and 32% of male gamblers in prison expressed they would like help with their gambling problem (Baron & Dickerson, 1999). Without treatment, incarcerated offenders cannot break the vicious cycle of gambling addiction, debt and crime. They are likely of re-offending.

In helping prisoners to treat their gambling problems, it is necessary to understand the situational factors that trigger to their gambling addiction (Turner, Littman-Sharp, Toneatto, Liu & Ferentzy 2013) and their motivations for change or to quit gambling (Kushnir et al 2016). One study found that participants were susceptible to one or two trigger situations of gambling but most participants were subjected to more gambling trigger situations (Fan 2016). Once they recognise the triggers to their gambling, they become more aware of their problems and enhance their motivations to change. Therefore, besides identifying their triggers situations, it is also important to explore their motivation to quit and recognise the period when they can restrain their gambling (Fan 2016).

Motivation reflects the person's inclination for change which is a prerequisite for treatment. Motivation is crucial in transforming and recovery from gambling addiction. Lack of motivation foresees people will be reluctant to commence, persist, comply with and succeed in quitting (Centre for Substance Abuse Treatment 1999). Therefore, it is important to identify the motivation for change of the prisoners with gambling problem to assist them to break their vicious cycle of gambling and recidivism. Evans and Delfabbro (2005) pointed out that it is common to examine the cause for gamblers to change in terms of Transtheoretical stages of change model. Higher motivation indicates keenness for change and is manifested in higher stage of change within the Transtheoretical Model (DiClemenetee et al 2004, Prochaska et al 1992, Kushnir et al 2016). In Transtheoretical model, people are ready for change as a result of internal factor of raising consciousness of themselves and external factors of their environmental influence (Prochaska and DiClemente 1982). According to Self-Determination Theory, motivations include internalized or autonomous motivation and external controlled forms of motivations. It is suggested that autonomous motivations are self-directed and self-awareness which result in sustained behavioural change and associates with successful

recovery while external controlled form of motivations result in less stable behavioural changes (Ryan & Deci 2000). A study of association between motivations for change and stages of change found that higher autonomous motivation for change was significantly associated with being in the preparation stage and predicted successful recovery from problem gambling, whereas higher external motivation was not associated with readiness for change or in the preparation stage of change (Kushnir et al 2016). Kushnir (2016) suggested that gamblers with autonomous motivations were more aware of their problem severity and were driven by internalized desire for changing their self-image while gamblers driven by external pressures for quitting gambling such as spouse pressure or financial consequence has reduced intent for change. However, another study reported that help-seeking gamblers were driven by external factors of experiencing a crisis and hit rock bottom rather than being motivated by internal awareness of their own gambling problem (Evans & Delfabbro 2005). Therefore, finding the nature of motivations for change are important in predicting the success of recovery. It is also important to identify whether their motivations are internalized autonomous or externalized pressures for change. Although there are a few studies reporting on the efficacy of gambling treatment program on prisoners with gambling problem (Nixon et al 2006, Fan 2014), there is no study in the motivation for change of prisoners with gambling problem. The review of the literature highlights a need to explore the motivations for change and quitting of their gambling addiction among prisoners. The purpose of this study is to explore the motivations for change and quitting of the prisoners with gambling problem.

METHOD

Design

This study involved the process of interviewing the participants, gathering and analysing data by qualitative research method. A phenomenological approach was used in this study to analyse the data and to collate the themes and sub-themes of motivation of quitting or readiness for change (Strauss & Corbin 1990). In this study, a semi structured interviews with a set of questions were designed to interview 15 prisoners in order to look for emerging themes of their motivations for change. It is designed that through a Phenomenological approach, experience from the perspective of the prisoners can be examined through their descriptions of their lived experience. Prisoners were asked to describe their experiences as they perceive them. Themes and patterns are sought in the interview data.

Participants

This study aimed at recruiting prisoners with gambling problems. Promotion of study was done through placing flyers on notice boards and in newsletters, as well as an information session for the prisoners. For those interesting in joining the study, they could inform the transitional managers at their prisons. Then the transitional managers arranged the appointment for researcher to meet them. Prisoners joined the program voluntarily. All participants were asked to sign a consent form to express their voluntary participation. They were allowed to withdraw from the study anytime if they wished. To screen for eligible participants, they were asked to do the Early Intervention Gambling Health Test (Eight) Gambling Screen (Sullivan 1999). The EIGHT Gambling Screen comprises eight questions to assess problem gambling, with four or more 'yes' answers indicating that gambling may be an issue in the person's life. A score of less than 3 represents Level 1 or →

non-problem gamblers. A score of 4 or 5 represents Level 2 or problem gamblers. A score of 6 or more represents Level 3 or pathological gambling (Sullivan 2006). Those participants were assessed either problem gambler or pathological gambler and eligible for this study.

Procedures

During this program, participants were interviewed and went through the standard schedule and open questions to cover topics of personal history of gambling, impact of gambling on their life, periods when they stopped gambling, their motivation to change and their goals in the future. Through motivational interviewing technique, participants were encouraged to share their personal experience. In addition, participants were asked to do a "life map" exercise to depict their gambling history and to review any period when they abstained or indulged in their gambling. As no electronic device was allowed for any audio or video recording inside prison, their description of experiences were noted on paper by the researcher. Then the researcher typed the transcript of the interview.

Analysis

There were 13 prisoners completed the interview and total 13 interview transcripts were recorded. The content of transcript was analysed using NVivo 11 to collate into key themes and sub-themes. Researcher created and organized some nodes before started coding. Nodes were organised into a hierarchy which helped drawing connections between themes. After completed coding, visualization techniques was used to explore trends. A chart was made to do coding by the nodes. Then an Explore diagram was created to see how themes are connected.

Results

The results were drawn from 13 participants, 9 males and 4 females who finished the study. Their data were analysed. Their age ranged from 20 years old to 44 years old, with an average age of 32 and median age of 30. Their ethnicities include Caucasian Australian, Indigenous Australian, British, Italian, Vietnamese and Jewish. Their sentences were related to income producing crimes such as trafficking controlled drugs, fraud and stealing. Some of them were sentenced for assault (Table 1).

The aim of this study was to explore the motivation for change of their gambling problem among the prisoners in Australia. During the process of analysis, researcher was mindful of the diverse background of the target group. Their ethnicities have depicted different attitudes towards gambling and distinct motivations to quit. Personal factors, including age, gender, country of origin, family support, cultural affiliation and migration experience, all have impact on their pathway to gambling and motivation to change.

The most significant finding among all participants is their common goal of quitting, cutting back or abstaining gambling, limit setting, self-banning from casino, and planning for alternative activities. They also wanted to start a new life in the future. Most of them wished they could totally quit gambling and never gamble again in the future. Some of them realised their gambling problem was so deep rooted that they were not able to quit but wished to restrain it and set limit on gambling.

"...My gambling problem has caused me to prison. I know I cannot totally quit gambling but I wish to control it..."

Their motivation for change was based on their awareness of severe impact of gambling on their life. However, despite they have experienced a series of significant life-events and crisis such as relationship break-up, mental health issue of anxiety, stress or depression, job losses and financial pressure over a long period of time, they did not seek professional help until they finally hit the rock bottom of being arrested and sentenced to jail. Only until they were in prison, were they able to contemplate their gambling problem and the impact of gambling on their life. Therefore, they all wanted to re-structure a new life once release from jail.

TABLE 1. CHARACTERISTICS OF THE PARTICIPANTS

Cultural background	Gender	Marital status	Age	Types of gambling	Types of offence
1. British	Male	Divorced	23	Casino card games	Trafficking controlled drugs
2. Indigenous Australian	Male	Married	20	Casino card games	Trafficking controlled drugs
3. Italian	Male	Single	24	Casino card games	Trafficking controlled drugs
4. Australian	Male	Married	30	TABS	Embezzlement
5. Indigenous Australian	Female	Married	43	Casino & TABS	Trafficking, controlled drugs
6. Indigenous Australian	Female	Married	29	Casino	Assault
7. Vietnamese	Male	Divorced	37	Casino, Card games	Trafficking
8.Australian	Male	Divorced	44	On-line gambling	Assault
9. Jewish	Male	Divorced	40	Stock Market	Fraud
10. Australian	Female	Single	23	Scratch Card	Embezzlement
11. Indigenous Australian	Male	Divorced	36	TABS	Trafficking controlled drugs
12. Indigenous Australian	Male	Single	27	Casino, card games	Trafficking controlled drugs
13. Australian	Female	Defacto	40	Casino	Trafficking controlled drugs

FIGURE 1. THEMES OF MOTIVATION TO QUIT GAMBLING

In analysis of the data, significant issues have been identified and common themes emerge related to their motivations for change (Figure 1).

Impact of gambling:

All participants reported their gambling problems have severely ruined their life. Impact of gambling on life is huge and diverse, including loss of money, selling their properties, bankruptcy, business loss, broken families and domestic violence. The estimated average amount of money each participant lost was around AU$400,000 to $500,000. Some of them even lost up to millions of dollars. Most of them reported they had lost at least one house in gambling. Some of them even reported lost more than one property. They had struggled with those impacts for an extended period of time before they were arrested and sentenced to jail finally

Break down of their family:

In addition to financial pressure on families, gambling problem also caused feeling of deceit and loss of trust which resulted in marriage breakdown, family breakdown and deterioration of relationship between gamblers and their children.

"...My gambling problem made the relationship with my now teenager daughters worse and broken. My daughters did not want to live with me and they even refused to come to prison to visit me..." (A female prisoner)

"...I found my gambling problem has great impact on my life including ... relationship with my wife deteriorated...." (A male prisoner)

"...relationship with my ex-wife was so stressful which drove me to resort to gamble to escape this feeling. Finally, I assaulted her during an argument. I still feel angry of my ex whom has ruined my life ... and I end up in jail." (A male prisoner)

Furthermore, situation sometimes accelerated into domestic violence which resulted in divorce and family breakdown. However, victim in domestic violence does not confine to female. Husband sometimes could be the victim as he tried to stop his partner's sneaking out to gamble.

"... I divorced with my husband because I gambled too much. I neglected my children and ignored my family.... I could not help myself stop gambling because of craving... Finally I ended up in a fight with my ex-husband... My ex tried to stop me to go to casino but I lost my mind and drove the car to hit him on driveway..." (A female prisoner)

Disruption in their career:

Most of the participants were either employees or business owners. Before their gambling problem deteriorated into severed level or during their initial stage of their gambling development, they were hard working employees or business owners. However, when they so addicted to gambling in the later stage, gambling have been craving their whole mind and life. They admitted that gambling caused them to lose their job or their business.

"... I thought I could win back all the previous loss but finally I lost my business and owed a huge debt ..." (A male prisoner)

"...You know I am a businessman, I am clever and have earned a lot in stock market before.....However, I felt stressful when I started to lose in stock market in 2008 during the economic crisis. I thought my lost was only temporary and I could chase back all my lost with my talent...." (A male prisoner)

"... I felt stress because of my business which has driven me to gamble in order to relax... But as I gambled more, I was more under financial pressure which drove me to continue gambling in order to chase back the loss..." (A female prisoner)

"...I stole the scratch card from the newsagency where I worked and I was finally caught..." (A female prisoner)

Commit crime and gone to jail

All participants depicted that their pathway to jail originally started from social gambling. They all remembered they had a big win in their early stage of gambling experience. This winning experience drove them to continue gambling to hope for another big win and to chase their loss. However, the reality was contrary and they continuously lost in the long run. It resulted in huge debt and finally caused them to take the risk to commit crime in order to make money to pay their debts and to continue their gambling. They believed that once they had a big win, they could pay back what they believed of just borrowing instead of stealing from their employers. In fact, they could not stop gambling until they were arrested. And it is this rock bottom and crisis point which drove them to contemplate their gambling problem in their life and made the decision to quit gambling.

Family Tie:

Another important phenomenon found among some prisoners is their family ties. Some prisoners with CALD community or Indigenous Australian prisoners have shown a characteristic of a tight knit community.

"..."You know the family tie in my (Italian) culture is very strong here." (A male prisoner)

"... I helped my family and friends to invest. It is my (Jews) culture which I bear the burden and responsibility to help my family and friends to make money...." (A middle age male prisoner)

" ... I want to quit gambling so I can set a good example to my children and family in my (Indigenous) place." (A male prisoner)

Family Reputation and Feeling Shame:

Different ethnicities have diverse influence on the clients' motivation to change and their view on community tie and family reputation. For some ethnicities, family reputation is very important in their culture. They depicted that their sentence to jail was a shame to themselves, and to their families in their communities. Because family reputation is very important, saving face is vital for them. 'Saving Face' will act as a motivation for them to quit gambling.

"...I have ruined my family reputation in my (Italian) community and I felt very guilty. My sentence to prison is a shame to my family. It brings disgrace and humiliation to my parents, uncles, aunties and the whole family." (A young male prisoner)

"... I have lost so much, including my business, my family, my freedom and reputation to my family because my (Vietnamese) community is so small and news spread very fast within the community. My sentence brought a lot of shame to my family. I want to re-build my life....." (A middle age male prisoner)

"... I helped my family and friends to invest. In my (Jews) culture, I bear the burden and responsibility to help my family and friends. This made me very stressful when I started to lose in stock market in 2008 during the economic

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"...I want to spend more time with my parents and family once I get out of here. And I want to fix the relationship with my family."

crisis..... I want to rebuild my reputation in my family and community in the future." (A middle age male prisoner)

" ... I find I am addicted to it and gamble too much as this is the only leisure to kill time in prison. I realise my gambling problem and I do not want to continue it once I can go back to community. I do not want to bring more shame to my family." (A young Indigenous male prisoner)

Saving Face:

In response to the shame on their family reputation, some prisoners want to fix this damage and to save the reputation of their family which is their motivations to quit and to change their life.

"... I regret I have ruined my family reputation in my (Italian) community and I feel very guilty.... I am studying here (prison) and doing a diploma course now. I don't want to waste the time here and to achieve something before release. So when people ask what I have done over the past few years after being released, I can tell them I am studying. I hope my effort can help to fix the damage I have done in my family...."

All these theme and subthemes of family tie, family reputation, feeling shame and saving face have a common characteristic of collectivistic in orientation. These collectivistic values are more common among prisoners with CALD backgrounds or Indigenous background. They have family and extended family commitments. They also feel the needs to sacrifice their personal needs for the beneficial of their families and communities.

Individual needs

Personal goal and achievement

Some prisoners wished to seek personal achievement and take care of themselves in the future. Their goals are more individualistic in nature, such as own their property again, run their business. It is because they aware that it is difficult for them to get a job with a criminal record, so they need to be self-employed or run their own business. For example:

"...My goal is to quit gambling, to re-build my life, set up my own electrician business..."

"...Now my goal is to quit gambling, forget the dream to have a big win, and to get a job once released. Then I can afford to buy a house again..."

"...I want to have a better life in the future and not back here (prison)..."

Their goals and motivation to quit are more person-centred. They prefer to seek achievement for themselves and pursuit a better life. They show more concern of their own needs and interests.

Self Image

Since they have been arrested for stealing, fraud or drug trafficking and sentenced, they wanted to have some achievement to re-build their own reputation. They finally realised that no achievement can get from gambling. They need to achieve it by their own effort. Moreover, some of them also wanted to fix their own image and set up a good model for their children and in their Indigenous community. For example:

"...gambling run in my family and community.....I want to quit gambling so that I can set a good example to my children and family." (An Indigenous male prisoner)

Re-structure their life

All participants experienced severe disruption in their life because of gambling, committing crime and sentencing to jail. They lost their jobs and business. Some of them also experienced relationship break down with their wives or teenager children. Their motivation for change is to re-structure their life, to get a job and to fix their relationship with their partners, children and families. For example:

"...I want to spend more time with my parents and family once I get out of here. And I want to fix the relationship with my family." (A young male prisoner)

RELATIONSHIP WITH FAMILY MEMBER

Bond with children

Because of being in jail, they were separated from their families and children. Some of them also regretted it because their children were just born or still were toddle. It is the most precious time of parenthood. They felt sorry not able to see their children grow up and it is the most gorgeous time in childhood. While some female prisoners expressed their wish to fix the relationship with their teenager children whom were angry at their mothers who always neglected them and sneaked to gamble. Therefore, their main motivation for change is fix the bond with their children and to re-unit with them.

"...My goal is to re-structure my life and re-build the relationship with my family because I regretted going to jail which made me not able to see my new born son.....Now I find family is almost important to me...." He has even composed a rap song and he sang this song to remind his journey of going astray. The song is about the story of his life and he wanted to express how he missed his son.

"...I always sneaked out to casino or TABS to gamble. I like to play poker machine and I had my favour machine and I could play for a few days continuously without sleeping nor go to toilet so I put on pad instead.... The only time I stopped going to casino was while I was pregnant and nesting at home and then needed to look after the baby. When my children grew up, I started gambling again....My gambling problem made my relationship with daughters getting worse and broken. They are teenager and they do not want to live with me and they even refuse to come to prison to visit me. So my goal is to quit and fix the relationship with my children." (An Indigenous female prisoner)

When she told about her daughters, she broke into tears and she realised children and family are important to her which she did not think about it when she was indulged in gambling.

Marital relationship

The other major motivation for change is to fax their marital relationship. Although most of the participants have divorced with their partners, some of them still get the support of their partners whom have not left them.

"...Luckily, my husband still supports me and he has not left me. He is currently looking after my daughters. I hope to re-structure my life including the relationship with my children, to get a job, being a good mother and to rebuild-the relationship with my husband when I am released."(A female prisoner)

Another example is:

"...Lucky my wife still supports me and I want to fix the relationship and →

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In this study, impact of gambling including break down of their family, disruption in their life, and incarceration were the crisis point which forced the prisoners to contemplate their gambling problem and motivated them to change.

to prove her I have changed and quit. I find quality time with my family is more important." So his motivation is to re-build the relationship with his wife. (A male prisoner)

Other findings

In addition, some prisoners also depicted that financial pressure was not the main effect for them to continue gambling. Drug dealing already provided a way to make quick money which helped them to pay the debt and also continued to support their gambling. However, they felt extreme stressful in committing crime. Instead, they gambled in order to relax. Therefore, once they involved in trafficking drug, they gambled more. One male prisoner depicted:

"...In fact, after I involved in trafficking drug, I had made a lot of money. However, I felt extreme stressful during trafficking drug because I always worried to be caught by police, I needed to relax. The only way I coped with stress was go to casino which could help me to forget everything while I was gambling..."

Discussion

Superficially, it is believed that the common motivation for change was due to hitting bottom of being arrested and sentenced to jail. After analysis of the experience of the prisoners with gambling problem, both internalised autonomous factors and external pressure were found in this study. There are four key themes found in this study, including impact of gambling, family tie, individual needs and restructure their life.

In this study, impact of gambling including break down of their family, disruption in their life, and incarceration were the crisis point which forced the prisoners to contemplate their gambling problem and motivated them to change. Evan & Delfbbro (2005) and Suurvali et al (2010) hypothesised that if gamblers face severe gambling related harm and negative consequence which is beyond a threshold, they will be driven to change and to seek help. Moreover, Suurvali et al (2010) also hypothesised that change in environment or lifestyle is the main reasons for resolution and quitting among gamblers. In this study, incarceration is a vital crisis point which changes their lifestyle and environment for the prisoners. This significant externalised life event has motivated them to change.

On the other hand, Evan and Delfbbro (2005) suggested that motivation for change was due to severe gambling related harm and not for positive reason. However, some finding of this study is contradictory to this hypothesis. In this study, some prisoners with specific cultural backgrounds were driven by positive reasons to change for family reputation. Most studies reported that feeling shame and stigma are the barriers for gamblers to accept their problem and not to seek professional help (Scull & Woolcock 2005, Beattle et al 1999, Feldman et al 2014). Problem gambling is hidden due to shame and loss of reputation for themselves and their families in their communities. They were unwilling to bring up their gambling problem as they feared the news will spread within their communities and then their families would be stigmatised very soon (Scull & Woolcock 2005). Another study of CALD Communities also reported that seeking assistance was considered taboo because gambling is a stigma and shame to the gamblers, their families and the community (Feldman et al 2014). Feeling shame will drive gamblers to keep it secret. Result of this study showed a different perspective. When gamblers already hit the bottom of incarceration, they changed for positive reason. Shame or stigma became the motivation for them to change instead. In this study, prisoners from Indigenous background or high context culture such as Italian, Vietnamese and Jews considered the importance of family reputation which motivated them to change. Those ethnicity backgrounds have a similar cultural value of a closed family relationship. Reputation to their families and communities is vital in their culture. The family is more important than individual needs. They were educated to conform to group and social norms (Triandis 1988, Singelis et al 1995). It was reported that 'Saving Face' was common among migrants, for example Vietnamese (Feldman et al 2014). This collectivistic value is an important element motivating them to change their gambling addiction.

Furthermore, most prisoners also wanted to change for positive reasons including re-structuring their life and fixing the relationship with their partners, children and family members. A female prisoner also mentioned that she abstained from gambling during her pregnancy and the time looking after her new born baby. This finding shows that gamblers not only motivate to change under negative consequence. They also changed for positive reasons. Suurvali et al (2010) found that relationship is one of the main reasons for help seeking among problem gamblers and also hypothesised that development in the gamblers' lives such as getting married, start a family may make gambling less interesting. They gradually quit it unconsciously or do it without planning. This explained a number of prisoners described their motivation for change due to their new born babies or to fix their relationship with their children in this study.

On the other hand, prisoners with Western culture background more inclined to motivate to change for individual needs and achievements. It is more close to western ideology of individualism (Hofstede 1980). In individualistic culture like most Western countries such as the USA and Australia, individuals seek achievement for themselves. They are concerned about their own needs, interests and goals. Individualists seek to pursue their wants for a better life. Their ethnicities were low context culture in mature which depicted different attitudes towards gambling and distinct motivations to quit.

Therefore, this study found that prisoners with gambling problem were motivated to change due to both internal autonomous factors and externalized pressure. They were also driven by both positive and negative reasons to change which were influenced by their cultural value.

On the other hand, few prisoners in this study reported physical or mental health issues as their motivation for change. Other studies reported negative emotion and mental health issue is the main reason for quitting gambling while financial pressure is the second motivations for problem gamblers to change (Evans & Delfabbro 2005, Hodgins & el-Guebaly 2000). However, in this study, no prisoners mentioned financial pressure as their motivation for change. This may be due to the prisoners already being incarcerated →

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This two-day (8:30am-4:30pm) program presents a highly practical and interactive workshop (case-based) for treating traumatised clients; the content is applicable to both adult and adolescent populations. The techniques are cognitive behavioural, evidence-based, and will be immediately useful and effective for your clinical practice. The emphasis is upon imparting immediately practical skills and up-to-date research in this area. **In order to attend Treating Complex Trauma, participants must have first completed this 'Treating PTSD' program.**

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Clinical skills for treating complex traumatisation
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This two-day (8:30am-4:30pm) program focuses upon phase-based treatment for adult survivors of child abuse and neglect. This workshop completes Leah's four-day trauma-focused training. The content is applicable to both adult and adolescent populations. The program incorporates practical, current experiential techniques showing promising results with this population; techniques are drawn from Emotion focused therapy for trauma, Metacognitive therapy, Schema therapy, Attachment pathology treatment, Acceptance and commitment therapy, Cognitive behaviour therapy, and Dialectical behavior therapy.

3 - 4 August 2017, Wellington (NZ) CBD
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for a period and they did not gamble nor need to face the financial pressure as before. They also went over the most stressful period of going to court and waiting for sentence. Therefore, financial pressure and mental health are not the motivations for change among prisoners in this study.

Limitation of study

This study has explored the motivations for change of prisoners with gambling problem. However, there are a few limitations in this study. Since this is a qualitative research, data were drawn from limited number of participants. Moreover, this study was done in Australia only despite prisoners of different cultural backgrounds were recruited. Therefore, a quantitative research of a larger sample of participants in other countries is recommended in the future.

Note

This project was funded and approved by Beyond Gambling Grant. And the project was approved by the Department of Corrective Services to be carried out in WA prisons. All procedures performed in this project involving participants were in accordance with the ethical standards of the institutional and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Informed consent was obtained from all participants in this project.

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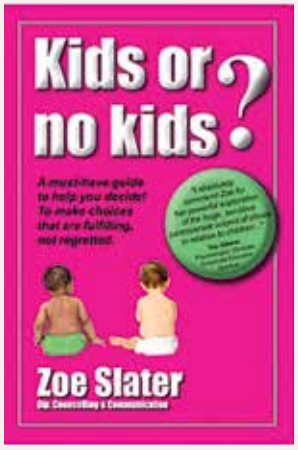
BIOGRAPHY

Bernard W.S. Fan is a Level 4 ACA Member. Bernard holds a Bachelor of Arts Degree, Master of Counselling Degree, Diploma in Financial Counselling, Graduate Diploma in Child Psychotherapy Study, Certificate in Gambling Counselling and is a Phd Candidate. He is a Family Counsellor in WA, Gambling Counsellor in Perth, Alcohol and Other Drug (AOD) Counsellor in WA.



Kids or no kids? by Zoe Slater

Review by Tom Parker
ACA Industry Liaison Officer

Zoe's Slater book *Kids or no kids?* Is a guide to determining the choices that might be necessary and crucial to you or your client's lives. If you are working as a counsellor with clients who are expecting, or soon-to-be-expecting, this is a book that provides insight into the choices made by many different women through a series of interviews and self-assessment workshop.

Not only does this book provide insight, but also examines the top five influencers on why women are having children later in life (or not at all) and also examines the debate that is currently underway. For those interested in the emotional factors surrounding having children and hearing the real stories of others making those decisions; it is recommended that you buy this book

Zoe Slater
Zoe Slater has practised for many years and gained unique insight into the psyche of many, from all different walks of life. Zoe Slater's book Kids or no kids? Will give the reader much food for thought.

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Best Practice by Merrilyn Hughes

Review by Tom Parker
ACA Industry Liaison Officer

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For many counsellors across Australia, owning a successful private practice is a dream. Many do not immediately realise that in addition to being an excellent counsellor, it is exceedingly important to be a smart minded business-thinker to have a successful private practice.

Merrilyn Hughes' book, *Best Practice* is an in-depth account of what made Keystone Counselling successful and documents the journey that Merrilyn Hughes had taken over her career as a Counsellor, Author, Coach and Speaker. The book highlights some of the ways to ensure longevity and success in a fee-for-service world – often requiring the counsellor to be professional, ethical and creative; all at the same time.

For those that hope to open a successful private counselling practice one day, this book is a must-read; it provides context on the road travelled to success, the niches that can be taken advantage of in private practice, the lessons learned along the way and many instances in which you can prepare yourself to be the best version of yourself in private practice through ethical, professional and personal development.

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Anthony Gray	ATHELSTONE	08 8336 6770 or 0437 817 370	Upon Enquiry	FTF
Annie Cornish	HENLEY BEACH	0407 390 677	Upon Enquiry	FTF
Pamela Mitchell	WATERFALL GULLY	0418 835 767	Upon Enquiry	FTF
Maxine Litchfield	GAWLER WEST	0438 500 307	Upon Enquiry	FTF
Ellen Turner	HACKHAM WEST	0411 556 593	Upon Enquiry	FTF

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**
Kerry Turvey	TANUNDA	0423 329 823	Upon Enquiry	FTF
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon Enquiry	FTF
Carol Kerrigan	ENGLFIELD	0410 567 479	Upon Enquiry	FTF
Barry White	PORT ADELAIDE	0488 777 459	Upon Enquiry	FTF/PH
Adrienne Jeffries	STONYFELL	08 8332 5407	Upon Enquiry	FTF/PH/WEB
TASMANIA				
Jane Oakley-Lohm	BLACKSTONE HEIGHTS/ LAUNCESTON	0438 681 390	$110 GST inclusive, $80 for new students of one year	FTF/PH/GRP/WEB
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
VICTORIA				
Graeme John Riley	GLADSTONE PARK	03 9338 6271 or 0423 194 985	$85	FTF/WEB
Sandra Brown	FRANKSTON/MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Brian Whiter	CARLTON/MOORABBIN	0411 308 078	$100	FTF
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Derek Goodlake	SANDRINGHAM	0403 045 800	$110	FTF/PH/WEB
Joanne Ablett	PHILLIP ISLAND/ MELBOURNE METRO	0417 078 792	$120	FTF/GRP/PH/WEB
Angeline Crossin	ASCOTVALE/ESSENDON	0451 010 750	$100 F/F, $90 Skye,$50 Group, $70 Students	FTF/GRP/WEB
Jo-Ellen White	BLACKBURN SOUTH	0414 487 509	$100 ind. $50 Group. Stu Dis $80	FTF/PH/GRP/WEB
Kim Billington	SANDRINGHAM/STKILDA/ ARMIDALE/MENTONE	0488 284 023	$110 : 2hr group $60	FTF/PH/GRP/WEB
Sandra Robinson	MANSFIELD/BENALLA	0403 175 555	$110 individual 1 hour session. $50 - group per he	FTF/WEB
Bettina Revens	NEWPORT/ WILLIAMSTOWN	03 9397 7075 or 0432 708 019	$120 indiv	FTF/PH
Paola Gina Salvagno	DONCASTER/ TEMPLESTONE/BALWYN	03 9812 7520 or 0430 157 857	$120 p/h $100 - students enroled in counseling	FTF/PH/WEB
Melissa Harte	PAKENHAM/ SOUTH YARRA	0407 427 172	$132 to $143	FTF
Lynda M Carlyle	EAST MELBOURNE/ SPRINGVALE SOUTH/ RIPPON LEA	0425 728 676	$135 per hour	FTF/PH/WEB
Kathleen (Kathy) Brennan	NARRE WARREN	0417 038 983	$35 Grp, $60 Indiv	FTF/GRP/PH/WEB
Gayle Stapleton	BERWICK	0459 075 284	100 p/h Negotiable	FTF/PH/GRP/WEB
Rosemary Petschack	DIAMOND CREEK	0407 530 636	80 p/h	FTF/PH
Jacquie Wise	ALBERT PARK	03 9690 8159 or 0439 969 081	Upon Enquiry	FTF/PH/GRP/WEB
Bridget Pannell	MELBOURNE	0423 040 718	Upon Enquiry	FTF/PH/GRP/WEB
Matt Glover	CROYDON HILLS/EAST DONCASTER	0478 651 951	Conc: $70, Full: $90 Group: $30/hour	FTF/PH/GRP/WEB
Rosslyn Wilson	KNOXFIELD	03 9763 0772 or 03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB

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VICTORIA *CONTINUED*				
Charlene Pereira	RINGWOOD/YARRAGLEN/ MELBOURNE	03 9999 7482 or 0403 099 303	Ind $140; $90 P/T practitioners; Group on aplication	FTF/PH/GRP/WEB
Shivon Barresi	ROXBURGH PARK	0413 568 609	Ind. $80 ph, Group $60ph	FTF/PH/GRP/WEB
Rosie Barbara	SYDENHIAM/WYNDHAM	0433 277 771	Ind:$110/Grp:$50 each min of 4 hours	FTF/PH/GRP/WEB
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Sandra Hatton	Kewarra Beach	0425 722 311	Indiv. $80/hour; sml group $80/2hours	FTF/GRP
Sophie Lea	MORNINGTON PENINSULA	0437 704 611	Individual $100/hour	FTF/PH/WEB
Stephen O'Kane	BLACKBURN	0433 143 211	Upon Enquiry	FTF/GRP
Deborah Cameron	BRIGHTON	0447 262 130	Upon Enquiry	FTF/GRP/WEB
Batul Fatima Gulani	MELBOURNE	0422 851 536	Upon Enquiry	FTF
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	Upon Enquiry	FTF
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon Enquiry	FTF
Barbara Matheson	MELBOURNE	03 9703 2920 or 0412 977 553	Upon Enquiry	FTF
Debra Darbyshire	BERWICK	0437 735 807	Upon Enquiry	FTF
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260 Or 03 9786 8006	Upon Enquiry	FTF
Beverley Kuster	NARRE WARREN	0488 477 566	Upon Enquiry	FTF
Patricia Reilly	MOUNT MARTHA/ GARDENVALE	0401 963 099	Upon Enquiry	FTF
Molly Carlile	INVERLOCH	0419 579 960	Upon Enquiry	FTF
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Claire Sargent	CANTERBURY	0409 438 514	Upon Enquiry	FTF
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Paul Montalto	THORNBURY	0415 315 431	Upon Enquiry	FTF
Marie Bajada	BALLARAT	0409 954 703	Upon Enquiry	FTF
Kaye Allison Jones	CAMBERWELL	0417 387 500	Upon Enquiry	FTF
Marguerite Middling	NORTH BALARAT	0438 744 217	Upon Enquiry	FTF
Zohar Berchik	SOUTH YARRA	0425 851 188	Upon Enquiry	FTF
Natalie Wild	BORONIA	0415 544 325	Upon Enquiry	FTF
Andrew Reay	MOORABBIN	0433 273 799	Upon Enquiry	FTF
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon Enquiry	FTF
Anna Atkin	CHETLENHAM	0403 174 390	Upon Enquiry	FTF
Lynne Rolfe	BERWICK	03 9768 9902	Upon Enquiry	FTF
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF
Joan Wray	(MOBILE SERVICE)	0418 574 098	Upon Enquiry	FTF
Gaye Hart	BITTERN	0409 174 128	Upon Enquiry	FTF
Belinda Hulstrom	WILLIAMSTOWN	04714 331 457	Upon Enquiry	FTF

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VICTORIA *CONTINUED*				
Tabitha Veness	FERNTREE GULLY	0400 924 891	Upon Enquiry	FTF
Tra-ill Dowie	PORT FAIRY	0439 494 633	Upon Enquiry	FTF
Danielle Aitken	SOUTH GIPPSLAND/ MELBOURNE METRO	0409 332 052	Upon Enquiry	FTF/GRP/PH/WEB
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon Enquiry	FTF/GRP/WEB
Nyrelle Bade	EAST MELBOURNE/ POINT COOK	0402 423 532	Upon Enquiry	FTF/GRP/WEB
Simon Philip Brown	WATSONIA	03 9434 4161	Upon Enquiry	FTF/PH/GRP
Anne Meredith Brown	COLDSTREAM	0428 221 854	Upon Enquiry	FTF/PH/GRP
Michelle Wood	Mansfield	0497 037 436	Upon Enquiry	FTF/PH/GRP/WEB
Dorothy Dullege	RINGWOOD NORTH	0433 246 848	Upon enquiry	FTF/PH/GRP/WEB
Jenny Anne Field	UPPER FERNTREE GULLY	0404 492 011	Upon Enquiry	FTF/PH/GRP/WEB
Sandra Clough	TRARALGON	0412 230 181	Upon Enquiry	FTF/PH/GRP/WEB
Lehi Cerna	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB
Judith Beaumont	MORNINGTON	0412 925 700	Upon Enquiry	FTF/PH/GRP/WEB
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
Petra de Kleijn	TATURA	0413 824 073	Upon Enquiry	FTF/PH/WEB
Gabrielle Skelsey	ELSTERNWICK	03 9018 9356	Upon Enquiry	FTF/PH/WEB
Cas Willow	WILLIAMSTOWN	03 9397 0010 or 0428 655 270	Upon Enquiry	FTF/PH/WEB/GRP
Lisa Derham	CAMBERWELL	0402 759 286	Upon Enquiry	FTF/WEB
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF/WEB
Sara Edwards	DINGLEY	0407 774 663	Upon Enquiry	FTF/WEB
Heather Bunting	GLEN IRIS	0421 908 424	Upon enquiry; special rates for students	FTF/PH/WEB
John Dunn	COLAC SW AREA/ MT GAMBIER	03 5232 2918	Upon Enquiry	FTF/GRP/WEB
WESTERN AUSTRALIA				
Julie Hall	YANCHEP/BUTLER/ JINDALEE/JOONDALUP	0416 898 034	$100	FTF/PH/WEB
Dr Patricia Sherwood	PERTH/BUNBURY	0417 977 085 or 08 9731 5022	$120	FTF/PH/WEB
David Fisk	NORTH LAKE	0412 781 865	$100 (neg) Upon Enquiry	FTF/GRP/WEB
Eva Lenz	FREMANTLE/COOGEE	08 9418 1439 or 0409 405 585	$85 concession $65	FTF/PH/GRP/WEB
Clare Robbins	KALAMUNDA	08 9293 4668 or 0408 548 838	$95 individual; $75 Group per person	FTF/GRP
Sharon Vivian Blake	FREMANTLE	0424 951 670	Indiv $100, Grp $60	FTF/PH/GRP/WEB
Carolyn Midwood	DUNCRAIG	08 9448 3210	Indiv $110, Grp $55	FTF/PH/GRP/WEB
Trudy McKenna	NEDLANDS	0438 551 210	Indiv $120, Grp $50 Concess $30	FTF/PH/GRP/WEB
Narelle Williams	MIDLAND/PERTH	0429 000 830	Individual $100 : Students $85	FTF/WEB
Marie-Josee Boulianne	BEACONSFIELD	0407 315 240	Upon Enquiry	FTF
Cindy Cranswick	FREMANTLE	0408 656 300	Upon Enquiry	FTF
Lynette Cannon	CAREY PARK	0429 876 525	Upon Enquiry	FTF

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WESTERN AUSTRALIA *CONTINUED*				
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
Karen Heather Civello	BRIDGETOWN	0419 493 649	Upon Enquiry	FTF
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
Alan Furlong	WINTHROP	0457 324 464	Upon Enquiry	FTF
Fiona McKenzie	GERALDTON	0427 928 505	Upon Enquiry	FTF
Allison Lord	CLARKSON	0403 357 656	Upon Enquiry	FTF/PH/GRP
Genevieve Armson	CARLISLE	0412 292 999	Upon Enquiry	FTF/PH/GRP/WEB
Jenna Trainor	BEDFORD	0431 817 807	Upon Enquiry	FTF/PH/GRP/WEB
Lillian Wolfinger	YOKINE	08 9345 0387 or 0401 555 140	Upon Enquiry	FTF/PH/WEB
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
Victoria Laws	NORTH PERTH	0415 604 847	Upon Enquiry; student rates available	FTF/PH/GRP
INTERNATIONAL				
Country	**Contact**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
Hong Kong	Deborah Cameron	+65 9186 8952	Upon Enquiry	FTF/GRP/WEB
Hong Kong	Yat Chor Wun	+852 264 35347	Upon Enquiry	FTF
Hong Kong	Polina Cheng	+852 9760 8132	Upon Enquiry	FTF
Hong Kong	Cary Hung	+852 2176 1451	Upon Enquiry	FTF
Hong Kong	Dina Chamberlain	+852 6028 9303	Upon Enquiry	FTF
Hong Kong	Giovanni Ka Wong Lam	+852 9200 0075	Upon Enquiry	FTF
Hong Kong	Fiona Man Yan Chang	+852 9198 4363	Upon Enquiry	FTF
Hong Kong	Winnie Wing Ying Lee	N/A	Upon Enquiry	FTF
Hong Kong	Wing Wah Hui	+852 6028 5833	Upon Enquiry	FTF
Hong Kong	Yuk King Lau	N/A	Upon Enquiry	FTF
Hong Kong	Frank King Wai Leung	+852 3762 2255	Upon Enquiry	FTF
Hong Kong	Joyce Chan	(+852) 92507002	$90 AU, $550 HKD	WEB
Malaysia	Prem Kumar Shanmugam	N/A	Upon Enquiry	FTF
Singapore	David Kan Kum Fatt	+65 9770 3568	Upon Enquiry	FTF
Singapore	Su Keng Gan	+65 6289 6679	Upon Enquiry	FTF
Singapore	Ellis Lee	N/A	Upon Enquiry	FTF
Singapore	Abigail Lee	N/A	Upon Enquiry	FTF
Singapore	Kwang Mong Sim	N/A	Upon Enquiry	FTF
Singapore	Saik Hoong Tham	+65 8567 0508	Upon Enquiry	FTF
Singapore	Eugene Chong	+65 6397 1547	Upon Enquiry	FTF
Singapore	Jeffrey Gim Tee Po	+65 9618 8153	$100.00	FTF/PH/GRP/WEB

SUBMISSION GUIDELINES

Want to be published?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

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

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

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

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

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

Editorial policy

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

Previously published articles

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

Articles for peer review (refereed)

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

Conditions

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

Deadline

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

AIPC

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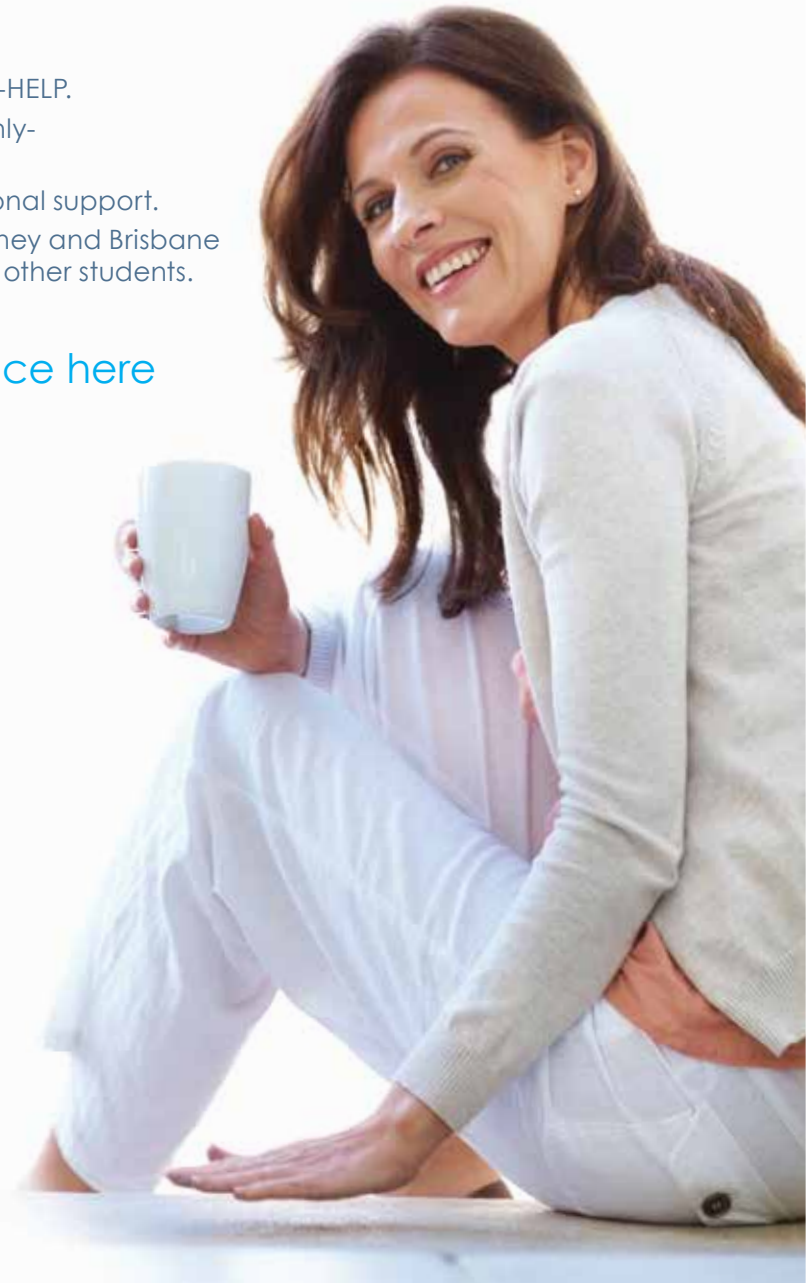

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Adelaide	|	1800 246 324
Regional NSW	|	1800 625 329
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Gold Coast	|	1800 625 329
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AIPC

Gain Entry Into An ACA Professional College

With An ACA Accredited Specialty Vocational Graduate Diploma

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

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

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

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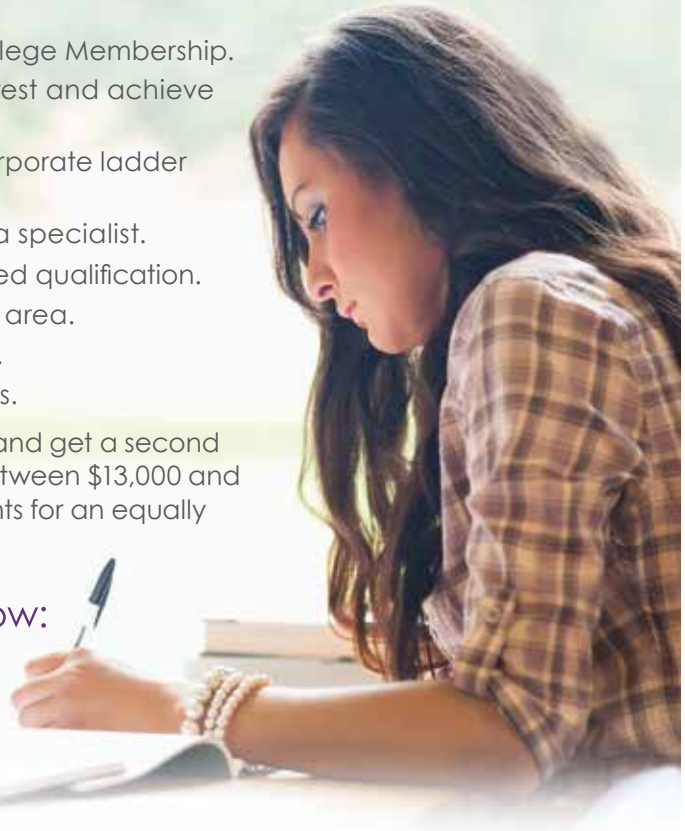
Each of the VGD's can be undertaken externally at your own pace. Here's how a graduate qualification can advance your career:

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



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