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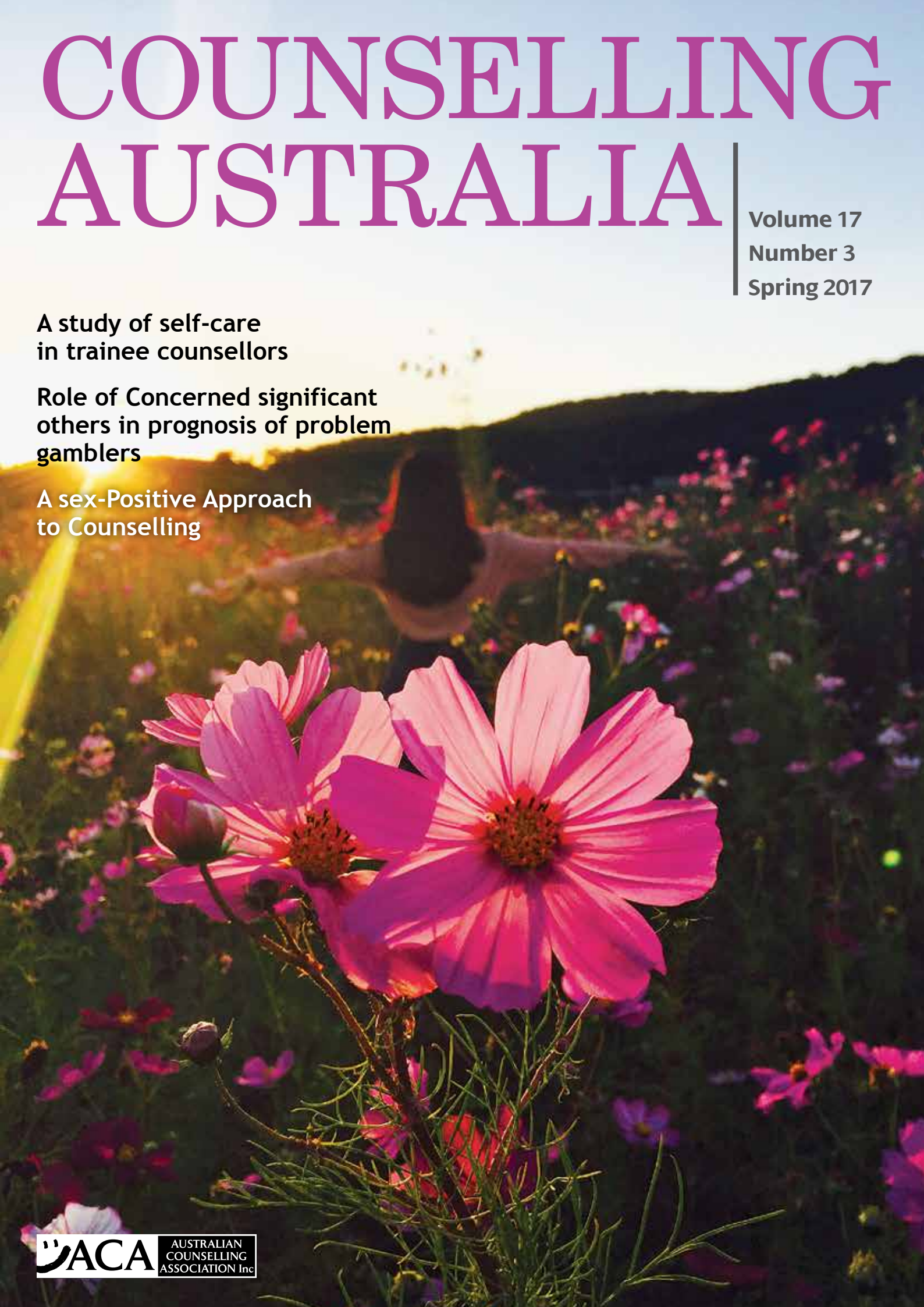

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PEER REVIEWED ARTICLE

A study of self-care in trainee counsellors

By Sanjay Dorji

Abstract

BACKGROUND:

Self-care is regarded as one of the most important practice for the profession of counselling, and self-care practice is highlighted as an essential requirement for trainee counsellors by most of the training providers, and counselling bodies. However little is known about the actual self-care experience of a trainee counsellor. Aim/methodology: This study used a qualitative phenomenological approach to explore the self-care experiences of trainee counsellors at one of the universities in Western Australia. Findings: The findings of the study showed that participants consider self-care as a very critical part of their role as counsellors; individuals have their own ways of looking after themselves, and their self-care practice has evolved with their experience. Overall, four overarching themes emerged from the data: the need for self-care, self-care and supervision, self-care and self-evolution, and self-care and ethics, and within these themes ten sub-themes emerged.

IMPLICATIONS:

The study is a good reminder for counselling training providers of the importance of including self-care practice as a part of their training programs, and it discusses various ways to facilitate self-care throughout the training.

Introduction

Almost every counsellor will have his or her own story of self-care experience to share. Indeed they may have their own understanding of the term 'self-care', and may have designed their own self-care practice. In general, self-care can be defined as the practice directed towards promoting individuals' psychological, emotional, and physical wellbeing (Hughes 2014). Self-care is regarded as an important consideration for helping professionals who practice in the field of counselling, trainee and fully-fledged counsellor alike (Christopher, Dunnagan et al. 2006, Thomas 2010, Mayorga, Devries et al. 2015). Today, monitoring wellness has become an ethical responsibility for individual practitioners, and this is frequently discussed in the counselling literature (Harrison and Westwood 2009, Lambie, Hagedorn et al. 2010, Francis and Dugger 2014, Hughes 2014). Likewise, two well-established counselling bodies in Australia, Psychotherapy and Counselling Federation of Australia (PACFA) and the Australian Counselling Association (ACA), have highlighted the importance of self-care in their Codes of Ethics (ACA 2015, PACFA 2015). Therefore, both personal and professional self-care has become one of the guiding principles for individuals in the field of counselling.

Individual counsellors name various situations and experiences, which demand the need for self-care, but in general self-care practices are required to maintain good work-life balance, good ethical practice, and to maintain good quality of services to the clients (Lawson 2007, Lambie, Hagedorn et al. 2010, Prosek, Holm et al. 2013). For a counsellor, a good self-care practice reduces burnout, compassion fatigue, and vicarious traumatization (Trippany 2004, Lawson 2007, Hardiman and Simmonds 2013). Burnout is characterized as emotional exhaustion, depersonalization, and reduced feelings of personal accomplishment (Maslach and Jackson 1981). There are several factors that can lead to burnout, including work overload, lack of locus of control, unsupportive work peers, and ineffective supervisors (Lambie, Hagedorn et al. 2010). Compassion fatigue refers to a emotional state that a counsellor experiences due to the process of engaging with clients who are in pain (Bozgeyikli 2010). Vicarious traumatization refers to the accumulative effects of extending empathy while working with clients who have experienced traumatic life events (Meyer and Ponton 2006). Counselling professionals need to stay aware of these potential impairments because these can impact both the personal and professional wellness of counselling professionals, and can expose them to a degradation of their quality of life.

Trainee counsellors experience many challenges and stresses imposed by academic work, training placements, self-disclosure, reflective work and group work. Additionally, trainee counsellors always have to negotiate with competing demands and time pressure emerging from family, work, and school responsibilities (Prosek Holm et al. 2013, Mayorga, Devries et al. 2015). In their clinical training experiences, trainee counsellors typically experience more anxiety and more role confusion at the beginning, and this decreases with time as they gain more experience (Bernard 2009). Research has found that counselling students have

Trainee counsellors experience many challenges and stresses imposed by academic work, training placements, self-disclosure, reflective work and group work.

higher level of wellness than normal population of students (Myers, Mobley et al. 2003, Smith, Robinson et al. 2007). However, this doesn't mean counselling students are immune to distresses; in fact they have more challenges to master the ambiguity of counselling process, and the nature of working with the clients (Skovholt 2011).

Some of the suggestions in the literature to maintain professional wellness for counsellors are (a) to seek an effective professional supervision from supervisors and peers (Hill 2004, Bernard 2009), (b) to attend ongoing professional and organizational trainings at various workshops, seminars, and conferences to keep on track with current needs and issues in the field and to enhance professional identity (Lawson 2007, Harrison and Westwood 2009, Hughes 2014), (c) to develop awareness of diversity and multicultural pluralism in professional roles with adequate empathy to serve clients (Sharma 1998, Hughes 2014), and (d) to maintain clear boundaries, honour limits at work, and create meaning in fulfilling daily tasks to achieve professional satisfaction (Cummins, Massey et al.2007). Not surprisingly, one study on self-care indicated that individuals who sought personal counselling had fewer feelings of burnout and an increased sense of personal growth (Linley and Joseph 2007). Unfortunately many counsellors report that they do not seek counselling as a self-care resource (Kottler 2003). Exploration of students' self-care experience may possibly give some explanation as to why they do not seek counselling themselves.

As a means to encourage trainee's self-care skills, some educational institutions around the world have incorporated the requirement of individual counselling, and other useful self-care components as an essential requirement within their counselling training programs (Newsome, Christopher et al. 2006, Boellinghaus, Jones et al. 2013, Prosek, Holm et al. 2013, PACFA 2015, ACA 2015, Mayorga, Devries et al. 2015). This is a good indication of the increasing emphasis and importance placed on self-care. Unfortunately, there is little research exploring the self-care practices of trainees in counselling programs. Self-care is viewed as an individual trainee's responsibility; although students may be receiving indirect self-care assistance in the form of supervision, peer support, course content etc. Therefore, exploring graduate students' experiences of self-care will be helpful in counselling program development and advocating initiatives in implementing healthy and appropriate self-care practices.

What is Self-Care?

For a counsellor, self-care can be as simple as an act of having meal on a time, and having enough sleep, and can be elaborated as taking a set break of half an hour in between the sessions. Self-care strategies identified by the American Counselling Task Force include meditation, journaling, reading for pleasure, hobbies, volunteering, going to the movies, visiting friends, laughing, going to see a counsellor, crying, exercising, drinking plenty of water, sleeping enough, eating regular meals, and yoga (ACA 2004). All of the above strategies, along with emphases on seeking individual counselling, and supervision, are discussed under the clause of 'self-respect' in a booklet on code of ethics produced by the Psychotherapy and Counselling Federation of Australia (PACFA 2015). In the similar line, a report on Australian counsellors and psychologists studying 1025 therapists suggests four major self-care strategies: 1) discussing the problem with a colleague (54%), 2) trying to see the problem from a different perspective (53%), 3) giving yourself permission to experience difficult or disturbed feelings while reviewing privately how the problem had arisen (43%), and 4) consulting relevant articles or books (43%) (Schofield and →

Roedel 2012). However, this report was limited to understanding self-care from a professional counsellor's perspective.

As a note of caution, a trainee counsellor should be mindful of the use of negative coping strategies that are likely to further compound their difficulties. Examples of such practices include self-medicating with various substances, such as alcohol, drugs, and food, seeking emotional support or gratification from clients, and engaging in minimization, denial, or rationalization (Barnett, Baker et al. 2007). However, there is very limited research exploring the prevalence of negative coping practices amongst trainee counsellors.

Spirituality has been suggested as a positive factor to enhance self-care for trainee counsellors (Roth 2000, Hardiman and Simmonds 2013, McLellan 2016). Therefore, counsellors are encouraged to explore their spiritual values, which may serve as a source of refuge in difficult times.

Self-care and ethics

Generally, counsellors who have good self-care practices usually see themselves as ethically proficient practitioners (Zakaria 2013). The pursuit of psychological wellness through ongoing self-care efforts has been described as an ethical imperative (Myers, Mobley et al. 2003, Lambie, Hagedorn et al. 2010). At the heart of a sound ethical counselling practice, there lies a framework of respect, care, and sensitivity toward others in ensuring the highest professional standard of services within the counselling profession realm (ACA 2015, PACFA 2015). This framework guarantees the care of self, care of clients, and care of colleagues, which are all based upon a counselling professional's personal and professional morals, values, principles, and personhood quality (Zakaria 2013). A counsellor cannot be an ethically sound practitioner without having a strong self-care practice.

Self-care and supervision

Supervision is a process in which the therapeutic skills of the supervisee is developed with assistance from a supervisor (Cooper, O'Hara et al. 2007). In general, a trainee counsellor believes the presence of an academic faculty member as a supervisor is an important factor in evaluating, and contributing to their growth (Hill 2004). The students expect the supervisor to contribute to the adoption of wellness practices. In one study of trainee counsellors' supervision experience, participants were asked what they expected from supervision, and what they experienced in supervision. Participants provided more information related to expectations than experiences, and stated that supervision was crucial in the times of difficulties, and for their personal or professional growth (Lonn 2015). Similarly, the majority of full time counsellors have named supervision as a very important tool for their professional growth, and good source of help when dealing with challenges (Skovholt and Ronnesstad 2003, Hughes 2014).

Self-care and self-enrichment

In counselling training, students learn to hear and observe what is going on within them, especially in learning to be more empathetic and congruent. In searching for their own identity, the counselling professional needs to know their own unique, true, caring, and real professional 'self', and this process could create internal turbulences for the trainee counsellors (Lambie, Hagedorn et al. 2010, Zakaria 2013). On the brighter side, in working towards understanding of the 'true' self, a trainee student may enhance the skills of compassion, empathy, self-efficacy, awareness, and resilience; all of these can contribute to self-care behaviour immensely (Siyez and Savi 2010, Bozgeyikli 2012). Techniques such as loving-kindness meditation, positive psychology, acceptance and commitment therapy (ACT), and mindfulness, increase well being, and compassion, thus are potential tools to foster self-care in trainee counsellors (Siegel 2001, O'Donovan and May 2007, Wise, Hersh et al. 2012, Boellinghaus, Jones et al. 2013). Educating trainees about self-care practices help them manage stress associated with deforming, and reforming their sense of 'self' (Myers, Mobley et al. 2003, Lambie, Hagedorn et al. 2010).

METHODOLOGY

Introduction

The purpose of this qualitative study was to explore the self-care experience of trainee counsellors. For this study, a qualitative methodology study was chosen mainly because qualitative research approach seeks to inquire into the meanings which people employ to make sense of and guide their actions (McLeod 1999). This fits

perfectly with the rationale of the current study, which was to understand the experience of self-care with a research question, 'How do counselling trainees take care of themselves both during and after the program?' Given both the paucity of such research in this area and the exploratory nature of this study, a phenomenological design was adopted as a research paradigm. The approach of phenomenology has its root in the work of early 20th century German philosopher Edmund Husseri. He dedicated his life towards digging the essence of human existence, and phenomenology was adopted as his tool for finding the ultimate truth (McLeod 2001, p.35). Like in the most of other field, phenomenological approach in counselling research includes setting aside prior assumption to gain access to the 'lived experience' of the participant (Wertz 2005). The main data source was individual in-depth interviews and the corresponding transcripts. To avoid the researcher's preconceived notion of the phenomenon, and to consider the perception of participants as a primary source of knowledge, a transcendental phenomenology paradigm was used (Moustakas 1994). Transcendental attitude is achieved through the procedures known as 'bracketing', 'epoche' or 'reduction' (McLeod 2001). With this researchers can obtain the perspective to be able to identify the core themes and essences in the data (Tuohy, Cooney et al. 2013). In this study the researcher identified the specifics of the trainee students' self-care experiences, and the context in which their experiences occurred. The participants' subjective understanding revealed the essence of their experience related to the research questions.

Participants

Purposive sampling was used in this study because this method of sampling is widely used in qualitative research for the identification and selection of experience-rich cases related to the phenomenon of interest (Palinkas, Horwitz et al. 2015). The type of purposeful sampling this researcher employed was a combination of criterion sampling and convenience sampling. By using criterion sampling, the researcher was assured that all participants experienced the phenomenon under investigation (Palinkas, Horwitz et al. 2015). The sample was a convenience sample as students were recruited from the Master's program in the Department of Counselling at the institution, who are all easily accessible for the study. Participants were selected based on enrolment in a Master's level placement unit at one of the universities in Western Australia. This population was selected for this study because the students had enough experience in the course, and the placement to be able to respond to the research questions.

DATA COLLECTION PROCEDURES

Participants were current and former students in the Department of Counselling. One of the senior lecturers helped in disseminating the information letter, flyer and consent form to graduates, and to current students in the counselling course. An announcement was made in an online post for counselling students. Three participants consented to a recorded interview. The researcher solely collected all the data.

Data analysis

Recorded interviews were transcribed and uploaded into NVivo. This software reduces a great number of manual tasks and gives the researcher more time to discover tendencies, recognize themes and derive conclusions (Alyahmady and Al Abri 2013). One of key steps involved →

is in highlighting the significant statements that offered an understanding of how the participants experienced the phenomenon (Thorne 2000). Participants' statements were not weighted or given special importance; instead each was considered to be of equal importance.

SOME OF THE KEY STEPS IN DATA ANALYSIS ARE

Epoche

In the Epoche, the researcher sets aside his/her prejudgments, biases, and preconceived ideas about the phenomenon and views the data naively and freshly through a clear mind (Moustakas 1994, McLeod 2001, Wertz 2005).

Phenomenological Reduction

In Phenomenological Reduction, the main task is describing in textural language just what one sees, and for this study, the researcher planned to observe the steps of: Bracketing, horizonalizing, Clustering the Horizons Into Themes, and Organizing the Horizons and Themes into a Coherent Textural Description of the phenomenon (Moustakas 1994, McLeod 2001, Wertz 2005).

Imaginative Variation

In phenomenological study, researcher uses his imagination to change the feature of experience to seek other possible interpretation of the phenomenon under investigation (Turley, Monro et al. 2016). The researcher is able to explore for different possible meanings for the experience of self-care expressed in the data.

Invariant Essence

In the final stage, the textural and structural descriptions were produced to describe the core of the lived experience under investigation (Moustakas 1994). It provided the detail account of the experience of self-care, and the context in which it emerged. The goal was to provide a description of the universal experience of the so that the reader feels like he or she has an accurate understanding of the experience the participants described (Creswell 2013).

Direct quotes from participants were used to provide a "thick" description of the experience and to preserve the participants' subjective experience. In this way, readers have an opportunity to hear the participant's voices. The conclusions drawn by the researcher were supported by direct participant quotations.

Findings

The analysis revealed four major themes and 10 subthemes, as illustrated in Table 1. Participants identified: a need for self-care, knowledge of self-care practices, supervision requirements, and ethical responsibilities as shaping their self-care practices and experiences.

Theme 1: The need for self-care

Impact of the course

Participants shared the need for self-care emerging out of the counselling course mainly due to the experiential nature of the course, personal disclosure, group work, reflective work, academic pressure, and inadequate support from the course provider. '*Prior to coming to the course, I didn't know how much the experiential nature of the course was going to impact me*' (Kate). '*I suppose there is this pressure of datelines, and expectations*' (Pam).

Impact of clinical placement work

Another challenging situation for the participants arose when they started working with clients, both during the placement at university, and working as fully-fledged counsellors. All of the participants have highlighted the need for self-care during these experiences. Difficulties due to countertransference are another concern shared by the participants. '*sometimes feeling like you are identifying too much with certain clients*' (Pam). '*I think the other time self-care becomes very important is while dealing with difficult clients, I had a few, particularly, one client actively suicidal, and I needed self-care then*' (Jane).

Self-evolution

The participants expressed challenges necessitating self-care practices when their old sense of 'self" was challenged to create a new sense of 'self' as a counsellor. One of the participants narrated her experience of how she has had to re-adjust her professional 'self' throughout this course: '*I was used to having the power, and what was worst was I was a school principal and I really had the power, I had to lose that*' (Jane). Another participant described self confrontation as a part of evolution of self: '*this course has put a mirror right in front of my face, and like it's put*

The need for self-care	Self-care practices	Self-care supervision	Self-care and ethics
Program/course	Internal	Individual	Self-care and ethical responsibility
Client experience	External	Group	
Self Evolution		Mentoring, and peer support	Self-care, Ethics and Performance

360 mirror on me. I had to look at things I haven't ever looked at, couldn't bear to look at. I feel like I have evolved and developed through this course enormously, I feel like I have been stripped down to bare bones (Kate).

Theme 2: Self-care practices

Participants shared their experience about practicing different ways of taking care of themselves in various situations, and these practices can be put into the categories of external and internal self-care practices.

External self-care practices

In this category, the kinds of self-care practices where participants used some external agent to facilitate their self-care are listed. Participants named: Seeing a therapist, supervisions, physical exercise, eating and sleeping on time, socializing, yoga, tai chi, taking day off, talking to other people, humour, and relaxation as prominent external self-care practices. Among all of these, seeing a therapist, and supervision were seen as the most effective modes of external self-care by participants:' *I see a therapist for myself for that as well, who has been extremely helpful*' (Kate). ' *That I need to be able to go to my supervisor and say I don't feel proper, maybe I shouldn't work, and the self-care was being able to say it, and in saying it*' (Jane).
Additionally, participants shared being part of association like PAFCA, professional development and mentoring as other forms of self-care practices: '*Becoming a member of PACFA, I think has been an important self-care tool too*' (Jane).

Internal self-care practices

In this, the kinds of self-care practices participants engage internally by themselves are listed. Participants have named: Reflection, Gratitude, Mindfulness, Acceptance, and Imaginary. Participants have shared self-reflection as of the most effective internal self-care practices: '*what you get when you are reflecting, because it's like a bit of peace or clarity or something like that, that I find more helpful than ticking the box*' (Pam). '*I guess self-care is to do with self-awareness, and attending to yourself*' (Kate).

All the participants are spiritual, and mentioned spirituality as one of the major self-care practice. One of the participant

mentioned the role of spirituality in initiating gratitude, and grounding: 'I guess spirituality or religion or whatsoever it may be, the higher place that I look to bring me to a space of gratitude, so, it's like a grounding in me' (Kate).

Isolating, and blaming themselves are two ways in which participants named as negative self-care strategies. 'I can isolate myself and just become quiet, which is odd because I am so social' (Kate). 'Stopping doing the things that I know that are going to make me feel better, like maybe not going out as much, and or withdrawing a bit more' (Pam).

Theme 3: Self-care and supervision

Participants shared their experience of understanding the importance of supervision throughout the training experience: 'individual supervisions, and group supervisions, I see that as the care that university provided, it taught me the importance of supervision' (Jane).

INDIVIDUAL SUPERVISION AND SELF-CARE

All the participants regard individual supervision as one of the most important aspects of self-care. '*I had a particular supervisor, my one-on-one supervision, who really invested in her supervision with me, and I felt it groomed me personally*' (Kate). '*I felt supervision has been really helped me think about things more clearly,*' (Pam). One of the participants acknowledged the help of having mandatory supervision, and also, the role the individual in making the supervision meaningful: '*Yes, the supervision was a big one, yes, I think, in terms of self-care, I mean you don't directly think of that because you don't seek out the supervision, the supervision is put in there, but I guess how I looked at it is what I took to the supervision, I would take myself to supervision because I wanted to be cared for* (Kate).

GROUP SUPERVISION AND SELF-CARE

Participants did not report positive experiences with group supervision in terms of self-care. One of the participants described a difficult group situation which affected her experience: '*when I mentioned that I had a bad incident with a group* →

supervision, for my own self-care, when I have a expectation to be held, and when that is not met, that is really difficult for me' (Kate). Another participant shared her dissatisfaction about the type of group session at her work place:' *I am not going to go into criticism, we had good but very intermittent group supervision*' (Jane).

PEER SUPPORT AND MENTORING

Participants really value the role of their peers in their self-care experience:' *I would really say that group of women that I have got to know, because we share, listen to each other, but also share things that might be helpful so, yeah, I think of the group as self-care*' (Pam). Another participant had a similar experience with the cohort support:' *I think the relationships that were formed with other students, and that peer support, sometimes wobbly, but was important, was part of self-care*' (Jane). Participants also shared about the benefits of mentoring as a self-care practice: '*I suggested students could become mentors when they graduate, come back and offer free services to help students, because we need holding*' (Kate). '*The mentoring, the casual mentoring, talking over a glass of red wine, it's good*' (Jane).

Theme 4: Self care and ethics

SELF-CARE AND ETHICAL RESPONSIBILITY

Participants had an understanding of self-care as an ethical responsibility of being a counsellor:' *I think for a counsellor to be good counsellor, and to be ethically responsible, they need to be looking after themselves, if you are walking to that room and you are not looking after yourself, you bring that into the room, and that's not ethical, so, you need to be caring for yourself, that's your ethical responsibility*' (Pam). Another participant shared her view on the importance of ethical decision making while working with the clients:' *if you don't look after yourself, you can't care for your client, just as you must make the decision to not to work with someone whom you can't work with, and not to work when you are not well*' (Jane).

ETHICS, SELF-CARE AND PERFORMANCE

Participants shared about personal issues affecting their performance in therapy session: 'you must take care of yourself, as Jung talks about the wounded healer, if you are a wounded healer, you have to take care of yourself, to be able to be the healer' (Jane). One participant shared about a difficult session experience due to something major going on in her own life, in addition she mentioned the role of integrity in being ethical: 'when I have been with the client, and I got something really major going on in my life, it very hard to listen, you really have to ask yourself to push that to one side, and focus on what this other person is telling you, so, yes I think ethically, it is very important, but only you are ever going to know about it, because that is whether that integrity, you know your own integrity, because no one can hop into your head' (Pam).

Discussion:

Though the common understanding of self-care is similar, every participant had his or her own way of looking at it, defining it, and attending to it. Through their experiences participants shared the critical need for self-care in various aspects of this field, and also their ways of addressing the need for self-care through different ways. In particular, participants in this study have reiterated the need for self-care due to evolution of the 'self', and relationship between ethics and self-care, which is in line with previous studies (Lambie, Hagedorn et al. 2010, Wise, Hersh et al. 2012, Zakaria 2013). Although the participants named individual supervision as an important place that offered good self-care, they did not report a similar experience with group supervision, which is contrary to the literature (Skovholt and Ronnestad 2003, Hill 2004, Hughes 2014, Lonn 2015).

In this study, mentoring, and peer support are explicitly named as healthy self-care practices, which is a good contribution to the knowledge pool on self-care practices. In general, all the participants saw the 'training' as the primary place where self-care was needed and also as a place of key source for self-care support. Participants' awareness of self-care, and self-care skills grew along with their journeys to become counsellors.

Conclusion:

The study explored the self-care aspect of experiences of two counselling students, and one alumnus of a Counselling course at one of the universities in Western Australia. The semi-structured interviews using quantitative paradigm revealed four major themes, and ten sub-themes. Through their experience participants shared the need for self-care, the importance of self-care, and things they do to take care of themselves. Except for the group supervision session, all the themes, and sub-themes are consistent with the literature, and past findings.

The main limitation of this study was the small sample size because three participants do not necessarily represent the broader trainee population, and all the participants being female imposed a limitation in sharing the experience from a different gender's perspective.

This study has reiterated the importance of self-care practice in the profession of counselling, and this is a good reminder for counselling program providers of the importance of including self-care practice as a part of the program through direct means like making it mandatory for the trainee counsellors to seek a therapist, and through indirect means like including the theoretical aspects of self-care in the course content. To examine the changes in self-care practices for trainees from pre to the post training, a longitudinal study of self-care experience is recommended. Other potential studies could explore self-care through mentoring, and peer support, and any negative self-care practices of trainee counsellors.

BIOGRAPHY

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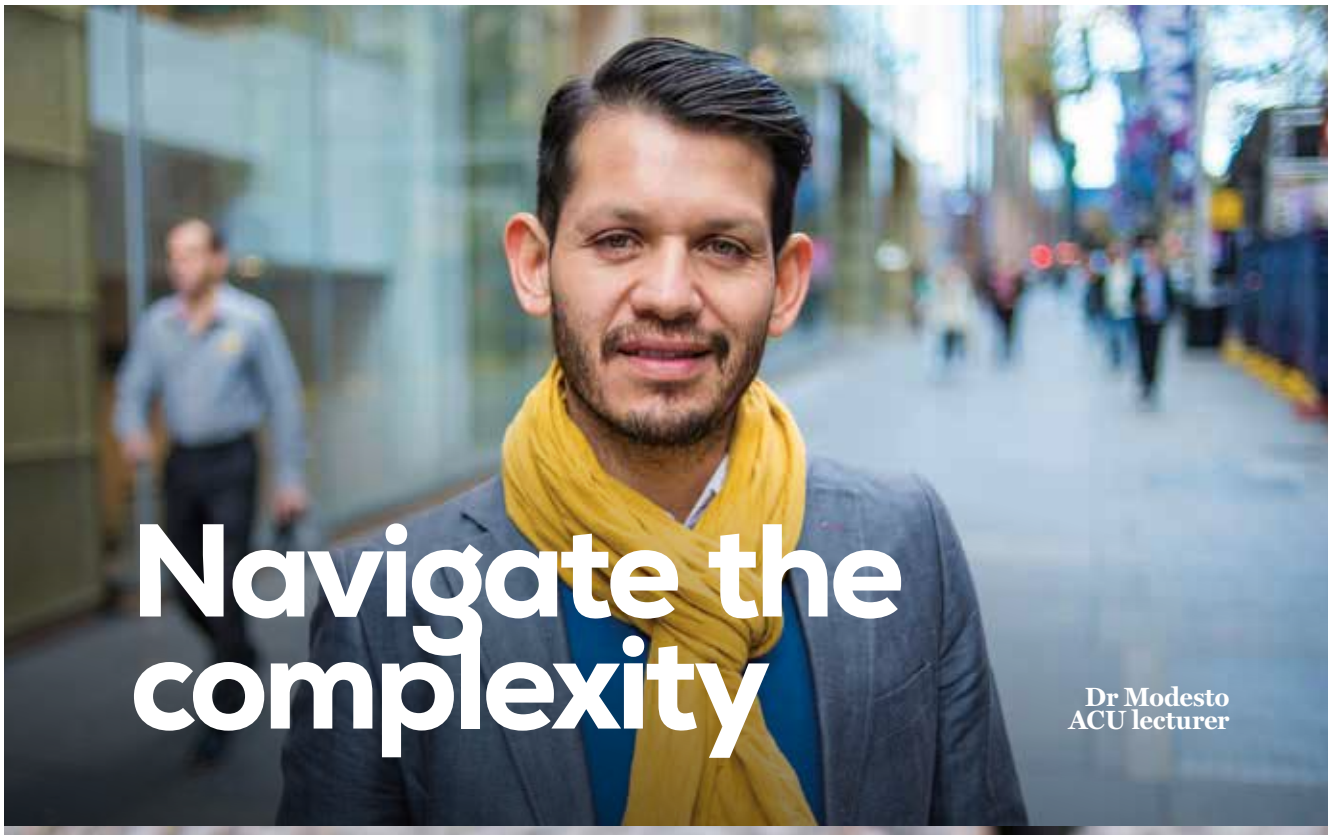

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PEER REVIEWED ARTICLE

Role of Concerned Significant Others in prognosis of problem gamblers: A qualitative study by Theory of Expressed Emotion

By Bernard Fan

Abstract

This study aims at finding the role of Concerned Significant Others (CSOs) on the prognosis of problem gamblers. This is a qualitative study to examine the impact of CSOs on problem gamblers by the Theory of Expressed Emotion (EE) to analyse memoirs of the family members of problem gamblers. This study has found that CSOs had expressed negative attitude towards their gambling family members and are classified as High-EE, during the period when the problem gamblers relapsed. On the other hand, CSOs were more prone to express positive attitude towards problem gamblers during gamblers' abstinence. CSOs' attitude towards problem gamblers can have positive or negative influence on their prognosis of gambling addiction depending on their expressed emotion.

Background and rationale

Gambling is a common social and leisure activity across different countries. It is a harmless activity for most people but it can become problematic for people who are indulging in gambling activity. The DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, fifth edition) has classified gambling as a potential behavioural addiction (American Psychiatric Association, 2013). The DSM-5 indicates that the symptoms of Gambling Disorder are gambling which persistently and repeatedly leads to clinically significant impairment or distress over a 12-month period if a person meet four or more of 10 criteria. Beside the problem gamblers themselves, family members of problem gamblers are the most common people experiencing the negative impact of gambler's addiction problem. It is estimated that one problem gambler affects on average 10 to 15 other people (Productivity Commission Report 1999). The people surrounding people with gambling problems are identified as Concerned significant others (CSOs). Concerned significant others do not confined to family members such as parents, partners, siblings and children of problem gamblers but also include friends, colleagues, workers and others in the general community who have close contact with problem gamblers.

There are a number of studies done on CSOs (Salonen et al. 2015, Svensson et al 2013, Wenzel et al 2008). Most studies reported negative impacts on CSOs including financial burden, physical health, psychological distress, marriage and relationship breakdown and career influence (Lorenz & Yaffee 1989, Hodgins et al 2007, Chan et al 2016)). Other negative consequence of problem gamblers on CSOs include harassment and legal threats by the gambler's creditors, distress in their children, additional responsibilities arising from the gambler's neglect of family responsibilities, insomnia, depression and suicide attempts (Heineman 1987, Lorenz & Shuttlesworth 1983, Patford 2009, Gaudia 1987, Lorenz & Yaffee 1988). In a study of Norwegian population, CSOs of gamblers reported experiencing family's conflicts, financial problem, impaired mental and physical health (Wenzel et al 2008). In another study of Chinese community, CSOs reported high psychological distress, poor general health and bad quality of life (Chan et al 2016). In a Sweden study, both male and female CSOs experienced poor mental health, risky alcohol consumption, economic hardship and more negative life events. Female CSOs also reported less social support while male CSOs reported more legal problems and afraid of losing their jobs (Svensson et al 2013).

In conceptualizing the experience of CSOs of family members with addiction problem, there are two models: the co-dependency (CD) and stress-coping model. Co-dependency (CD) is described as unhealthy relationship between the family members and people with addiction.

Co-dependency contributes the family members to suppress their own emotion, focus externally, self-sacrifice and attempt to control the family member's addiction behaviour (Dear et al 2005). The disease model of Co-dependency views co-dependency as a disease takes a similar form as that for alcoholism. The family's tolerance of unacceptable behaviour and loss of control over emotion increases parallel to the drinker's tolerance for alcohol and loss control over drinking. Co-dependency is described as being causally related to the addictive behaviour, such as alcoholism (Miller 1994). In other words, Co-dependency contributes to the deterioration of the addictive behaviour. However, it is criticized that concept of Co-dependency is based on speculation and impression to describe the behaviours of CSOs. Moreover, there is lack of empirical evidence support and consensus about a definition of Co-dependency (Miller 1994, Calderwood & Rajesparam 2014). The other model describe the CSOs is the stress-coping model. The Stress-Coping model or Stress-Strain-Coping-Support (SSCS) model assumes that a family member with an addiction problem,

Family environment is one of the important variables in determining the prognosis of patients.

include substance abuse or gambling constitutes stressful life circumstances and puts other family members experiencing negative impact in the form of physical health and psychological distress. Different people may respond to stressful conditions in different ways. Stress coping model assumes that CSOs still have the strength to cope with the adversity and stressful circumstances and have the capacity to determine their own destiny and not being powerless (Orford et al 2010).

Most studies mainly focused on the impact of problem gambling on CSOs. Little research has done on the attribution of CSOs on dysfunction or deficiency to family members with addiction problems (Orford et al 2010).

In the past few decades, it has been speculated that environmental factors have influence on patients with mental problem. Family environment is one of the important variables in determining the prognosis of patients. Expressed Emotion (EE) theory hypothesises the effect of family environment upon patients with mental issues. The construct of expressed emotion (EE) is an important measure of the family environment. The nature of expressed emotion is described as family attitude and feeling towards the patient. It is composed of five components: critical comments, emotional over-involvement, hostility, warmth, and positive remarks. Critical comments are defined as statements that constitute unfavourable comments upon the behaviour or personality of the patient. Hostility is defined as generalized negative feeling expressed against the patient rather than against particular behaviour or attribute of the patient. Emotional over-involvement is defined as an unusual degree of over-concern, overprotection, self-sacrificing, and devoted behaviour of family toward the patient. Warmth is the feeling of sympathy, interest, concern, and empathy toward the patient. Positive remarks are statements of praise, approval, or appreciation of the behaviour or personality of the patient (Leff & Vaughn 1985). EE reflects the extent to which the close family members of an identified patient express critical, hostile, or emotionally over-involved attitudes toward the patient. The EE Theory is a highly reliable psychosocial predictor of psychiatric relapse. The EE Theory hypothesizes that patients living in a family environment that is characterized by critical, hostile, or emotionally over-involved or intrusive attitudes, (i.e. high-EE relatives) will have higher relapse rate than those living with low-EE relatives (Leff & Vaughn 1985). The predictive validity of EE has also →

Over-protection : "We just hide the truth of his gambling problem in order to borrow money from my relatives"

been found for a broad range of other psychopathological conditions, including substance abuse (O'Farrell, Hooley, Fals-Stewart, & Cutter, 1998). Therefore, it is assumed that Expressed Emotion Theory is appropriated to apply to analyse the impact of Concerned Significant Others (CSOs) on the prognosis of problem gamblers family members.

The purpose of this paper is to analyse the role of CSOs on the prognosis of problem gamblers and hypothesis the mechanism of the attitude of family members in attributing to the relapse or recovery of the problem gamblers. This paper hypothesises that Concerned Significant Others (CSOs) can impose influence on the prognosis of family members with gambling problem. CSOs' attitude and emotion towards problem gamblers can have positive or negative influence on their prognosis of gambling addiction. The first hypothesis is if CSOs expressed emotion is negative and classified as high-EE, high-EE is associated with relapse of gambling during that period. Second hypothesis is if CSOs expressed emotion is positive attitude of Warmth and Positive Remarks, positive attitude will be associated with better prognosis of problem gambler's recovery.

Method

This is a qualitative study to examine the impact of Concerned Significant Others during their description of the family members with gambling problem.

Procedure

This study has utilized Leff and Vaughn (1985) the Theory of Expressed Emotion and Camberwell Family Interview (CFI) to analyse CSOs attitude towards family members with gambling problem. Conventionally, EE is assessed by the Camberwell Family Interview (CFI). Camberwell Family Interview (CFI) was originally developed by Brown and Rutter (1966) in a study of family relationship. An abbreviated form of interview was later designed by Vaughn and Leff (1976). CFI is a semi-structural interview with the primary caregiver of a patient who has recently relapsed and been admitted to a mental hospital (Leff & Vaughn 1985). Each interview takes about 60 to 90 minutes. It must be administered by a trained interviewer. The author of this study was a qualified CFI rater on completion of the Expressed Emotion training course being run by Dr. Christine Vaughn.

Samples

Ideally, EE is assessed with the data obtained by the Camberwell Family Interview (CFI) of the key relatives of patients whom have relapsed, admitted to hospital recently and have been discharged within 3 months. The content of interview was typed in a transcript for the raters to analyse. In this article, author has applied an alternative ways of analysing the data. The study has chosen a book titled "Seek-help Self-help Mutual-help: Stories of the family members of problem gamblers" which is published by a gambling counselling service – Rehabilitation Centre for Problem Gamblers in Hong Kong (2014). The book is published in Chinese which contains memoirs of eight cases. Eight family members were interviewed by one of the counsellor of the Rehabilitation Centre. The content of interview was then edited by the centre-in-charge of the Rehabilitation Centre. In the preface, the editor noted that the memoirs are the portrayal of family members and Concerned Significant Others about the moments and events that took place in their lives. Their memoirs are not stories but factual record of their living experience and feelings with the problem gamblers. Therefore, each memoir carries the same weight as the transcript obtained by CFI.

Data Analysis

The data were analysed according to the Theory of Expressed Emotion and Camberwell Family Interview analysis procedure. Since the book is published in Chinese, author also referred to Chinese version of "Using the Camberwell Family: Guidelines and Notes" (Philips & Wei 1995) in addition to the original English version of "Using the Camberwell Family: Guidelines and Notes" (Leff & Vaughn 1985). Level of expressed emotion is determined mainly by three components of critical comments, hostility, and emotional over-involvement. A relative who scores six or more on critical comments, displays any incidence of hostility, or rates three or higher on emotional over-involvement is classified as a high-EE relative. In the Chinese version of "Using the Camberwell Family: Guidelines and Notes", there is one more component for determining high EE for Chinese families, it is "withdrawal" (Philips & Wei 1995). If they do not meet the above criteria, they are classified as Low-EE. Despite critical comments, hostility, emotional over-involvement and withdrawal are the key components to predict relapse. Warmth and positive remarks have not been discarded in the assessment. The author analysed eight memoirs and classified them to either High-EE or Low-EE.

Results

Among eight cases, the CSOs or key relative family members are 1 son, 1 daughter, 3 mothers and 3 wives. Analysis of eight cases reported that all family members are classified as High-EE during the period when their problem gambling family members were peak in their gambling and relapsed to gamble. On the other hand, only seven cases reported their gambling family members restrained from gambling in the later stage and their CSOs did express positive attitude of either Warmth or Positive Remarks when they described recovery of their gambling family members. Only one case did not express positive attitude and the gambler did not report restraint from gambling. Details of EE result is shown in table 1.

One finding is all gambling family members had relapse a number of times. Some of them relapsed even as much as 5 times. In the memoirs, seven problem gamblers had joined the gambling treatment program. Among those who joined the gambling treatment program, seven of them restrained from gambling since they joined it and completed the abstinence course. Four of them had relapsed even after joined the treatment program.

Another finding of the memoirs are seven cases of their family members had reported continuously helping their

problem gambling family members and took all the debt and paid back the debt on behalf of their problem gamblers, which highlighted the self-sacrifice and over-protection of the Emotion Over-Involvement. Only the last case reported the problem gambler applied for bankrupt and did not mentioned the wife had took the debt and paid for her ex-husband.

Examples of attitude and expressed emotions are shown as following:

Critical Comments:

"He always argued with mother over money issue"; "He always had bad temper"; "She just liked to sponge food off others, to eat and drink on others expense"; "She did not repent and kept gambling and owed seven hundred thousand dollars"; "He was always with dissolute companion and fair weather friends to casino"; "He took my life"; "We always fought and in conflict"; "he did not change and cannot be trusted"; "I always remembered his dark side"; "He is gentle puzzled".

Hostility:

"He is a rotten gambler"; "He's gone / dead"; "There is only one thing to mum, it is 'hate'"; "He is a failure ...he is my burden"; "He is bad husband"; "He is hopeless and dump".

Emotion Over-Involvement:

Over-protection : "We just hide the truth of his gambling problem in order to borrow money from my relatives"; "I have spoiled his gambling behaviour"; " I have taken all his debt"; " I tried my best to protect his reputation"; " I have underestimated his gambling problem"; " I did not know how to set the boundary".

over-concern : " I felt frustrating"; " I felt guilty if not pay his debt".

self-sacrificing – I had paid back his debt a few times and each times the debt was worse than the last time".

devoted behaviour – " I got depression and had suicide attempt"; The mother broke into tears while talking about her son.

Withdrawal:

"She's gone / dead. ..... We never celebrated Mothers day for her",

Warmth:

"I have learned to forgive him"; "I have accepted her gambling problem but she is also a good mother and grand mother"; "I accepted him and not abandon him"; " I understand the cause of his gambling because of his low self esteem... I encouraged and concerned my son....and patiently guiding him"; "he has learned the lesson"; "I accept unconditionally",

Positive Remarks:

"He has changed...Now he cares the family, his mother and his son. He does not hurt my mother anymore."; "He contributes to society"; "He know how to handle his problem"; "I am glad that he finished his degree".

In their memoirs, some CSOs described that they have admitted having developed a Co-dependent relationship with their problem gambling family members.

Discussion

Most studies only reported the impact of gamblers on their family members. There is lack of research to examine the influence of the Concerned Significant Others (CSOs) on gamblers. This study looked into the role of CSOs and hypothesized the attribution of the CSOs on the prognosis of the problem gamblers.

The Stress-Coping model assumes that behaviour of addiction and negative consequence of addiction is stressful for family members whom would respond in different ways. Some family members may be able to maintain positive calming attitude which would be effective in coping with the stress while others may not be deal with the stress satisfactorily (Orford et al 2010).

This study has found that key family relatives and CSOs had expressed

The result of this study indicates that the Concerned Significant Others, including family members and friends, are also important in the recovery of problem gamblers.

negative attitude towards their gambling family members and are classified as High-EE, during the period when the problem gamblers relapsed and gambled a lot. On the other hand, the CSOs were more prone to express positive attitude towards problem gamblers when they successfully restrained from gambling. Expressed Emotion Theory hypothesizes that high-EE relatives and low-EE relatives interact with patients in different ways. A high-EE relative is more critical, hostile or emotional over-involved toward a patient which predicts a higher relapse rate for the patient (Leff & Vaughn 1985). The vulnerability-stress model explains that a high-EE relative is more emotionally arousing to the patient, while a low-EE relative tends to have a calming effect. Stressful life events as well as social environmental stress can interact with pre-existing vulnerability characteristics of the patient and produces psychotic episodes (Nuechterlein & Dawson 1984). This study assumes that when the CSOs are too critical and hostile to problem gamblers, their negative attitudes may be stressful to problem gamblers. Stressful family environment may trigger problem gamblers to relapse of gambling. Centre for Addiction and Mental Health (CAMH) Inventory of Gambling Situations (IGS) has identified that "Conflict with others" is one of the triggers to problem gambling (Littman-Sharp et al 2009). Rosenthal and Lesieur (1996) hypothesis that some problem gamblers are "escape seekers" and they resort to gambling as a way to escape to numbing or oblivion. Peden (2011) assumed that CSO's of problem gamblers may unintentionally contribute to the gambling problem. Their relationship problems may contribute problem gamblers to gambler in order or escape a nagging spouse and relapse. Therefore, High-EE CSOs' negative attitude could be trigger for problem gamblers to relapse in order to escape the adversity of family environmental stress. On the other hand, when the problem gamblers are able to be abstinent, it is encouraging for the CSOs whom may respond in positive attitude towards problem gamblers and CSOs positive attitude is rewarding for the gamblers in return. These positive attitudes explain the variation of prognosis of patients. One study has reported that high warmth and positive remarks are associated with better prognosis of mental patients (Philips & Wei 1995). The Expressed Emotion literature does not indicate a unidirectional relationship between relative's EE and relapse. There exists an interaction between the patients and relatives and EE ratings are not necessarily static over time (Vaughn 1989). It explains the possibility of the CSOs being able to change from negative attitude to positive attitude towards problem gamblers when gambling family members show progress in abstinence.

The EE literature does not indicate a simple unidirectional relationship between relatives' EE and relapse. The evidence suggests an interaction between the patient and relative in many instances (Leff & Vaughn, 1985). Neither are EE ratings necessarily static over time.The EE literature does not indicate a simple unidirectional relationship between relatives' EE and relapse. The evidence suggests an interaction between the patient and relative in many instances (Leff & Vaughn, 1985). Neither are EE ratingsnecessarily static over time.The EE literature does not indicate a simple unidirectional relationship between relatives' EE and relapse. The evidence suggests an interaction between the patientand relative in many instances (Leff & Vaughn, 1985). Neither are EE ratingsnecessarily static over time

Implication

The result of this study indicates that the Concerned Significant Others, including family members and friends, are also important in the recovery of problem gamblers. The Community Reinforcement and Family Training (CRAFT) Approach assumes that the CSOs can facilitate and impede the recovery process, and is therefore instrumental in the treatment of individuals with addiction problems. Moreover CSOs are in frequent contact with the family members with addictive problems, CSOs tend to be emotionally invested and are crucial in helping their family members to seek treatment and to change their addictive behaviour (Meyers et al 1999, Miller & Meyers 2001). Therefore, it is important to provide counselling service to Concerned Significant Others as well. Neglect of the influence of Concerned Significant Others may hinder the rehabilitation of the problem gamblers.

Limitation

This study has the limitation in method of collecting data and sampling. It relies on analysis of the reported memoirs of eight cases published by the gambling rehabilitation service. The data and depicted memoirs were edited and might be subjected to discrepancy of the original interview transcript. However, it is really hard to collect data of the recovery journey of the problem gamblers which can be extending over a number of years. Moreover, the original design of Camberwell Family Interview (CFI) is time-consuming to administer and labour intensive to rate (Hooley & Parker 2006). The widespread use of CFI in research is limited because of the scarcity of qualified

raters (Cole & Kazarian 1988). Therefore, this study analysed the cases is based on the introspective past. Introspective past is assumed that a client is able to report from the same point of view as the event and client is reliving the past and its spontaneous expression of feeling which is expected to be the same feeling of the past. This kind of introspective reporting will be less likely to occur when the respondent is faced with direct questions about their feelings (Brown & Rutter 1966). The findings must nevertheless be interpreted with caution for a number of reasons. Causal conclusion therefore cannot be drawn and longitudinal research might therefore be undertaken in the future.

Conclusion

This study shows that the role of family members or CSOs of problem gamblers may not be only passive victims bearing the negative impact of the gambling created by the problem gamblers. Family members can also attribute to the prognosis of the problem gamblers. The attribution of CSOs can be both negative and positive depending on their expressed emotion. Theory of Expressed Emotion and this family environmental factor provides an alternative hypothesis in explaining the prognosis of the problem gamblers.

Biography

Bernard W. S. Fan

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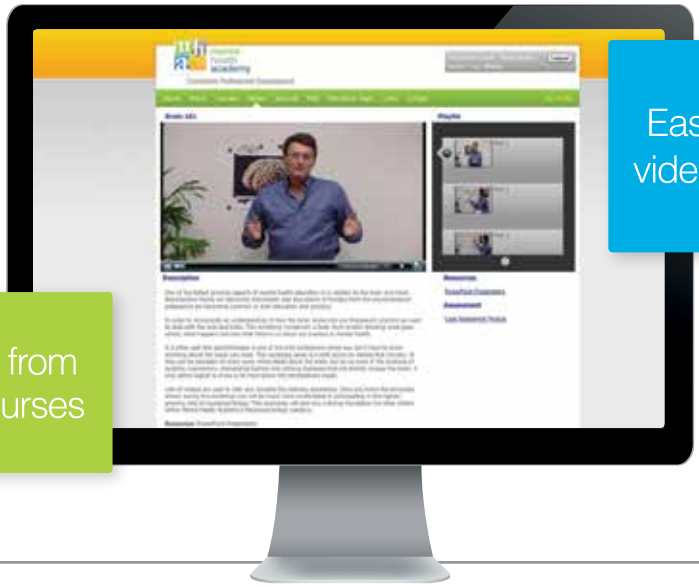

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PEER REVIEWED ARTICLE

A Sex-Positive Approach to Counselling

By Kim Gotlieb

Sex Positive counselling expands the landscape of possibility for our clients to explore their relationship to sex, gender and sexuality. Our ability to address these needs can be limited by negative cultural voices as well as our own levels of awareness.

Freud created a revolution by framing many psychological behaviours in the context of sexual fantasy. He is also well-remembered for his therapeutic relationship which was remote in the extreme. He sat behind the client and had them leave from a door in front, so they never actually saw him.

Some seven decades after his controversial and ground-breaking work, the therapeutic alliance is generally formed in much more engaging ways. Somatic Psychotherapy and other well-recognised modalities integrate touch into their intervention options. Many avenues of inquiry have realised the wisdom of the body and the narrative which can be nestled in the visceral fibre of this vessel which we inhabit.

A further development in the increasing holistic and integrative approach to well-being, includes the opportunity to work with clients regarding their sexual expression, or lack of it, and their relationship with their "erotic vitality".

Erotic Vitality speaks to an energetic forcefield that should be available to us all the time. It will express itself in our sexual encounters but it is a quality of being which could inform and enhance all aspects of our everyday experience. However, it is somewhat diminished by cultural and/or psychological injunctions against a celebration of our bodies as sexually-engaged beings. The sex-negative legacy passed down by our ancestors, often compartmentalises our sexual identity into very limited realms of preferences, pathology and specific activities.

What might first present as depression, low self-esteem, anxiety, addictive patterns, isolation or eating disorders may have their core underpinning in our clients' relationship with their body and their sexuality. When we are able to make more space for addressing issues related to the body and sex, it can open up many healing aspects of our clients' process including renewed creativity, joie de vivre, optimism, joy and sense of well-being.

Sex and sexuality are clearly an integral part of the issues which present themselves in our work as counsellors. Our ability to support clients in these areas will often require us to reflect on our own relationship with these concepts. How do we unpack those forces which have shaped our sense of sexuality and erotic vitality. What can we do to expand the landscape

"A couple's sexuality often serves as a metaphor for their relationship, so when things are going wrong in the bedroom it might point to partnership difficulties in non-sexual areas."

through which our clients can experience health and well being?

Our work as counsellors is often referred to as "talk therapy" which can run the risk of deferring to a didactic and somewhat cerebral areas of inquiry. The brain needs to be occupied. However, it is possible to retrain its function to reduce the clutter. Breathwork and Mindfulness practices can expand the framework of our work in ways that benefit our clients' hoped-for outcomes. These practices encourage one to be in the moment, withhold judgment and notice moment-to-moment thoughts, feelings and sensations, allowing them to pass like clouds on a blue-sky day.

Embodiment and Presence are two principles which can help maintain a holistic approach to our work. Embodiment refers to the notion of a body-mind continuum. The more we can support our clients to connect with the moment-by-moment subtle awareness of their physical body, the more the links between thought and emotion, narrative and experience become self-evident. Presence is the state of aliveness in which clients are tuned into a range of receptors, both cerebral thought and visceral sensation, which provide the individual with a grounded sense of being. This faculty can allow the person to deal more effectively with whatever situation may emerge in the changing landscape of their day-to-day lives. As counsellors, we can also benefit from tracking how much we are in touch with our own bodies and how much we are able to be fully present to the needs of our client.

"A couple's sexuality often serves as a metaphor for their relationship, so when things are going wrong in the bedroom it might point to partnership difficulties in non-sexual areas." (Sex Counsellor - Dr. Pamela Stephenson-Connolly) More generally sexual issues are often linked to archetypal rhythms and patterns in our psyche and our behaviour.

The physical and sexual nature of our clients, requires us to step into the increasingly complex subject of gender. Opening to aspects of gender diversity, gender presentation, gender dysphoria, and transgender upend all notions of pink-for-girls and blue-for-boys. The developing body of knowledge regarding gender and gender fluidity is achieving much around shifting the landscape of this conversation. However, progress is slow and it can be relevant for us to consider the differing influences which may inform male and female youths, as well as many adults who enter our consulting rooms.

Much of our programming around sex is informed by our early childhood experience.

Girls' sexual rite of passage tends to be more obvious with the moment of their first period, which usually requires them to step forward and communicate around their sexual maturity, in order to procure sanitary products. Girls will sometimes benefit from the feminine principle which is more communicative, collaborative and community-oriented. They are more prone to discuss intimate matters: sometimes with their peers, sometimes with adult women.

For boys the process is typically more secretive, perhaps with a "wet dream" or their first orgasm. This can be a complicated experience layered with shame and/or shock. With an absence of healthy role-models, mentors or narrative, boys generally find most of their sex education from porn sites, augmented by the fanciful languaging of male bravado. Neither of these provide a very reliable, realistic or grounded sense of the landscape of their erotic vitality. There is increasing data emerging around the impact of internet pornography on both sexual satisfaction and sexual relationships. It is important that we provide a space for these matters to be addressed. "We are as sick as our secrets", so that making safe spaces for clients to share some of their "secrets" can be highly beneficial.

Whenever the sexual impulse unfolds, it has a tendency to play out fixed patterns of behaviour which, over time, offer a diminishing sense of satisfaction and fulfilment. A good sex life can heal many aspects of a person's psychology that years of counselling may never manage to address.

Language mirrors the restrictive nature of our culture. There are simply insufficient words to address the range of subtle and nuanced experiences which belong to our sexual experience. Anthropologist Franz Boas enlightened us about the Eskimos having 50 words for snow. These words emerged to describe experiences of differentiation which became culturally useful because they related to the lived experience of these people.

The limited lexicon we have around sex and eroticism also perpetuates a denial of the lived experience of our sexually-charged humanity. For many, the word "erotic" conjures images of sex shops, lingerie and elements of kink. However, this word should also describe the broad nature of our energetic relationship with arousal and its affect on the internal process of our bodies, and perhaps our interaction with others. Sexuality relates to the nature of arousal, attraction, a variety of sexual activities, elements of identity, the reproductive organs, and a raft of mechanical and emotional experiences. Our erotic process moves beyond this framework to hold space for an expanded view of our sexual identity. It makes room for the array of energetic experiences, both subtle and intense, that can emerge in the context of our sexual expression. Limiting sexuality to sexual acts diminishing the range of possibilities implicit in these aspects.

From a philosophical standpoint, there is something of an existential tension when we consider that in childbirth, the one becomes two. However, Erich Fromm points to the potential that in erotic engagement, "two people who were separate become one". David Deida echoes these sentiments in his ground-breaking book, Finding God Through Sex: Awakening the One of Spirit Through the Two of Flesh. These tensions →

A mind map, tracking the events and influences which have affected us, is one of the most effective ways to explore our own values and relationship with sexuality.

will often prove challenging within the context of our sexual experience. They can also play out in other areas of our life and our relationship world. Opening to this underpinning, provide us with additional tools, which can prove helpful and enlightening to aspects of our clients' process. Patterns of behaviour can become patently obvious, when revealed in diverse aspects of their experience.

Trauma, both subtle and intense, is often in the background of an exploration of sexuality. For many of our clients, the innocence and value of their erotic process may have become withdrawn, damaged or distorted through experiences which have left a residual trauma, which requires attention and healing. The ability to unpack, explore and restore healing to our clients' history is an aspect of our work which is so rewarding.

One of the great perks our profession offers, is the level of growth possible for those of us who, as practitioners, journey "with" our clients sufficiently to see the various ways their process can mirror elements of our own structure, both known and more hidden. Process work presents a notion that clients select their counsellor as much for our "broken" parts as for our faculty of healing. We can all move forward in this context toward a more liberated and expressive community of "sex positive" adults.

The professional discourse in our industry has been somewhat muddied by the many examples of impropriety between counsellor and clients. The best defence against these issues is not by avoiding them, but through a more engaged relationship with our own sexuality. There is a challenge in maintaining our professional integrity, appropriate boundaries and duty of care while also opening to discussing the nature of clients' intimate sexual/erotic experience or the lack of it.

How do we explore blindspots and default behaviours that may be a little outside our awareness? We may like to think that we are non-judgmental, but many responses can reflect shades of shaming that can be damaging. It can be present in our languaging, but it can be even more impactful, when it is picked up by our clients through subtle movement signals: signs of agitation or embarrassment. Lips and eye gestures as well as tone and atmospheric shifts, can communicate unintentional and problematic negative signals which lead to suppression and shame on the part of our clients. Each of us, counsellor and client, have blindspots. In our role as

counsellors, we are called upon to develop single-minded attentiveness and vigilance in maintaining the therapeutic principles which underpin the virtue and value of this work.

Working on our selves

A mind map, tracking the events and influences which have affected us, is one of the most effective ways to explore our own values and relationship with sexuality. On a large piece of paper create a time line. Just begin to randomly fill in those memories, thoughts or feelings which come to mind. Make space to reflect on who else was around at the time, and whether their worldview, words or actions may have influenced you at that time.

As the tapestry unfolds, notice threads of similarity or difference. Where is there more activity and where is there less? Was this a dormant phase or is it possible you have gone blank? What else was happening at these times, which may seem unrelated? Our emotional world tends to favour pleasant over unpleasant experiences. Our memory will often be biased to favour some folk over others, depending on how we choose to remember them. Are the emotions subtle or intense? Be especially attentive to the gaps, or "nothing much" reflections, as they often hold very useful material, when given time to unfold. It can be useful to take time to rest at various stages in the exercise. Maintain some measure of awareness of your body, during the process. Allow the breath to deepen. Be open to emotions and sensations. Note them on your sheet. Exercise self care and obviously seek help if you uncover trauma or other challenging material which requires more specific and perhaps professional support.

This can be a brief piece of work or a lifetime of unfolding. There is a potential to develop a greater sense of the various elements which have influenced your own sense of sexuality: personal, political, cultural, familial and your peers. This will help support your ability to make space for the range of experiences which may present in the context of your counselling or therapeutic work.

Awareness is the key to developing the personal integrity required to expand into this area of inquiry. We all have biases and value systems, and the more we are able to work with them internally, the more we will avoid seeing them inadvertently present themselves in a glance, or a tone or a comment, which does not serve the work you are pursuing with your client.

"The price of freedom is eternal vigilance". (Aldous Huxley) If we are to create space for more freedom of expression around the sexual aspects of our clients' process, we must be ever-vigilant of our own process and the subtle and not-so-subtle shifts in the nature of the therapeutic alliance.

Working with aspects of sexuality and fostering a stronger relationship with the body, is a powerful step toward addressing the pervasive cultural shaming that is repressive and potential damaging to the well-being of our clients. As we move forward to a more liberated, sex-positive, expressive, dynamic landscape of therapeutic possibility, we make space for more creativity and higher levels of healing, understanding and freedom for ourselves and our clients.

BIOGRAPHY

Mr. Kim Gotlieb

I have worked as Psychotherapist/ Counsellor in private practice for over 30 years, working with private clients as well as EAP providers & registered NDIS practitioner. My specialist areas are: Anxiety, Depression, Sexuality, Relationship, Trauma & Gay Issues. I have facilitated workshops and group processes in a range of areas; including sexuality, power & privilege, gay & hiv issues. My work is informed primarily by Process-oriented Psychology and Narrative Therapy as well as being influenced by Sexological Bodywork. I am currently preparing a module to support counsellors in working more freely with aspects of clients' sexuality and erotic vitality.

QUALIFICATIONS

Current Member Australian Counselling Association - No. 3003
NDIS registered health professional
1999 Master of Applied Science majoring in Critical Perspectives in Psychological Practices
University of Western Sydney (Hawkesbury)
1998 Certificate In Process Oriented Psychology
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Working with aspects of sexuality and fostering a stronger relationship with the body, is a powerful step toward addressing the pervasive cultural shaming that is repressive and potential damaging to the well-being of our clients.

PEER REVIEWED ARTICLE

Losing Daddy

By Alana Vaney

When you are five years old, how do you make sense of your Daddy dying? Your Daddy, who has been sick all your life, suddenly disappears and doesn't ever come back. The Daddy who loved you so much. How do you make sense of that?

Amy's parents brought her to me for play therapy to help prepare for her father's death. It turned into a process of helping her unroll a knotted ball of complicated feelings. In this year, Amy had to step out into a new life, where people related to her differently and where expectations changed.

Her story began before she was born when her father was diagnosed with a degenerative disease. There were already three children in her family but she came along as a surprise. Her father was still up and about and delighted to be present at her birth. However, by the time she was four, the disease was rapidly disabling him. Now she was five years old and the time was approaching when her father would die.

Her parents wanted a counsellor who would stay with the family through the duration. The older children had also been coming to play therapy for several sessions, especially before their father died. By the time I saw Amy, I knew the family quite well and was in touch with them weekly. On the Strengths and Difficulties Questionnaire, {Goodman, 2000,}Amy's score was in the normal range but revealed that she had some concentration issues and was often not considerate of others' feelings. She was also often non compliant and attention seeking.

Amy, a beautiful child with long golden hair, seemed vital and eager to play. She came six times before her father's death. I noted in her first sessions what a happy and creative child she seemed to be. I thought she was well adjusted. She painted in bright colours, made birthday cakes with the playdoh and chatted about the cruise the family was planning. She did not understand that Daddy would die soon.

Maria Nagy, 1959, conceptualised a three stage model of awareness of death in children and linked the stages to approximate chronological ages. She postulated that children from ages five to nine begin to comprehend the finality of death, but believe it happens only to other people. It seemed that Amy was clinging to her normal life and was not developmentally able to let in the realisation that Daddy was dying. Christine Longaker,1997, also writes about this stage: "Children imagine death as an external danger-like a bogeyman or robber-a fearsome intruder who can be outwitted or overcome as in a cartoon show."

Non directive, child centred play therapy gives children a non-threatening way to express feelings and share events and experiences. Using the toys and the relationship with a safe, encouraging therapist, children can play out their needs, relationships and traumatic experiences. In experiential play, children can explore the trauma and eventually replace it with a sense of internal well-being. However, this is not a tailor made process. Each child forges their own path and it can be a mystifying and circuitous path for the therapist to follow. Amy's journey was intensely puzzling to me many times. I often needed the clear heart and mind of my supervisor to understand what might be happening in Amy's therapy. My experience told me that I didn't have to understand everything but I did need to trust in the power of play and in Amy's sense of self. In Play Therapy, I reminded myself, the therapist follows the child.

Landreth, writes: "Children are the best sources of information about themselves. They are quite capable of appropriately directing their own growth, and they are granted the freedom in the play therapy relationship to be themselves in the process of playing out their feelings and experiences." Landreth, The Art of the Relationship. 2002

By session four Amy's play had deepened as she began to explore family dynamics through the dolls. In the dollhouse, there was so much switching of rooms, with the dolls running up and down the stairs and nobody was able to get comfortable. Everything kept breaking down and Amy said, "We can't stay here." It looked as if she was feeling the imminent discomfort of change. Her parents, though affectionate, were not able to give her a lot of attention as her father's condition deteriorated. The children were in conflict with one another.

Max Porter, has written about this conflict between two boys in his novel, Grief is a Thing with Feathers, 2015:

"They slapped. A little cuff, a little jab. The "short fat prince" would move his chair and send his brother tumbling to the marble floor. Trips, shin kicks, tickles. Then, as they missed their mother more and less, the fights got better, worse."

Amy and her siblings were similarly

"Losses are so painful and frightening that many young children, able to endure strong emotions for only brief periods, alternately approach and avoid their feelings so as not to be overwhelmed.

caught up in a war for attention. Their mother was pulled in so many directions and dealing with her own grief. She would often sit with the children and talk about feelings, read them books about grieving but it still didn't stop the anger and violent games. Amy seemed to be the chief protagonist. Perhaps she was the child who could understand what was happening least.

"Losses are so painful and frightening that many young children, able to endure strong emotions for only brief periods, alternately approach and avoid their feelings so as not to be overwhelmed. Because these emotions may be expressed as angry outbursts or misbehaviour, rather than as sadness, they may not be recognised as grief related." Bereavement during Childhood and Adolescence, NCBI Bookshelf

A more puzzling game began: Easter Bunny. I was the bunny and she was the cheeky girl, imperiously ordering Easter eggs, wanting them delivered to Famous Boat. She was getting ready to go on that cruise.

"Make it snappy!" she demanded.

At the time I did not understand what this bossy play was about.

After the death of her father, Amy's behaviour changed radically. Her play became increasingly demanding, even bizarre. She became obsessed with bodily processes, at times throwing pretend vomit, snot, earwax, wee and poo at me. When I reflected that she was feeling angry, she denied it vehemently. She had regressed significantly. For many sessions her play involved torture, cruelty and aggression. Her paintings spoke of the grief beneath the anger, in the hearts with black cracks across them. When I reflected "Looks like a broken heart" she insisted "No, it's a rock." When I reflected again that the heart looked broken, she conceded, "Only a tiny bit.'

This disturbed play reached a pitch when Amy screamed loudly in my

ear after whispering "I've got something important to tell you." She then continued playing without telling me the important thing in words. The regression continued: she baby talked, was often unco-operative and imperiously demanded attention. "Can we please not talk about Dad?" she asked. The feelings were too painful and perhaps she was tired of all the attention Dad's death was getting. Before this experience, Amy had been regarded as the cute one in the family. Her older sister called her "baby" and acted as a parent figure. She also had a Nanny who had been with her since birth and she was used to getting her needs met by others. Now her cheeky, demanding behaviour was causing concern.

"Sometimes children's anger is an attempt to invite their parent(s) back into a parenting role. When parents grieve, the child may feel abandoned or unimportant, as if they have lost not only the person who died, but those who grieve as well. Or they may fear that everything in their world is out of control and unconsciously try to challenge someone to restore order and predictability." NSW www.bereavement care.com.au

At this stage, I confess a mistake. By session eleven, I thought that Amy needed firmer boundaries and higher expectations. I thought she had been "spoilt" by permissive, indulgent parenting because of the tragic events in her family. Her mother was trying to deal with her own grief as well as help her children through the process. She was also frustrated by Amy's refusal to get ready in the mornings independently. I think I took on the mother's pain and wanted to make things easier for her, unwittingly sacrificing the child's needs for her mother's needs.

Despite my advice to Amy's mother to firm up the boundaries and expectations, Amy resisted all efforts to get her to be independent. At school, her attention was wandering and her teacher began to suggest that she may have to repeat her Grade One Year. In the Playroom, Easter Bunny was still going strong, ruder and more violent than ever. Amy, as the angry lady, was determined to get her eggs without being polite.

As her mother had become more forceful in her expectations, Amy had dreams of being locked in a cage. She often climbed into her mother's bed during the night.

"Bereaved children can wake from dreams that are violent or traumatic….. they may seek security in the warmth if someone else's bed. Almost every grieving child we have worked with has eventually expressed the belief that if they stay awake or sleep with the person whose death they fear, they will notice changes in breathing, notice anything that might be wrong and be able to save their life." www.bereavementcare.com.au

When one parent has died, there are naturally concerns about the remaining parent. Who will look after us? children typically wonder.

Heather Teakle, My Daddy Died,1992, writes:

"I am particularly alert to any discomfort I feel when with someone in grief. Perhaps it is something he or she has said. Or some behaviour exhibited. I may want to correct, modify, interrupt or contradict something said, some part of an experience. Such discomfort is a signal that there is in myself some unresolved area about the issues of death and loss. It is my own discomfort, nothing to do with the other person, and in being aware of this discomfort I am less likely to project it on to those I am trying to support. I seek outside support from a supervisor to further the process."

After supervision, I realised that Amy was so full up with feelings that she actually couldn't concentrate on her daily tasks. Her regressive behaviour needed some support. So I asked her mother to let her be "little" some of the time and support her in getting the tasks done. The Nanny had been so full of compassion for her that she was letting her be little and it took me some time to understand this was what Amy needed. Previously I had thought that Nanny needed to firm up. However, her mother and I had to respect her need to continue this play.

Amy still had so much processing to do! A large rabbit called Rabbitoh and a vet came into the play. Sometimes she was the vet and sometimes the Rabbit. Rabbitoh was sick and his treatment from the vet was interesting. He had "wee" dribbled all over him from the baby's

When parents grieve, the child may feel abandoned or unimportant, as if they have lost not only the person who died, but those who grieve as well.

bottle and his bottom was scrubbed brutally. As the vet, she injected the rabbit violently.

Animal play involved crocodiles eating a whole family, turtles bullied by crabs and evil cats. The themes of violent disturbance and the need for power dominated her play. She set up games where I had to obey her absolutely and in a way that I couldn't possibly win. She would be the conductor and I would play one of the musical instruments. If I didn't follow her command exactly, I would get into trouble. I reflected "You want to get me in to trouble!" She agreed "Yes, I'm getting you in trouble." I imagined this may have been the way she sometimes interacted with her older brothers. How desperately she needed to be in control!

Easter Bunny receded. Slave girl now featured strongly. Amy would order me ferociously "Do this! Do that!" I was utterly subservient to her but inside I was struggling. Was it right to let her boss me so forcefully? I felt really uncomfortable and didn't understand what was happening. Supervision helped me realise that I needed to place the Bop Bag into the victim/slave role as it was confusing for Amy and myself to let her "abuse" me. I stood behind Bop Bag and directed him according to Amy's commands. I think this change was helpful to Amy as well as myself because after I made the "abuse" a little more distant, she would suddenly drop the demands and become gentle, asking "Can we play playdoh, Alana?"

I reminded myself that the roles she was playing and the emotions she was releasing were all part of therapeutic play. The rawness and the cruelty disarmed me sometimes but I knew I needed to let it happen while remaining the adult in charge.

Bop Bag became the slave for a few sessions. I continued to speak for him and manipulate him the way Amy instructed. This felt better but I still wondered why she needed to play out the slave/ boss relationship. My supervisor was once again enlightening. Amy's family had a number of people who worked for them as staff. They ran a business and the father's illness had caused them to hire the nanny and household staff. Perhaps Amy had seen people get instructions. Perhaps she was familiar with this relationship and needed to play it out, in an extreme childlike way.

Her mother was tied to her father and had to do most things for him. Her siblings also had to attend to her father when he rang the bell. The whole situation was extremely stressful and Amy was playing it out. The therapy was allowing her to explore this way of relating to people but through the relationship with me, she could recognise that there were other ways to relate.

'In grief, children tend to become exaggerated versions of their former selves. They may act out in anger at the world for destroying their hopes and illusions; at parents and other significant adults for not being able to prevent the event that is causing them pain." www.bereavement.care.com.au

Amy needed time to adjust. After the death of a parent, the surviving parent may not realise this and expect the child to return to normality quickly. But Amy had only known the situation where all the family was in a sense imprisoned by a horrendous illness. Amy's mother tried hard to keep communication going about her children's' feelings, giving them permission to ask questions and express sadness. Demanding compliance from Amy had not worked but her continued non compliance remained challenging.

Slave/victim continued and Rabbitoh was also involved, A trust me/trust me not scenario developed. She was Bop Bag and I was Rabbitoh, who wanted to make friends. She instructed me to put Rabbitoh's arms around Bop Bag in a hug and then suddenly backed away so that Rabbitoh fell down. She seemed to working on the two sides of herself-the trustworthy, loving person and the angry, cruel one. Her relationship with me was now very attached so that she felt safe enough to play out these deeply wrenching themes. She did not play like this at home, her mother reported but the manipulations she practised on her brothers were perhaps part of this persona. It was difficult to handle and her older brothers were often caught up in it.

By session sixteen, there was a gleam of light, a lessening of the intense play. →

However, when I put in limits for the safety of the toys or finishing a session, Amy resisted and found it very hard to comply. In this session, she began to play in the water tub and suddenly said: "I'm the daughter and you're my Dad. We're fishing." So we played fishing with the rod and the net and I found it hard not to cry. Here was the grief; here was the raw need of missing Daddy.

This was a turning point. The play continued with the same themes, the same games but now it was interspersed with home corner play. Amy was doing what Mum did, organising the household, looking after the kids and going shopping. Rabbitoh had to be cared for, even if he did vomit up his eggs. Her teacher was very sensitive to her needs and carefully structured Father's Day activities. Amy made a card and put it on a shelf at home. Children often seem to naturally look upwards when they want to communicate with their late parents. She was noticeably more affectionate. Elements of mastery were arising as she staged circus shows demonstrating her gymnastic skills. She swung a dog around by its nose. When I put a limit in about damaging toys, she cried: "I would never break anything beautiful!" Underneath the anger and aggression, Amy was an artist!

Heather Teakle writes about helpful ways to support a young child who is grieving. She noticed her daughter was restless and complaining more than usual after the death of her father:

"Each time I became aware of it, and more importantly of its significance, I cuddled her and said something as simple as "Are you missing Daddy?" Her response was to snuggle into me for a minute or two before climbing down and getting on with her play, the grizzles and related behaviour having disappeared."

Amy's passion for play at home and in the playroom was intense. She needed to play out her passionate feelings. There wasn't time for or interest in tidying her room.

I began to think she was getting ready to finish therapy. The "mean" play still featured but generally the play was so much more nurturing. When I suggested to her that soon she would finish in the playroom, she looked dismayed. "I've still got problems, you know!" In supervision this was pointed out to me as a mastery statement.

In reaching mastery, the clues can be confusing for the therapist to read. In Play Therapy no specific goals have been established. The therapeutic relationship has concentrated on the child rather than a specific problem. The journey is deeply individual and can revisit themes and play sequences many times.

However, there was still some stinging play to come. In retrospect, I was insensitive to her attachment need. She'd lost her Dad and also her beloved grandmother was ill. She needed to feel stronger before we finished. After a holiday, she returned, thinking it was her last session. But she was still uncompliant at home and her teacher felt strongly that she needed another year in Grade One which was a blow to her self esteem. When I told her she could keep coming once every two weeks she shouted "Yes!"

The next four sessions were closer to Amy's everyday life. She played out being a mother of a baby, a mother who had so much to do: going to the toilet, going shopping, even painting a picture. Even when the baby called out "I want you!" mother was called off to do other things. A Nanny called the real name of Amy's nanny appeared. Now Amy acted being Nanny. She switched back to being Mum asking Nanny, "Will you look after my baby for the holidays? I'll pay you $50." The servant/boss relationship needed exploration again.

Rabbitoh landed up at the vet again and he came in for some really rough treatment with injections in his eye, nose and mouth. "Do you want to die or have this stop?" she asked. Toys were thrown to him as a distraction. Amy was often still in the extreme stage of therapy. Some of her play was creative and mild like Find the Treasure, Taking the Dragons to the Beach and Schools. In the latter game she was the teacher and I was the bad kid, not allowed to do anything and sent to the naughty chair.

By session twenty three there was still a great deal of disturbance in the play. I was ashamed to have suggested that soon she would finish. Her attitude to death appeared callous. "We'll just get another one," she stated when the family dog looked close to dying. "He's dead," she said flatly about a toy puppy lying on the ground.

Deaths of animals, beloved pets can trigger grief. Daddy and the dog feel part of the same story. Here, Amy seems to be protecting her vulnerable self and coming into a more objective awareness of death, when it is perceived as final and inevitable. In grief there can be a loss of hope and the

natural buoyancy of an optimistic outlook.

She was more aware of the process of therapy. She noticed that her siblings no longer saw me and she asked her mother, "How come I'm the only one still going to Alana?" When she was told that she still needed the sessions, she answered, "Well I'm going to keep being bad so I can go!"

A pattern was emerging: creative, nurturing play for one session and angry, cruel play in the next.

"During the process of preparing for ending, some children may regress temporarily for part of the session and demonstrate behaviours observed in earlier sessions. This may be the child's way of re-examining old behaviours and experiencing the satisfaction of being able to compare the present with the past." Landreth

A puppy named Pouncy now arrived in her sessions. He had an uncontrollable jumping habit and Amy brought him several times to me as the vet. I was instructed to give him medicine; injections, obedience training etc but nothing cured him. Amy despaired of him and eventually gave him to Millie, an older, bigger dog and confined them in the tent/kennel. Obvious comparisons with her own behaviour came to mind. Amy seemed to be problem solving about herself through Pouncy.

But there was more nurturing Daddy play. She went fishing with him again. She rolled the "fish" in the sand, saying it was salt. Also she stepped with wet feet into the sand and said to me sweetly, "Do you like my slippers, Daddy?" At such times it is hard to keep on role playing but I also felt exultant that she was playing out her need for Daddy so clearly.

Over the Christmas holidays I did not see Amy. On return in the New Year, her mother reported that while they were away, Amy's behaviour was great but on returning home, she reverted to her old ways. Mother's attention was much divided at home. I cannot help feeling that Amy basked in her mother's full attention.

Amy continued playing the Pouncy game for three more sessions. However, she turned the vet's place into Pet Shop and purchased a new dog. Fluffy was floppy, soft and obedient. Amy cuddled and cosseted him. She chained up Pouncy and introduced Fluffy to old dog Milly. The Nanny relationship seemed to appear again. Perhaps Fluffy was nurtured and loved the way Amy wanted to be cared for. It looked as if she was retiring Pouncy and embracing a softer identity. Her play progressed gradually towards mastery in a zig zag fashion. I made a map of the play sequences and saw the play and repeat pattern about fifteen times.

I was now in no hurry for her to finish. Amy was doing a wonderful job herself in recovering from her life situation. I had learnt so much from her. Firstly, not to be fooled by a sweet, "well adjusted" exterior. A host of snares can be beneath that lid. Secondly, to understand mastery and the power of attachment better: the child may be part way there but still needs to hang on to you. Thirdly, never underestimate the force of a child's ability to play out her own solutions, however bizarre they may seem.

When Amy did finish her therapy with me, it was a smooth, easy transition. I took heart from Landreth's words about finishing therapy:

"Child and therapist have shared-sometimes tentatively, sometimes eagerly and sometimes in rocky ways-in developing and building a meaningful, sensitively caring relationship. Tender moments have occurred, times of great excitement, joy that could almost not be contained, periods of anger and frustration screamed out at the world, points of grand discovery, intervals of quiet being together when words or sounds were not necessary, and a season of shared understanding and acceptance. Such a relationship can never be terminated, for it goes on and on as part of those persons who shared in it."

N.B.I have not used the true names of the people in this article, except for myself. Amy's mother read the article and gave her permission for it to be published.

BIOGRAPHY

Alana Vaney has recently retired from her Play Therapy practice. Before that she worked in schools in various roles helping children deal with challenging circumstances, be it grief, bullying, learning problems, friendship skills etc.

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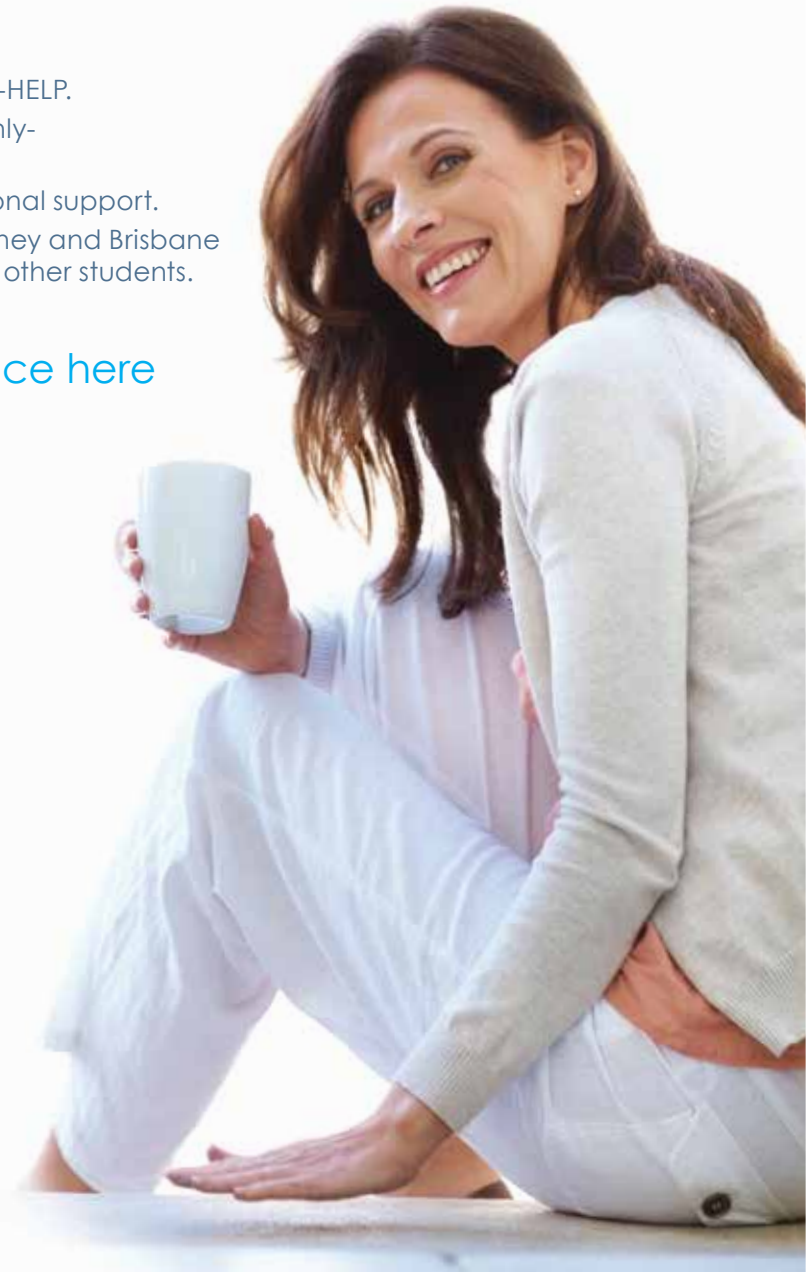

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PTSD in children quickly and effectively treatable within hours

Children and adolescents with posttraumatic stress syndrome (PTSD) can be successfully treated with only a few hours of EMDR or cognitive behavioral writing therapy (CBWT). This is the finding of a new research paper by the University of Amsterdam (UvA) and GGZ Rivierduinen (Trauma Center for Children and Youth). The paper was published on Thursday, 29 June in the Journal of Child Psychology and Psychiatry.

PTSD is a psychiatric disorder which can develop after exposure to a traumatic event such as a terrorist attack, a road traffic accident, sexual or physical abuse. Previous research shows that PTSD can be treated effectively in adults with Eye Movement Desensitization and Reprocessing (EMDR) or trauma-focused cognitive behavioral therapy/imaginary exposure. Until now, however, strong evidence for the efficacy of EMDR in children has been lacking.

For their study, Carlijn de Roos, a clinical psychologist and UvA researcher, and her fellow researchers compared the effect of EMDR with that of Cognitive Behavioral Writing Therapy (WRITEjunior) in children and adolescents in the age group 8 to 18 who had experienced a single traumatic event like a traffic accident, rape, physical assault or traumatic loss. Both forms of treatment confront the traumatic memory without any preparatory sessions. In EMDR the traumatic memory is activated while at the same time the child's working memory is taxed with an external task (following the fingers of the therapist with the eyes). In writing therapy, the child writes a story on a computer, together with the therapist, about the event and the consequences, including all the horrid aspects of the memory. In the last session, the child shares the story of what happened to him or her with important others.

A few hours sufficient

A total of 103 children and adolescents took part in the study. On average, four sessions were sufficient for successful treatment. 'EMDR and writing therapy were equally effective in reducing posttraumatic stress reactions, anxiety and depression, and behavioral problems. What's more, both proved to be brief and therefore cost effective', says De Roos. 'We literally used a stopwatch to time the length of both trauma treatments. This showed that EMDR reaches positive effects fastest (2 hours and 20 minutes on average) compared to the writing therapy (3 hours and 47 minutes on average). The most important thing, of course, was that the results were lasting, as shown during a follow-up measurement one year later.'

Significance for the field

About 16% of children who are exposed to trauma develop PTSD. 'Children who do not get the right treatment suffer unnecessarily and are at risk of developing further problems and being re-traumatized', says De Roos. 'The challenge for health professionals is to identify symptoms of PTSD as quickly as possible and immediately refer for trauma treatment.' According to De Roos, screening for PTSD should become standard practice within the field of childcare for all disorders. 'When PTSD is determined, a brief trauma-focused treatment can significantly diminish symptoms. A brief treatment will not only reduce suffering by child and family, but also lead to tremendous healthcare savings.'

It is important to conduct follow-up research into the effects of EMDR and writing therapy in children with PTSD symptoms who have suffered from multiple traumatic experiences and in children younger than eight, De Roos adds.

De Roos carried out this study as part of her PhD at the University of Amsterdam (UvA). Her supervisors are Prof. Ad de Jongh, professor by special appointment of Anxiety and Behavioural Disorders at the Academic Centre for Dentistry Amsterdam (ACTA) and Prof. Paul Emmelkamp, professor of Clinical Psychology. Her co-supervisors are Bonne Zijlstra (UvA) and Dr Saskia van der Oord (KU Leuven). De Roos previously worked at GGZ Rivierduinen and was recently appointed clinical psychologist at the Academic Center for Child and Adolescent Psychiatry in Amsterdam.

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Carlijn de Roos, Saskia van der Oord, Bonne Zijlstra, Sascha Lucassen, Sean Perrin, Paul Emmelkamp and Ad de Jongh, 'Comparison of EMDR Therapy, and Waitlist in Pediatric PTSD Following Single-Incident Trauma: A Multi-Center Randomized Clinical Trial' in Journal of Child Psychology and Psychiatry (June 29th 2017). DOI: 0.1111/jcpp.12768.

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Deborah Gray	HERVEY BAY	0409 295 696	ftf,skp & grp: $100 + GST/ Grp: $90	FTF/ Ph, Grp, Skp
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Patrick Michael Glancy	AROONA	450977171.00	$95	FTF, Skype

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Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
QUEENSLAND *CONTINUED*				
Steven Josef Novak	BUDERIM	0431 925 771	N/A	FTF
Roslyn Price	REDLAND BAY	0401 266 170	80/hr for practitioners $80/ hr for students	FTF/PH/GRP/WEB
Sherrie Brook	MURRUMBA DOWNS	0476 268 165	Upon enquiry	FTF
Beverley Howarth	PADDINGTON	0420 403 102	Upon enquiry	FTF/PH/WEB
Brenda Purse	SUNSHINE COAST	0402 069 827	Upon enquiry	FTF
Rev Peter Gee	EASTERN HEIGHTS/ IPSWICH	0403 563 467	$65	FTF/GRP/PH/WEB
Christine Russell	SCARBOROUGH	0439 437 007	80	FTF/PH/GRP/WEB
Robyn Brownlee	NANANGO	0457 633 770	Upon enquiry	
Christine Perry	BUNDABERG	0412 604 701	$70	FTF/WEB
Anne-Marie Houston	BUNDABERG	0467 900 224	Upon enquiry	FTF
Patricia Fernandes	EMERALD/ SUNSHINE COAST	0421 545 994	$30-$60	FTF/PH
Yildiz Sethi	WAKERLEY	07 3390 8039	Indiv $90, Grp $45	FTF/GRP/PH/WEB
Pamela Thiel-Paul	BUNDALL/GOLD COAST	0401 205 536	$90	FTF
Maartje (Boyo) Barter	WAKERLEY	0421 575 446	Upon enquiry	FTF
Yvette Marion Johnstone	MURRUMBA DOWNS	07 3496 2861	$70	FTF/GRP/WEB
Gary Noble	LOGANHOLME DC	0439 909 434	Upon enquiry	FTF
Heidi Edwards	GYMPIE	0466 267 509	$99	FTF/WEB
Diane Newman	BUNDABERG WEST	0416 715 053	Upon enquiry	FTF/PH
David Kliese	SIPPY DOWNS/ SUNSHINE COAST	07 5476 8122	Indiv $80, Grp $40 (2 hours)	FTF/GRP/PH
Bernice Botha	ORMEAU	0449 611 521	Gp: $50p/h Idv: $90p/h Stu: $75p/h	FTF/Ph,Grp,Skp
Jenifer Joy Jensen	KURANDA	0414 262 040	Upon enquiry	FTF
Ronald Davis	LABRADOR	0434 576 218	Upon enquiry	FTF
Deborah Stevens	KINGAROY	0411 661 098	Upon enquiry	FTF
Valerie Holden	PEREGIAN SPRINGS	0403 292 885	Upon enquiry	FTF
Donna Mahoney	KEWARRA BEACH	0414 480 934	110 P/H	FTF/ PH, GRP/ SKP
Kaye Laemmle	HELENSVALE	0410 618 330	Upon enquiry	FTF
Sharron Mackison	CABOOLTURE	07 5497 4610	Upon enquiry	FTF/PH/GRP/WEB
Julianne Cutcliffe	SPRINGFIELD	0425 623 400	$50 Students $60 professionals	FTF, Phone, Skype
Kim King	YEPPOON	0434 889 946	Upon enquiry	FTF
Tanya-Lee M Barich	WONDUNNA	0458 567 861	Upon enquiry	FTF
Lynette Baird	MAROOCHYDORE/ SUNSHINE COAST	07 5451 0555	Grp $30 or Indiv $90	FTF/GRP
Frances Taylor	REDLAND BAY	0415 959 267 or 07 3206 7855	Upon enquiry	FTF
Penelope Richards	CHAPEL HILL	0409 284 904	Upon enquiry	FTF
Kirsten Greenwood	MUDGEERABA	0421 904 340	Upon enquiry	FTF
Neil Roger Mellor	PELICAN WATERS	0409 338 427	Upon enquiry	FTF
William James Sidney	LOGANHOLME	0411 821 755 Or 07 3388 0197	Upon enquiry	FTF/PH/GRP
Aisling Fry	LOTA	0412 460 104	N/A	FTF

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QUEENSLAND *CONTINUED*				
Lyn Patman	BROWNS PLAINS	0415 385 064	Upon enquiry	FTF
Bernadette Maree Wright	ALBANY CREEK	07 3137 1582, 0419 218 062	Indiv. $120 Group $50	FTF/PH/GRP/WEB
Iain Bowman	ASHGROVE	0402 446 947	Upon enquiry	FTF/PH/GRP/WEB
Maggie Maylin	WEST END	0434 575 610	Upon enquiry	FTF/PH/GRP/WEB
Monika Wilson	MALENY	0413 962 899	$100 P/P	FTF/ PH
Pamela M Blamey	TARINGA	0401 881 490	$100 f/t therapists $75 (p/t or students $60 group	FTF/GRP
Tracey Milson	ARUNDEL	0408 614 062	Upon enquiry	FTF
Ann Moir-Bussy	SIPPY DOWNS	07 5476 9625 or 0400 474 425	Upon enquiry	FTF/GRP/PH/WEB
Catherine Dodemont	NEWMARKET	0413 623 162	Upon enquiry	FTF/PH/WEB
SOUTH AUSTRALIA				
Anthony Gray	ATHELSTONE	08 8336 6770/0437 817 370	Upon enquiry	FTF
Deborah Green	BLACKWOOD	0474 262 119	Indiv $75: Groups $45	FTF, Group, Skype
Barry White	PORT ADELAIDE 5015	0488 777 459	Upon enquiry	FTF/PH
L'hibou Hornung	NAIRNE : PARKSIDE	0409 616 532	$80	F/F,PH,GRP/WEB
Kerry Turvey	TANUNDA	0423 329 823	Upon enquiry	FTF
Ellen Turner	HACKHAM WEST	0411 556 593	Upon enquiry	FTF
Richard Hughes	WILLUNGA	0409 282 211	Negotiable	FTF/PH/WEB
Annie Cornish	HENLEY BEACH	0407 390 677	Upon enquiry	FTF
Carolyn Grace	ADELAIDE	0401 337 448	Upon enquiry	FTF/PH/WEB
Adrienne Jeffries	STONYFELL	08 8332 5407	Upon enquiry	FTF/PH/WEB
Rachael Cassell	TORRENSVILLE	0434 570 992	$80 1 hour: $120 1.5 hours	FTF
Maxine Litchfield	GAWLER WEST	0438 500 307	Upon enquiry	FTF
Laura Wardleworth	ANGASTON	0417 087 696	Upon enquiry	FTF
Beverley Dales	GOLDEN GROVE	0413 303 576	$25 PP	FTF/PH
Carol Kerrigan	ENGLFIELD	0410 567 479	Upon enquiry	FTF
Pamela Mitchell	WATERFALL GULLY	0418 835 767	Upon enquiry	FTF
Susan Turrell	BLAKEVIEW	0404 066 433	55	FTF/GRP/WEB
Maxine Kikkert	MT BARKER	0457 358 874 (w) 0438254 255 (h)	$80; $60 (disc); GRP $30	FTF/GRP/PH/WEB
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon enquiry	FTF
Carol Moore	OLD REYNELLA	08 8297 5111 bus Or SMS 0419 859 844	Grp $35, Indiv $99	FTF/PH/GRP/WEB
Karen Grieger	NORTH ADELAIDE	0404 367 927	$70/hr(ind) $50/hr (concession) $30/hr Grp (3+)	FTF/GRP/PH
Shelley Murphy	BROOKLYN PARK	08 8443 5165; 0407 435 169	Ind. $80ph; Group - 2hrs - $40	FTF/PH/GRP/WEB
TASMANIA				
Pauline Mary Enright	SANDY BAY	0409 191 342	$70 per session: Concession $60	FTF/PH/WEB
Jane Oakley-Lohm	BLACKSTONE HEIGHTS/ LAUNCESTON	0438 681 390	$110 GST inclusive, $80 for new students of one year	FTF/PH/GRP/WEB
David Hayden	HOWRAH NORTH	0417 581 699	Upon enquiry	FTF

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VICTORIA				
Sheryl Brosnan	CARLTON NORTH/ MELBOURNE	03 8319 0975 Or 0419 884 793	Upon enquiry	FTF/GRP/PH/WEB
Maurice Grant-Drew	ELWOOD	0412 331 301	Upon enquiry	FTF
	SOUTH MORANG	0400 345 045	FTF $80/GRP $40/ WEB&PH $60	FTF/PH/WEB/GRP
Natalie Wild	BORONIA	0415 544 325	Upon enquiry	FTF
Molly Carlile	INVERLOCH	0419 579 960	Upon enquiry	FTF
Sandra Brown	FRANKSTON/MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Karli Anne Dettman	BLACKBURN	0403 922 245 text only	$100	FTF/GRP/WEB
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
Gayle Stapleton	BERWICK	0459 075 284	100 p/h Negotiable	FTF/PH/GRP/WEB
Rosie Barbara	SYDENHIAM/WYNDHAM	0433 277 771	Ind:$110/Grp:$50 each min of 4 hours	FTF/PH/GRP/WEB
Rosemary Petschack	DIAMOND CREEK	0407 530 636	80 p/h	FTF/PH
Sandra Hatton	KEW	0425 722 311	Indiv. $80/hour; sml group $80/2hours	FTF/GRP
Angeline Crossin	ASCOT VALE/ESSENDON	0451 010 750	$100 F/F, $90 Skye,$50 Group, $70 Students	FTF/GRP/WEB
Sandra Clough	TRARALGON	0412 230 181	Upon enquiry	FTF/ PH/GRP/ WEB
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon enquiry	FTF/PH/GRP/WEB
Tabitha Veness	FERNTREE GULLY	0400 924 891	Upon enquiry	FTF
Lynda M Carlyle	EAST MELBOURNE/ SPRINGVALE SOUTH/ RIPPON LEA	0425 728 676	$135 per hour	FTF/PH/WEB
Andrew Reay	MOORABBIN	0433 273 799	Upon enquiry	FTF
Carolyn Geer	BENTLEIGH	0419 572 970	Upon enquiry	FTF
Paola Gina Salvagno	DONCASTER/ TEMPLESTONE/BALWYN	(03) 9812 7520 or 0430 157 857	$120 p/h $100 - students enroled in counseling	FTF/PH/WEB
Kaye Allison Jones	CAMBERWELL	0417 387 500	Upon enquiry	FTF
Sharon S Erten	SOUTH MORANG	0400 345 045	FTF $80/GRP $40/ WEB&PH $60	FTF/PH/GRP/WED
Lehi Cerna	HALLAM	0423 557 478	Upon enquiry	FTF/PH/GRP/WEB
Robert Lower	BEVERIDGE	0425 738 093	Upon enquiry	FTF
Tra-ill Dowie	PORT FAIRY	0439 494 633	Upon enquiry	FTF
Bettina Revens	NEWPORT/ WILLIAMSTOWN	(03) 9397 7075: 0432 708 019	$120 indiv	FTF/PH
Heather Bunting	GLEN IRIS	0421 908 424	Upon enquiry; special rates for students	FTF/PH/GRP/WEB
Dorothy Dullege	RINGWOOD NORTH	0433 246 848	Upon enquiry	FTF/PH/GRP/WEB
Batul Fatima Gulani	MELBOURNE	0422 851 536	Upon enquiry	FTF
Michelle Wood	MANSFIELD	0497 037 436	Upon enquiry	FTF/PH/GRP/WEB
Kim Billington	SANDRINGHAM/STKILDA/ ARMIDALE/MENTONE	0488 284 023	$110 : 2hr group $60	FTF/PH/GRP/WEB
Nancye Cottrell	LYSTERFIELD	0424 739 891	$50/hr Disc $40/hr	FTF/PH/GRP
Patricia Reilly	MOUNT MARTHA/ GARDENVALE	0401 963 099	Upon enquiry	FTF

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VICTORIA *CONTINUED*				
Petra de Kleijn	TATURA	0413 824 073	Upon enquiry	FTF/PH/WEB
Sandra Robinson	MANSFIELD/BENALLA	0403 175 555	$110 individual 1 hour session. $50 - group per he	FTF/WEB
Catherine Ethel Noy	MORWELL	0477 159 168	$80	FTF/PH/GRP/ WEB
Stephen O'Kane	BLACKBURN	0433 143 211	Negotiable	FTF/ GRP
Matt Glover	CROYDON HILLS/EAST DONCASTER	0478 651 951	Conc: $70, Full: $90 Group: $30/hour	FTF/PH/GRP/WEB
Zoe Broomhead	RINGWOOD	0402 475 333	Upon enquiry	FTF
Lisa Derham	CAMBERWELL	0402 759 286	Upon enquiry	FTF/WEB
Sara Edwards	DINGLEY	0407 774 663	Upon enquiry	FTF/WEB
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon enquiry	FTF/ WEB/GRP
Charlene Pereira	RINGWOOD/YARRAGLEN/ MELBOURNE	03 9999 7482; 0403 099 303	Ind $140; $90 P/T practitioners; Group on application	FTF/PH/GRP/WEB
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Jacquie Wise	ALBERT PARK	03 9690 8159 or 0439 969 081	By Negotiation	FTF/ PH/WEB/GRP
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Bridget Pannell	MELBOURNE	0423 040 718	Upon enquiry	FTF/PH/GRP/WEB
Cas Willow	WILLIAMSTOWN	03 9397 0010 or 0428 655 270	Upon enquiry	FTF/PH/GRP/WEB
Zohar Berchik	SOUTH YARRA	0425 851 188	Upon enquiry	FTF
Gabrielle Skelsey	ELSTERNWICK	03 9018 9356	Upon enquiry	FTF/PH/WEB
Anne Meredith Brown	COLDSTREAM	0428 221 854	Upon enquiry	FTF/PH/GRP
Shivon Barresi	ROXBURGH PARK	0413 568 609	Ind. $80 ph, Group $60ph	FTF/PH/GRP/WEB
Beverley Kuster	NARRE WARREN	0488 477 566	Upon enquiry	FTF
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon enquiry	FTF
Helen Wayland	ST KILDA	0412 443 899	$75 Indiv	FTF/PH/GRP/WEB
Anna Atkin	CHETLENHAM	0403 174 390	Upon enquiry	FTF
Joan Wray	(MOBILE SERVICE)	0418 574 098	Upon enquiry	FTF
Kathleen (Kathy) Brennan	BERWICK	0417 038 983	Upon enquiry	FTF/GRP/PH/WEB
Paul Montalto	FAIRFIELD, FITZROY NORTH, VANILLA	0415 315 431	Upon enquiry	FTF
Danielle Aitken	SOUTH GIPPSLAND/ MELBOURNE METRO	0409 332 052	Upon enquiry	FTF/GRP/PH/WEB
Jeff Pemberton	BALLARAT	0422 375 899	80	FTF/PH
Belinda Hulstrom	WILLIAMSTOWN	04714 331 457	Upon enquiry	FTF
Gaye Hart	BITTERN	0409 174 128	Upon enquiry	FTF
Lynne Rolfe	BERWICK	03 9768 9902	Upon enquiry	FTF
Marie Bajada	BALLARAT	0409 954 703	Upon enquiry	FTF
Judith Beaumont	MORNINGTON	0412 925 700	Upon enquiry	FTF/PH/GRP/WEB
Tim Connelly	HEALESVILLE	0418 336 522	Upon enquiry	FTF
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon enquiry	FTF
Claire Sargent	CANTERBURY	0409 438 514	Upon enquiry	FTF
Keith John Hulstaert	BELGRAVE	0409 546 549	Upon enquiry	FTF

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VICTORIA *CONTINUED*				
Simon Philip Brown	WATSONIA	03 9434 4161	Upon enquiry	FTF/PH/GRP
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon enquiry	FTF/WEB
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon enquiry	FTF
Judith Ayre	BENTLEIGH	0417 105 444	Upon enquiry	FTF
Jenny Anne Field	UPPER FERNTREE GULLY	0404 492 011	On Request	FTF/ PH/GRP/ SKYP
Graham Hocking	PARK ORCHARDS	0419 572 023	Upon enquiry	FTF
Joanne Ablett	PHILLIP ISLAND/ MELBOURNE METRO	0417 078 792	$120	FTF/GRP/PH/WEB
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260 Or 03 9786 8006	Upon enquiry	FTF
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon enquiry	FTF
Jo-Ellen White	BLACKBURN SOUTH	0414 487 509	$100 ind. $50 Group. Stu Dis $80	FTF/ PH/GRP/ WEB Specialising is Autism Spectrum Disorder
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Debra Darbyshire	BERWICK	0437 735 807	Upon enquiry	FTF
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon enquiry	FTF
Ruth Giles	BAIRNSDALE	0425 726 933	Inv $70, Grp $40each	FTF/ PH, GRP
Nyrelle Bade	EAST MELBOURNE/ POINT COOK	0402 423 532	Upon enquiry	FTF/GRP/WEB
Rosslyn Wilson	KNOXFIELD	03 9763 0772 Or 03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Graeme John Riley	GLADSTONE PARK	03 9338 6271 or 0423 194 985	$85	FTF/WEB
Jenni Harris	KEW	0406 943 526	$90 per 3 hr session Small group only	FTF
Derek Goodlake	SANDRINGHAM	0403 045 800	$110	FTF/PH/WEB
Marguerite Middling	NORTH BALARAT	0438 744 217	Upon enquiry	FTF
Melissa Harte	PAKENHAM/ STH YARRA	0407 427 172	$132 to $143	FTF
Barbara Matheson	MELBOURNE	03 9703 2920 or 0412 977 553	Upon enquiry	FTF
Deborah Cameron	BRIGHTON	0447 262 130	Upon enquiry	FTF/GRP/WEB
John Dunn	COLAC SW AREA/ MT GAMBIER	03 5232 2918	By Negotiation	FTF/GRP/WEB
Brian Whiter	CARLTON/MOORABBIN	0411 308 078	$100	FTF
Sophie Lea	MORNINGTON PENINSULA	0437 704 611	Individual $100/hour	FTF/ PH, WEB
WESTERN AUSTRALIA				
Lillian Wolfinger	YOKINE	WA	08 9345 0387 or 0401 555 140	Upon Enquiry
Jenna Trainor	BEDFORD	WA	0431 817 807	Upon Enquiry
Julie Hall	YANCHEP/BUTLER/ JINDALEE/JOONDALUP	WA	0416 898 034	$100
Dr Patricia Sherwood	PERTH/BUNBURY	WA	0417 977 085 or 08 9731 5022	$120
Allison Lord	CLARKSON	WA	0403 357 656	Upon Enquiry
Ligia Emmel Barnett	GERALDTON	WA	0419 954 984	$80.00
Karen Heather Civello	BRIDGETOWN	WA	0419 493 649	Upon Enquiry

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WESTERN AUSTRALIA *CONTINUED*				
Genevieve Armson	CARLISLE	0412 292 999	Upon Enquiry	FTF, GRP, PH, WEB
Narelle Williams	MIDLAND, PERTH	0429 000 830	Individual $100 Students $85	FTF/WEB
Alan Furlong	WINTHROP	0457 324 464	Upon Enquiry	FTF
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
Cindy Cranswick	FREMANTLE	0408 656 300	Upon Enquiry	FTF
Lynette Cannon	CAREY PARK	0429 876 525	Upon Enquiry	FTF
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
David Fisk	NORTH LAKE	0412 781 865	$100 (neg) upon enquiry	FTF/GRP/WEB
Sharon Vivian Blake	FREMANTLE	0424 951 670	Indiv $100, Grp $60	FTF/PH/GRP/WEB
Fiona McKenzie	GERALDTON	0427 928 505	Upon Enquiry	FTF
Marie-Josee Boulianne	BEACONSFIELD	0407 315 240	Upon Enquiry	FTF
Merrilyn Hughes	CANNING VALE	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB
Carolyn Midwood	DUNCRAIG	08 9448 3210	Indiv $110, Grp $55	FTF/GRO/PH/WEB
Sally Ann Nevill	NARROGIN	0407 246 954	110	On request.
John Dallimore	FREMANTLE	0437 087 119	Upon Enquiry	FREMANTLE
Victoria Laws	NORTH PERTH	0415 604 847	Upon Enquiry; student rates available	FTF/GRP/WEB
Clare Robbins	KALAMUNDA	(08) 9293 4668: 0408 548 838	$95 individual; $75 Group per person	FTF/GRP
Anne Arrowsmith	MANDURAH	0458 525 039	Ind $140 Student $120	FTF/PH/WEB
Eva Lenz	FREMANTLE/COOGEE	08 9418 1439 Or 0409 405 585	$85 concession $65	FTF/PH/GRP/WEB
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
Trudy McKenna	NEDLANDS	0438 551 210	Indiv $120, Grp $50 Concess $30	FTF/PH/GRP/WEB
INTERNATIONAL				
Contact	**Country**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
Joyce Chan	HONG KONG	(+852) 92507002	$AU90, HKD 550	WEB
Frank King Wai Leung	HONG KONG	+852 3762 2255	Upon enquiry	FTF
Polina Cheng	HONG KONG	+852 9760 8132	Upon enquiry	FTF
Pui Kuen Chang	HONG KONG	+852 9142 3543	Upon enquiry	FTF
Eugnice Yiu Sum Chiu	HONG KONG	+852 2116 3733	Upon enquiry	FTF
Wing Wah Hui	HONG KONG	+852 6028 5833	Upon enquiry	FTF
Dina Chamberlain	HONG KONG	+852 6028 9303	Upon enquiry	FTF
Giovanni Ka Wong Lam	HONG KONG	+852 9200 0075	Upon enquiry	FTF
Fiona Man Yan Chang	HONG KONG	+852 9198 4363	Upon enquiry	FTF
Barbara Whitehead	HONG KONG	+852 2813 4540	Upon enquiry	FTF
Yat Chor Wun	HONG KONG	+852 264 35347	Upon enquiry	FTF
Cary Hung	HONG KONG	+852 2176 1451	Upon enquiry	FTF
Deborah Cameron	HONG KONG	+65 9186 8952	Upon enquiry	FTF/GRP/WEB
Eugene Chong	SINGAPORE	+65 6397 1547	Upon enquiry	FTF
Saik Hoong Tham	SINGAPORE	+65 8567 0508	Upon enquiry	FTF
David Kan Kum Fatt	SINGAPORE	+65 9770 3568	Upon enquiry	FTF
Su Keng Gan	SINGAPORE	+65 6289 6679	Upon enquiry	FTF
Jeffrey Gim Tee Po	SINGAPORE	+65 9618 8153	$100.00	FTF/GRP/PH/WEB

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.

Gain Entry Into An ACA Professional College

With An ACA Accredited Specialty Vocational Graduate Diploma

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

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

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

Get Direct Entry Into A Professional College

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

Flexible And Cost Effective

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

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

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

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

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

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Melbourne	1800 622 489	Adelaide	1800 246 324	Gold Coast	1800 625 329
Perth	1800 246 381	Reg NSW	1800 625 329	NT/Tasmania	1800 353 643