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Our hope: A group work journey to healing and empowerment

Internet pornography's effect on sexual attitudes and behaviours: A structured literature review revealing gender difference

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International Affiliation with the Philippines

By Philip Armstrong

On Friday the 3rd of November the Australian Counselling Association (ACA) had the pleasure of hosting representatives from the Philippine Professional Regulatory Commission (PRC), Philippine Guidance and Counseling Association PGCA) and the Philippine Department of Health. The object of the visit was to enter into an international mutual agreement between ACA and the PGCA. Counselling is a regulated profession in the Philippines which comes under the PRC which in turn comes under the Department of Health. This was the first time the PGCA/PRC had entered into a formal agreement such as this with another peak body.

The Philippine contingent was made up of:

- Dr Luzviminda Guzman: Philippine Professional Regulatory Commission (PRC), Chairman for Guidance and Counseling.
- Professor Sheila Marie Hocson: President of PGCA, Guidance Director and Professor of Far Eastern University-Manila and Makati.
- Professor Adelaida Gines, PhD: VP of PGCA, Professor of PNU Graduate School and Consultant of Perpetual Help College.
- Professor Evangeline Aguilan, PhD: Past President of PGCA and Guidance Head and Professor of Siliman University.
- Annabelle Sangalang, PhD. Treasurer,

Formal Signing (From left) Simon Clarke, Dr Philip Armstrong, Dr Luzviminda Guzman and Prefessor Sheila Marie Hocson

Here is the Philippine contingency with Dr Philip Armstrong and Simon Clarke. Along with Dr Judith Murray from UQ, Dr Mark Pearson from USC, Dr Paul Pagliano from JCU and Amanda Grehan from Kids Helpline who all took part in the benchmarking presentations.

ACA members and guests at the networking event

PGCA and former Guidance Head of University of the Philippine (UP) and currently Guidance Specialist at UP.

- Professor Carmencita Salonga PhD: Board of Director of Psychological Assoc of the Philippine and Guidance Director and Professor of Centro Escolar University
- Professor PhD, MD: Ricardo Guanzon, Board of Director of PGCA, Consultant and Professor of Don Mariano Marcos University
- Jean Goulbourn: Founder and President of Natasha Goulbourn Foundation
- Ma. Lourdes Sara: Philippine Department of Health, Chief of Hopeline
- Racquel Cagurangan: Consultant and Incoming Executive Director of Natasha Goulbourn Foundation (Hopeline)
- Frances Lim: CEO of Natasha Goulbourn Foundation (Hopeline)
- Sheribel Villasin: Guidance Director, Diliman Preparatory School

The morning started with Tom (ACA ILO) and myself meeting the Philippine contingent at their hotel and shuttling them to Faculty of Health, Queensland University of Technology, where we met with faculty members including the Executive Dean Professor Ross Young and Head of School Associate Professor Renata Meuter. We were shown around the Health Clinic and then given a tour of the Psychology and Counselling clinic.

From QUT we then moved on to University of Queensland (UQ) where we were met by Associate Professor Judith Murray the Director of Masters of Counselling program. Associate Professor Murray led us on a tour of the University grounds and the School of Nursing, Midwifery and Social Work and the counselling facilities. This was followed by some morning tea and great conversation.

The party then moved to the Samford Plaza Hotel where several other activities had been arranged. The afternoon started with a benchmarking activity which included presentations by Associate Professor Paul Pagliano from James Cook University, Dr Mark Pearson Sunshine Coast University, Associate Professor Judith Murray from UQ and Professor Hocson from PGCA. Amanda Grehan from Kids Help Line then gave a presentation which was very well received particularly from the Philippine contingent from Hopeline.

The afternoon ended with the formal signing of the reciprocal agreement in the form of a Memorandum of Understanding between ACA and the PGCA/PRC. The Memorandum was signed by the ACA President Mr Simon Clarke, ACA CEO Dr Philip Armstrong, PRC Dr Luzviminda Guzman and President of PGCA Professor Sheila Marie Hocson.

The day finished with a networking event attended by over 50 guests made up of ACA members, representatives from training providers and other industry stakeholders. A great day albeit a long one was had by all. ACA thanks the PGCA and PRC for taking part in this historical event. The Philippines contingent went on to Sydney to meet with the Black Dog Institute.

Technology Update

With Dr Angela Lewis

Given how ubiquitous Google is now in everyone's lives (think Search, Gmail and Chrome for starters), in this issue and continuing on in following issues, we are going to put the spotlight on the world of Google.

Let's begin with Google Chrome, which is Google's web browser. Other web browsers out there you may be familiar with are Microsoft Internet Explorer, Mozilla Firefox or Windows Edge.

How to save bookmarks in the Google Chrome browser

If you bookmark a website address, this means it is saved for you and you can easily return to the website in question without searching for it or typing the URL into the search bar again.

1. Open up the website/page you want to bookmark.
2. Look to the far right of the search bar and click the little star, doing this opens the Bookmark window.
3. Type in a name for your bookmark (otherwise you will just see a long website address or if you leave it blank you will only see the icon for the site).
4. The default folder for saving bookmarks called Other bookmarks. But if you click the down arrow next to this option you can choose to put your bookmark in a folder of your own choosing or even on the Bookmarks bar – the bar that sits across the top of the Google Chrome browser.

Note: if you select Choose Another Folder then you will be prompted to create a new folder (or just choose another folder from your previously created some folders).

5. Click the Done button when you have finished.

How to use your Bookmarks

- Click the 3 dots on the very far right of the search bar.
- From the pop-out menu select Bookmarks.
- From the list of bookmark names which will appear, click the one you wish to open.

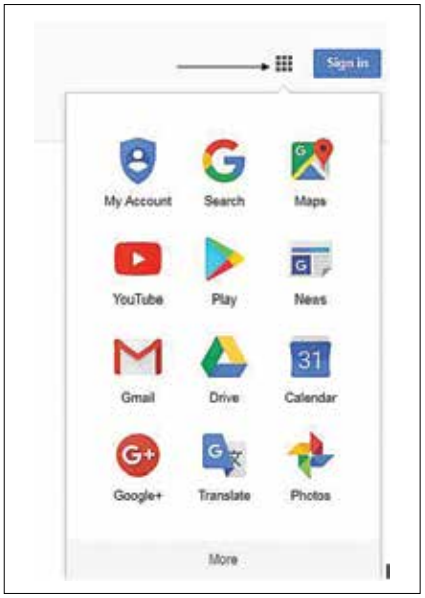
Free-to-use applications from Google

While many people will already have a Google email address (called a Gmail account) there's an extra bonus; because anyone with a Google account can now have access to a number of different software applications, as shown below.

While don't have the time to go through all these applications today, I will cover the key apps in more detail over coming issues. But for now here is a brief summary:

- Click the six dots logo to the right of the Search Bar and all available applications (apps) will show. There are some more under the More link, but we will look at these another time.
- Clicking any of the icons will activate the chosen app.

My Account: all your data around personal info, privacy, security and account preferences.
Search: internet browsing
Maps: ability to search Google Maps
YouTube: access to YouTube streaming



videos
Play: music and movies
News: news feeds from around the world and Australia
Gmail: free email account access
Drive: the ability to store data/documents in the cloud (will cover this thoroughly in a later column as there's lots to learn here)
Calendar: an online calendar similar to the Outlook Calendar.
Google +: a social network somewhere to the concept of Facebook
Google Translate: language translation.
Photos: free storage and organisation tool for photos.
Hidden under the Drive icon is your access to 3 free applications that are activated under a NEW button:
Google Docs: Google's version of MS Word
Google Sheets: Google's version of MS Excel
Google Slides: Google's version of MS PowerPoint.

In the next issue we will continue looking at some of the key Google apps mentioned in today's column as well as begin a deeper dive into the Docs, Sheets then Slides.

For more tips, hints and reference material on technology and social media, visit me anytime at www.angelalewis.com.au or search for my technology page on Facebook as Angela Lewis Consulting.

Tips

Quickly open closed tabs

If you have closed one of your tabs (e.g. containing a website you have a visited) and then need to get back their quickly, simply hold down the Ctrl & Shift keys and then press the letter T.

Voila, the last closed tab re-opens! Repeat the keystroke to re-open other tabs in the order they were closed.

New searches, new tabs

Try pressing Alt-Enter after you type a search term or URL into the Chrome search bar – that'll cause your results to open in a new tab instead of in your current tab.

Easily moving around web pages

You may already know that pressing the spacebar will scroll down one screen length on any web page… but did you know that pressing the Shift key and spacebar together will scroll up in the same manner? PS – this works in Internet Explorer too!

Pressing the Ctrl, Shift and B keys will toggle the browser's Bookmarks Bar in and out of view.

Any site you've saved into the Bookmarks Bar folder will appear along the top of the screen and when you repeat this key combination it will hide them.

PEER REVIEWED ARTICLE

Our hope: A Group Work Journey to Healing and Empowerment

By Dr Rebecca Braid and Susan A. Bennett

Implications Statements

The unique contribution of an empowered group work process run with client-centred focus creates a hope and a future for extremely disadvantaged clients. The relevance of the paper to social work includes the unique contribution that social workers make to client-centred focus and the encouragement of the clients' voice, particularly in relation to trauma.

As a result of authoring such work, social policy can be guided and managed by the clients it is intended to serve.

Abstract

This paper explores the experiences of women survivors of complex trauma affected by domestic violence, institutionalised childhood sexual abuse and family of origin abuse. Out of concern for the ongoing needs of complex trauma survivors, a collaboration emerged to conduct group work to ameliorate clients' needs in a private practice setting. That collaboration between two private practitioners piloted nine groups throughout 2016. Qualitative and quantitative documentation was collated of the changes that emerged through these groups for high risk clients. In light of the current therapeutic climate, which will be informed by the final Royal Commission into Institutional Responses to Child Sexual Abuse recommendations, the documentation of this form of intervention is critical. It is imperative that the client's voice be heard, respected and acknowledged in light of the Royal Commission findings to date. Our experience speaks to the healing that was evident amongst participants in the groups as they found their voice.

Introduction

The complex trauma clients seen by both private practitioners were all well supported in individual counselling. The clients came into the practice by private means, community health centres, Single Mothers Support and Heal for Life. The Safe Place for Women[1] groups were developed out of a recognition that the clients we were seeing would benefit from further support to overcome difficulties and stresses that they were encountering at that time. Our aim was to provide a safe place where participants could develop skills and explore healthy ways to improve their lives. In these groups participants can then improve their ability to tolerate distress and pain, improve their respect and compassion for themselves, interact with others without compromising personal values and beliefs, and make changes that allow for purpose and meaning in life (Cohen et al, 1995, p XV). The Safe Place for Women groups were informed by creative art processes and a therapeutic construction process[2] which gave meaning to participants' experience.

Complex Trauma

The management of complex trauma is an area of expertise in private practice. The presenting range of physical and psychological difficulties faced by survivors is overwhelming both for the client, their families and the practitioner. When clients present with complex trauma they are usually lost, with no hope, having been labelled by the court system and the medical model as difficult and overwhelmingly mistrusted in terms of their history giving. Current therapeutic interventions document clients' search for healing as a journey into further pain. "Even more challenging, some clients find that their trauma- related wishes and fears of relationship are so equally intense that therapy and the therapist evoke painful yearning, mistrust, hypervigilance, and anger, or fear and shame, rather than feelings of safety and comfort" (Fisher, 2017, p 6).

Rather than re-triggering further pain, the practitioners pondered the documented raw data from Dr Braid's research PhD, where clients clearly stated what they wished for in counselling from practitioners. "What you actually remember needn't necessarily be fact, fact, truth, truth, but what you are left with is an overwhelming impression and an overriding effect in a person's life and that's what you deal with…" (Braid, 1996, p 15). The extent of this overriding effect in the client's life can best be described by the following, "Why are you dragging this up now? Why? Why? It has controlled every facet of my life. It has damaged me in every possible way. It has destroyed everything in my life that has been of value. It has prevented me from living a comfortable emotional life. It's prevented me from being able to love clearly" (Bass and Davis 1992, p 33). As practitioners, we believe that encouraging clients to love clearly and deal with the effects of complex trauma can be strengthened by managed group relationships. The research spoke to the need for a managed group environment that bore witness to the complex trauma, and provided a restorative narrative environment. Such a group environment was unique in that it offered safety, and an opportunity to listen and believe. Further to this, the narrative had an expected outcome of 'resurrection', that is bringing to life something that was dead (Braid, 1996, p 289) As a result, Safe Place for Women emerged.

1 Copyright Eden Therapy Services

2 This process of construction involves multiple Lego pieces, both shapes and characters, used to build a narrative

Royal Commission

It is important to comment on the current therapeutic environment due to the Royal Commission into Institutional Responses to Child Sexual Abuse. Complex trauma survivors who are currently in counselling privately, under MHCP, funded by Relationships Australia's Wattle Place, or Victims Services funding are experiencing many reactions to the Commission's work. From its commencement in 2013 to 1 May 2017, the Commission has handled 38,698 calls, received 22,911 emails and letters, held 6706 private sessions and made 2,025 referrals to authorities including police (Royal Commission, 2017, accessed).

A former group participant, having discovered her voice, and with the assistance of further counselling, engaged in one of the Commission's Private Sessions. She was so strong in healing that she returned to the group process to encourage other participants. As she addressed the group participants in regards to Justice McClellan's concerns about the level of systemic failure of institutions to care for the vulnerable, this participant gives voice to a hope. Justice McClellan stated, "It was remarkable there were failures at more than 4,000 institutions identified in abuse allegations…including public and private schools, detention centres, out-of-home care, churches, orphanages and government bodies" (ABC News, 2017 accessed). It is in this complex community environment that we ran the "safe place" programs. The aim and purpose of the groups was to give voice to survivors' stories, to acknowledge them, recognise them, and begin to record them in a supported group environment.

The Groups: Safe Place for Women© Level 1 to 4

The groups were run in six week programs for two hours. The setting for the groups was the physical offices of Eden Therapy Services in Balgowlah, Sydney NSW. All clients were familiar with this physical setting as this was the location of their individual counselling sessions. Groups were run in the large open area of the offices while no individual counselling was happening. In this way safety was created through familiarity, and the only people in the practice area were the clients and group facilitators. Each week the group was introduced by the lead facilitator and the aims of the group's work discussed. The co-facilitator would then begin with a therapeutic construction piece in Week 1. This represented a way of moving and choosing construction pieces to materialise the pain and the experience of the pain in the process of the client's life. Perhaps another sentence explaining how this was introduced/explained to the group members? This provided a way for clients to see themselves and externalise their trauma. The creative process of the construction work accessed a part of the brain previously untapped by the counselling process, as one on one sessions often can focus on utilising verbal exchange, as it is limited to the conscious processes. Group participants are invited to discuss their constructions with no judgement and no comment from other participants, thus ensuring safety. Each participant's construction is then photographed by phone and stored for observation in Week 6 of the group.

Week 1 is then given over to developing and practising basic skills for managing distress, such as relaxation and breathing, which are used immediately in the group, with discussion time encouraged. The tools were recorded in folders for each participant to keep and use after the group finished. Tools were practised and added to throughout the six week program. In the final week of the six week program participants revisited their construction →

piece. Based on changes they had observed in themselves and other group participants, they were invited to represent their growth. This growth was evidenced by movement, rearrangement, addition or removal of construction pieces, This tangible outworking of change reinforced the healing journey for participants. One group moved through all four levels of the program culminating in the Safe Place for Women© Level 4 Empowerment Group. These participants had tools which then empowered participation in their community and world, achieving a high level of functioning and therapeutic change. The quantitative tool used to monitor this change was a basic DASS 21, administered in Level 2 at the start of the six week and the end of the six week program (Black dog Institute, 2016, accessed). The rest of this article will now focus on the qualitative results of the group program and honour the hope of the client's voice. As a result the following examples of the group process are highlights of the group journey and not necessarily in contextual sequence.

Empowered for Resilience

One exercise in Level 2 involved exploring fear, by creating three abstract paintings depicting fear. Paint was applied liberally to the first page. A sheet of blank paper was placed on top of the wet painting, and then pulled off revealing a transfer of paint. This process was repeated with a third sheet of paper transferring paint from the second artwork. The three paintings were placed side by side. The resulting artworks of fading colours, reflected diminishing fear. It was confronting for participants as they courageously faced and expressed their fear. They were invited to identify with one picture that would represent their current emotional state. Then they were invited to add to the painting an abstract representation of what they might be able to do if they were not afraid - for example, hobbies, activities, and relationships. It was curious to see that many desired to further their education. This exercise showed participants what their life could look like if they were able to move beyond survival mode.

One participant, a victim of domestic violence, dared to think about finding a man with whom she could have a safe and caring relationship, someone whom she could 'trust again'. Whilst there was no denying the state of hopelessness she was experiencing as a result of the abusive trauma, her emerging hope demonstrated a capacity for resilience. The concept that hope and hopelessness can coexist became evident, speaking 'to the complexity of the human response to trauma' (Flaskas, 2007).

Machinery of Hope

This exercise involved participants designing two machines through drawing and collage (Figure 1). The first machine used the trauma as raw material. Coping skills were used as the workings of the machine. Then 'product' is generated in the form of 'what my life looks like now after being influenced by these coping skills'.

The second machine uses 'product' from the first machine as the raw material. Participants were invited to think of alternative skills they may like to develop that would help them manage their life more effectively. These skills become the workings of the second machine and then the 'product' refers to what their life would look like if they implemented these new skills.

This exercise was from the Level 4 group process that focused on empowerment. The participants had made significant gains from previous group levels and were able to tolerate these challenges. Nevertheless, one participant found her artwork particularly confronting. She saw how coping skills, such as behavioural excesses and isolation, whilst being effective in the short-term, could be unhelpful and detrimental. She came to understand how they impacted her overall wellbeing, and had possibly damaged her relationships. Such discoveries can cause feelings of self-loathing and condemnation. The respect and comfort offered in the group process helped her and other participants with similar feelings. Hope emerged as she persevered with the work. She saw a happier and healthier version of herself, whilst at the same time was able to honour those coping mechanisms that helped her survive. The exercise caused her to look for healthier alternatives and begin to see the outcomes of making such changes. Rather than shunning that part of her life, the exercise helped integrate it as part of the overall narrative of the healing journey.

Brene Brown has spent years studying shame and brokenness. As a social worker, Brown (2015) refers to this integration and acceptance of all of self: "If integrate means 'to make whole', then its opposite is to fracture, disown, disjoin, detach, unravel or separate. I think many of us move through the world feeling this way. The irony is that we attempt →

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Course
July 27th - 29th
Time: 9am - 5pm

Course
October 26th - 28th
Time: 9am - 5pm

Eden Therapy's point of difference for this training is that your presenter Dr Rebecca Braid, PhD social worker is working in private practice and has been for 23 years. In addition she has a further 10 years spent working in hospital settings and community based organisations. Rebecca knows what it's like to supervise 'at the coalface' and has been supervising social workers, counsellors healthcare professionals, managers, business owners and clergy for many years. Over the years in private practice, Rebecca has also run training courses for therapists in complex trauma and spirituality and therapy.

Visit http://www.edencounselling.com.au/content/courses for further information or call 02 9907 0044.

ACA RECOGNISED PROFESSIONAL DEVELOPMENT

to disown our difficult stories to appear more whole or more acceptable, but our wholeness – even our wholeheartedness – actually depends on the integration of all of our experiences, including the falls." As Brene Brown states, the client in this example decided to acknowledge her failings and by doing this, integrated it as part of her healing.

Hope from a Height

One of the exercises of the group involved the age-old spiritual tool – the labyrinth. It was used as a metaphor for life's journey, where its twists and turns are like those we encounter in life (Longley, 2016). A drawing of the labyrinth was provided, and participants were invited to trace a pathway through to the centre, traditionally a place of peacefulness. Then they were invited to retrace their path out of the labyrinth back to the beginning. The path often reflects their current life journey and offers insight from a different perspective, which can provide a therapeutic shift. One participant decided that, rather than retracing her steps out of the labyrinth, she 'flew out' of the centre on an imagined plane and circled the outer perimeter of the labyrinth. As she looked down at the labyrinth from above, she had an 'Ah-ha' moment, and was able to gain some understanding as to what that journey was all about. She was in difficult circumstances (Family Law Court attendances) and it was hard for her to make sense of life – but she now had a sense of hope that this was OK. She believed understanding would come later and from a different perspective. She demonstrated robustness in the face of uncertainty.

Empowered to Rise

Each six week group, irrespective of the Level, was started and concluded with a construction exercise. The gains made during each group needed to be materialised in a concrete way. In week six each participant was invited to revisit their construction piece, which had been securely stored out of sight for the duration of the group. They transformed their work in a way that reflected the internal changes that had taken place.

Photo 1 Week 1 Client A

Photo 2 Week 6 Client A

Photo 3 Week 1 Client B

Photo 4 Week 6 Client B

Photo 5 Week 1 Client C

Photo 6 Week 6 Client C

These internal changes resulted from implementing tools that enabled self-care, nurturing, identifying supports and needs, connecting with emotions and early stages of emotional regulation. In one group (Level 2) there was a common theme that emerged in the construction work for three out of the four participants – that of rising higher (refer to photos).

Photo 1 from week 1 client A (represented by the brown haired female figure) felt overwhelmed and frightened by the hurdles she faced at that time– a battle for child custody - as a client who has experienced domestic violence. **Photo 2 from week 6** showed A elevated on a green structure. Her interpretation of the change: "I am higher up and feel stronger…I still have my days…there are a few hurdles still, but OK in all…". This client was able to improve her support network, as evidenced by more figures. We invited participants to view their work from different perspectives, as this may offer additional insights. Client A commented on her different perspective, "I have lots of new people in my corner… lots of support and others are cheering me on…". She was referring to the support provided by her therapist, other group participants, group facilitators and volunteers, the advocate and police. This evidenced the client being able to rise above her circumstances as a survivor of domestic violence.

Photo 3 from week 1 client B (represented by the female figure with purple hat): the lion represents spiritual support, other figures are the significant

others in her life. **Photo 4 from week 6 shows client B** towering over her construction wearing a cape and a sword. She commented, "I have wings on and am up high in the sky looking at the situation…God has brought me higher up…not affected by the influence of 'it'…" (referring to her trauma). This recurring theme of being higher up demonstrated the client's empowerment.

Photo 5 from week 1 client C (represented by the lioness) is wearing a crown that is half falling off '…I'm trying to be the strong one, but it doesn't feel like it…". **Photo 6 from week 6** shows the lioness has moved from the centre and is positioned high up on the wall, "…because I am not listening to what everyone wants and I am in more control of what I want…". In interpreting her work, she stated, the crown "... is on squarely and in control…(my)self is first and higher up… it's a step up…I am higher up on the food chain compared to others…". Yet again, the recurring theme is evidenced and a step up is sensed by the client as empowerment.

These positional shifts in the construction works reflect the internal shifts participants experienced through engaging with the weekly group work exercises. These tangible expressions of hope and strength reinforce the gains the participants made, providing 'evidence' that they were moving forward in their healing journey.

Difficulties in Running the Groups

The experience of facilitating the rich and varied reactions of the group participants was extraordinary. However, difficulties in running the group were experienced and need to be acknowledged for the development of future group processes. Three women in the groups emerged complex reactions to being present in a group setting. Considering that nine group were conducted in 2016 with thirty seven attendances, three group participant difficulties was minimal for complex trauma survivors.

One group participant found that the facilitation by the lead facilitator reminded her of how she would get into trouble by her mother. This understanding of her distress emerged later in the debrief with her. On the initial attending to Level 1 of the Safe Place for Women©, all participants are encouraged to see the offices as a safe area that they are familiar with. Group confidentiality forms are signed, encouraging each participant to focus on carrying the privacy of individual information with care. These forms are explained and signed with all group participants present and hearing the same information to again encourage safety and solidarity. This one woman, who was an historic abuse survivor, then began to attend to the exercises for the group, however could not bring herself to participate. She began observing the other members of the group and, against the group agreement, she allowed herself a verbal observation of another participant's work. She began to take notes on the other members' work rather than join in with the group activities. This was quickly alleviated by the intervention of the lead facilitator and was barely noticed by the other group participants. However the lead facilitator and co-facilitator were concerned enough at the end of this group to call and speak with the other participants in the follow up phone call to check to see if this behaviour had been detrimental to the group function. Only one of the other group participants said the behaviour had worried her. She felt that the observation of her was causing her to be triggered, as her perpetrator was very observant of her to catch her unawares as a child. This behaviour in the other group participant reminded her of being observed, and thus the facilitators decided to take action at the commencement of the next group. The lead facilitator was to intervene.

In the follow up call to the group participant who had decided not to join in the group activity, an invitation was made to be observant and thoughtful of her own behaviour and how this had affected her. It was revealed that she felt told off by the rules and regulations and rebelled against this. This was a pivotal moment for her and she wanted to return to the group and try again. This was agreed to and she was told that the lead facilitator would go over the rules for the benefit of all and that participation was important for her and the health of the group. Once announced at group the next week the other members saw her struggles and were very supportive and encouraged her to try to participate. They all did not expect total participation by her and gave her space to see how she would go. While not joining in entirely, this group participant, for the first time in her life, was able to have her fear of rules heard and attended to. As a result, she worked carefully and attentively in her individual sessions on the effects of her mother's cruelty in her life.

The management of this difficulty within the group suggests the necessity for the co-facilitation of group work especially when a lead facilitator has a therapeutic relationship with a group participant. The co-facilitation can mirror up a supportive "partnership" when many complex trauma survivors have experienced destructive partnerships in their family of origin. The facilitation partnership in line with the group agreement would benefit all including the group member who was →

The collegial process paves a way for navigating the pathway through the territory of hopelessness and despair which can affect many people experiencing complex trauma. In this way the counsellor and social worker lead the client toward multiple possibilities for empowerment.

feeling overwhelmed and triggered. This was a window for the participant into new ways of managing distress. The supportive environment of understanding that the other group participants offered also helped to ameliorate the group member's distress. Many months later in individual follow up sessions under her Mental Health Care Plan, the group participant offered an explanation of her behaviour. She said she was triggered into feeling she was being told off like her mother used to do. Through the revisiting of the group agreement, she realised that the stance of the facilitators, and the listening and negotiation and inclusion she was offered, assisted her to a breakthrough in her understanding.

A further difficulty emerged with another participant, that was quite different. This difficulty again manifested at Level 1 and emerged by week 4 at its fullest. The group participant had a history of sexual assault which had not been addressed until adulthood. She had recognised the effects this had on her anger, her parenting and her marriage. She was grieved by these effects and had sought counselling, only due to her teenage children's reactions to her emotional difficulties. In the group, she become increasingly overwhelmed by how much the rape had affected how she has communicated all her life, and how little she knew of self-care and her own bodily reactions to the grief. In Weeks 1-3 she had practiced the self-care breathing exercise, establishing a safe place and a container for emotions. As she struggled with these tasks the lead facilitator sat next to her in group while the co facilitator kept the group focused on the tasks at hand. This shared facilitation allowed for the smooth running of the group despite one group member needing one to one facilitation assistance. In this way the group participant was able to attend the full six weeks, and learn and practise how to accept assistance when it is offered. While this group participant was not offered Level 2 group work, the acceptance of assistance was a major step for her. It facilitated her managing a disclosure by her daughter of her own abuse by a family friend which went on to be investigated by police.

This group participant's collapse and need for support was easier to manage by the facilitator and co-facilitator. It is essential to note that while government funding bodies, with an eye to cost cutting, would not necessarily support co-facilitation in groups, it is imperative when an individual's reaction to the group content needs individual support in the group.

The final challenge to be addressed concerned a group participant who is an historic child abuse survivor. She managed all four levels of the Safe Place for Women© groups with the final level being called "Empowerment for Women". In Level 2 of the group work a visit was made by a volunteer who had presented to the private hearings for the Royal Commission. This input by a volunteer was very powerful in the group process. Her group presentation ran for an hour and included the story of this woman's survival of institutional sexual abuse and her joy in sharing that survival as an encouragement to other women to go on. In Level 3 she again visited the group process to answer any questions the participants had of her.

This group participant's reaction to meeting the volunteer was very emotional. She certainly was amazed to hear of this volunteer's story and see her resilience in the process of survival. The lack of police, community or court redress of the volunteer's abuse particularly caught the group participant's attention. Other group participants were also greatly affected and looked forward to asking the volunteer questions in the next group level when she would visit again. At this point the group participants were struck by the volunteer's story of survival. At the next Level when the volunteer presented again, the same group participant had a visceral or bodily reaction to the Q&A session. This participant was in the process of deciding to have her perpetrator wire tapped after nearly fifty years of not seeing or speaking to him. She began to have heart palpitations and was profusely sweating. The facilitators removed her from the group and helped her lie down on a couch. A volunteer group assistant who usually helps with set up and art supplies, sat with her until her family arrived and they took her to hospital for a check-up. She was fine and very pleased to have heard the strong story of survival at the group.

The difficulty that this group participant faced was physical and reactive. The news she was reacting to was the good news of the volunteer's survival, which helped her re-story her own trauma. The setup of the group assisted the handling of her reactions in a supportive environment, which was focused on her safety. Having a lead facilitator to continue the group while the co-facilitator went and fetched the volunteer assistant to sit with the group participant meant she felt cared for and was managed with safety. The rest of the group continued and the volunteer speaker kept her talk on track while acknowledging the extent of the bodily reactions all survivors can have. In this way the management of the group once again with facilitators, co facilitators, volunteer speakers and volunteer assistance gives evidence of care and commitment to safety and self-care in a dynamic way that cannot occur in other settings.

The therapeutic community needs to be encouraged to interact with the territory of complex trauma where hopelessness has been prevalent. Therapists in private practice could be curious to engage clients at a group level for the growth of their clients. The collaborative process between facilitators may become a powerful intervention in ameliorating complex trauma. The collegial process paves a way for navigating the pathway through the territory of hopelessness and despair which can affect many ppl experiencing complex trauma. In this way the counsellor and social worker lead the client toward multiple possibilities for empowerment. This leading is immediate and present in a very personal and intimate way. When the group is led appropriately the therapeutic cost to the group facilitators is tangible. In this way the facilitators carry the burden for the safety, expression and vulnerability of the group.

Our hope as therapists for the women who attended these groups is for their voices to be heard and respected, and to be believed and acknowledged by other survivors. Irrespective of the findings of the Royal Commission, our experience through group work demonstrated the

active survival and life participation of group participants. This has enabled a robustness and resilience for clients' healing. In this way the women go on, rather than being overwhelmed by sadness and loss. As the women in the groups find their voice, they experience healing, as described in the PhD research which emerged the resurrection theory, which is a movement from death to life, hopelessness to hope. We were awed by the desire of the women to engage with each other outside of the group. While group rules had facilitated first name basis contribution to the groups, the women themselves gathered and still do for mutual support and empowerment. It is very gratifying to know that group participants have chosen to modify this particular group rule to develop relationships outside of the group process. In conclusion we observe the concept of validity in regard to trauma survivors as best expressed in the improved life of the survivor. If we hold to this truth as evidenced in research conducted by Dr Braid in 1996, "validity for proof is in the changed and healed lives of the survivors", then the groups in 2016 were particularly valid. They increased hope and healing for complex trauma survivors (Braid, 1996, p Appendix 11). As a result, these groups are now run with a total awareness for the complex trauma survivor and their needs, to be empowered, strengthened and encouraged.

Acknowledgement

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We also give a special thanks to our volunteer who courageously addressed several groups about her experience of a private hearing at the Royal Commission into Institutional Responses to Child Sexual Abuse.

A special thanks also to Steven Bennett OAM, JP who offered his advocacy experience to the groups.

Biography

DR REBECCA BRAID

EXPERIENCE:

Dr Braid has been a practicing social worker for 33 years. She has worked in hospital settings, community based organisations such Cerebral Palsy Alliance and MS Society, and is currently in her 24th year in private practice. Rebecca specialises in complex trauma, and has been able to support clients to testify at the Royal Commission into Institutional Responses to Childhood Sexual Abuse. Rebecca has been running 'Safe Place' groups for a number of years, with great results for clients. Rebecca also supervises social workers, healthcare professionals, managers, business owners and clergy, and has completed a COA in Supervision training and is licensed to present the course.

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Mrs Bennett is a registered counsellor with the Australian Counselling Association (Level 4), has been counselling for 15 years, during which she also lectured and coordinated a counselling course at an NGO training organization. The past 9 years have been spent in private practice where she assists in facilitating 'Safe Place' groups. Susan also supervises counsellors and clergy and has completed the Certificate of Attainment in Supervision training course. Susan also has experience working with an EAP provider.

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http://www.abc.net.au/news/2017-03-27/victims-waited-too-long-for-response-says-royal-commission-chair/8390054 Accessed 10/5/2017

PEER REVIEWED ARTICLE

Internet pornography's effect on sexual attitudes and behaviours: A Structured Literature Review revealing gender difference

By Oliver Brooke

Abstract

Background

A substantial portion of Australians view internet pornography (IP), coinciding with the widespread adoption of high-speed internet in Australian homes. However, the effects of viewing IP are only beginning to be revealed including the negative impact on the brain from viewing IP. However, what are the effects on people's sexual attitudes and sexual behaviours?

Method

A structured literature review was undertaken to collate peer reviewed literature concerning IP's effect on sexual attitudes and behaviours, synthesising and reporting on articles that met the inclusion criteria published within the last three years.

Results

The main result identified across the literature was IP as a gender issue. There was a significant difference between male and female IP use. Effects are greater for men, especially for frequent users who watch IP with violence and male patriarchal and dominance themes. However, female partners of male users are directly affected with many negative consequences to their sexual attitudes and self-belief.

Conclusion

The critical synthesis of the literature establishes IP's overarching adverse effect on sexual attitudes and behaviours. The review of the literature indicates IP's consistent association with male patriarchal and dominance attitudes, permissive sexual scripts, riskier sexual behaviours and less relationship satisfaction and more distress.

There is a clear gender difference in the use and effects of using IP. These effects combine to affect relationships with both genders reporting less relationship satisfaction and more distress. These findings reinforce the need for increased awareness of the effect of IP. Counsellors must address co-occurring problems in male individuals who are regular users and be on the lookout for IP as an underlying issue in relationship distress and dissatisfaction.

Keywords

Internet pornography; gender differences; relationships; counselling

Background and Introduction

A substantial portion of Australians view Internet Pornography (IP), coinciding with reporting from the Australian Bureau of Statistics (ABS) of the widespread adoption of high-speed internet in Australian homes (ABS, 2016; Caruana, et al., 2017). Findings from the second Australian study of health and relationships reported that 84% of Australian men and 54% of Australian women had viewed internet pornography (Caruana et al., 2017). Some of the effects of viewing IP, reported in peer reviewed literature, are its impact on the brain (Banca, et al., 2016; Brand, et al., 2015; Kraus et al., 2016), and the influence it has on people's sexual attitudes and behaviours (Albury et al., 2008; Flood, 2010). However, there has not been a structured literature review of recent peer reviewed literature of the effect of IP on people's sexual attitudes and behaviours.

Purpose Statement

This literature review aims to collate peer reviewed literature about IP's effect on sexual attitudes and behaviours from the past three years, synthesising and reporting on the latest evidence to inform future research and add to counselling clinical knowledge.

Research questions

1. What are the effects of IP on sexual attitudes?
2. What are the effects of IP on sexual behaviours?

Research Paradigm

The epistemological standpoint is mixed methods, including both quantitative and qualitative literature to address the two research questions. Including, the collection and analysis of data about the prevalence of IP and collection of quantitative and qualitative studies about the effects of IP on sexual attitudes and behaviours. The ontological standpoint is

There is evidence to suggest Internet pornography's use has significant effects on male sexual attitudes around gender, body image, permissive sexual scripts and pro-sexual violence

to define (IP) as: Pornographic material (videos or images) accessed through the internet on an internet enabled device (tablet, smart phone, computer or another internet enabled device).

Methodology

The research questions were developed using Creswell, (2014), and the search process and literature review were completed using the 12-step method defined by Kable, Pich, and Maslin-Prothero (2012). These foundations formed the basis of a robust search process, collection of peer-reviewed articles, appropriate inclusion and exclusion criteria and a thorough quality appraisal of the literature.

Searched databases

The databases PubMed, PsychINFO and Academic OneFile, were searched in September 2017, to locate peer reviewed literature about the effects of IP on sexual attitudes and behaviours. Google Scholar and the ABS were searched to detect any appropriate surveys, documents or reports for background information.

Search limits

The literature search was limited by inclusion criteria: Only peer reviewed journal articles published in English during the past three years, related to IP's effect on sexual attitudes and behaviours and a full-text available online. Papers were excluded if the study population was lesbian, gay, bisexual, trans-gender or intersex (LGBTI), reported on physical effects, were written in a language other than English or focused on addiction to IP. Non-primary sources such as literature reviews and meta-analyses or other non-peer reviewed literature including opinion pieces, letters, news articles, commentaries, discussion papers and web pages were also excluded.

Search terms and process

Six search terms were included to search the databases, with article abstract and body searched. The search terms were checked in initial trials to check they were gathering relevant articles that met the search criteria before searching all the databases. Two synonyms for the word internet (web and online) were included as was one synonym of pornography (sexually explicit media). The term "effects" was included with the Boolean operator AND in some searches to gather more relevant articles when searching the combined terms of Internet and pornography otherwise there were too many irrelevant search results. Truncation and plurals were not used. The search terms:

- Web
- Online
- Internet
- Pornography
- Sexually explicit media
- Effects

The data bases were searched in sequence using the combined search terms and results are reported in Table 1 overleaf, excluding the results from google scholar and literature used in the background information. Repeating searches across all data bases continued to display the same articles confirming saturation of the literature. The reference lists of articles from 2017 were investigated to identify other relevant studies, a further three →

Table 1 Search results for the effects of IP on sexual attitudes and behaviours

Search Engine	Search (S) terms	# Retrieved (numbers in brackets used in combined searches)	# Met inclusion criteria	Table 2 Article ID
PubMed	S1 Web	(86746)		
PubMed	S2 Online	(125343)		
PubMed	S3 Internet	(89438)		
PubMed	S4 Pornography	(1970)		
PubMed	S5 Sexually explicit media	(102)		
PubMed	S6 effects	(7196732)		
PubMed	S6 S1 & S4	47	1	1
PubMed	S7 S1 & S5	7	0	
PubMed	S8 S2 & S4	186	9	2 – 10
PubMed	S9 S2 & S5	13	0	
PubMed	S10 S3 & S4	(352)		
PubMed	S11 S3, S4 & S6	32	3	11,12,13
PubMed	S12 S3 & S5	46	1	14
Totals		331	14	
PsychINFO	S1 Web	(8007)		
PsychINFO	S2 Online	(18,245)		
PsychINFO	S3 Internet	(48,512)		
PsychINFO	S4 Pornography	(392)		
PsychINFO	S5 Sexually explicit media	(50)		
PsychINFO	S6 effects	(121719)		
PsychINFO	S6 S1 & S4	21	0	
PsychINFO	S7 S1 & S5	1	0	
PsychINFO	S8 S2 & S4	101	8	15 - 20
PsychINFO	S9 S2 & S5	15	0	
PsychINFO	S10 S3 & S4	(148)		
PsychINFO	S11 S3, S4 & S6	33	2	21,22
PsychINFO	S12 S3 & S5	24	1	23
Totals		195	11	
Academic OneFile	S1 Web	(21,218)		
Academic OneFile	S2 Online	(517,378)		
Academic OneFile	S3 Internet	(15,120)		
Academic OneFile	S4 Pornography	(402)		
Academic OneFile	S5 Sexually explicit media	(15)		
Academic OneFile	S6 effects	(281,873)		
Academic OneFile	S6 S1 & S4	11	0	
Academic OneFile	S7 S1 & S5	0		
Academic OneFile	S8 S2 & S4	12	0	
Academic OneFile	S9 S2 & S5	2	0	
Academic OneFile	S10 S3 & S4	76	2	24,25
Academic OneFile	S11 S3, S4 & S6	2	0	
Academic OneFile	S12 S3 & S5	4	0	
Totals		107	2	
Manual Search				
Reference lists retrieved documents			3	26,27,28

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Table 2 Effects of internet pornography (IP) on sexual attitudes and behaviours

#	Title, Author/s and country	Study design	Sample	Key findings	Quality appraisal
1	Adolescents and web porn: a new era of sexuality by Bertoldo et al., (2016). Italy	Cross-sectional survey Convenience sample	1492 participants Age range 18-19	Internet Pornography (IP) positively correlated to reduced sexual interest towards real-life partners	Included
2	Narcissism and internet pornography use by Kasper et al., (2015). United States of America (USA)	Cross sectional survey Convenience sample	257 participants Age range 18–61	IP positively correlated to narcissism level	Included
3	Pornography, sexual coercion and abuse and sexting in young people's intimate relationships: a European study by Aghtaie et al., (2016) Italy, Norway, Bulgaria, Cyprus and England	Cross sectional survey & 91 qualitative interviews.	4564 participants Age range 14–17	Male IP use linked to holding negative gender attitudes and perpetrate sexual coercion	Included
4	Female partners of men who use pornography: Are honesty and mutual use associated with relationship satisfaction? by Alderson, K., & Resch, M. (2014). Canada	Cross-sectional survey Convenience sample	340 heterosexual females Age range 18–41	Female partners experiencing dishonesty about IP report distress and lower relationship satisfaction	Included
5	Pornography use and loneliness: a bidirectional recursive model and pilot investigation by Butler et al., (2017). USA, Canada and Australia	Cross-sectional survey Clinical sample	1,247 participants Age range 18–70	IP positively correlated to loneliness	Included
6	Predicting the emergence of sexual violence in adolescence by Thompson, R. E., & Ybarra, M. L. (2017). USA	Longitudinal study, six waves of data	1586 participants, Age range 10 - 21	Exposure to violent pornography strongly associated to sexual violence perpetration	Included
7	The influence of pornography on sexual scripts and hooking up among emerging adults in college by Braithwaite et al., (2015). USA	Cross-sectional study 3-month longitudinal study	Age range 18–25 Study 1: 969 participants Study 2: 992 participants	More frequent IP viewing was associated with a higher number of different casual sex partners, riskier sexual behaviours and more permissive sexual scripts	Included
8	Adolescents' use of sexually explicit Internet material and their sexual attitudes and behavior: parallel development and directional effects by Bickham et al., USA and The Netherlands	4-wave longitudinal survey 18-month study period	1,132 participants 7th -10th grade	Males increasing IP use paralleled an increase in permissive attitudes and sexual behaviour	Included
9	Differential developmental profiles of adolescents using sexually explicit internet material by Doornwaard et al., (2015) The Netherlands	4-wave longitudinal survey	787 Participants 8th – 10th grade	Higher IP use resulted in perceiving IP content as significantly more realistic and instructive	Included
10	You looking at her "hot" body may not be "cool" for me: integrating male partners' pornography use into objectification theory for women by Kroon Van Diest, A., & Tylka, T. (2015). USA	Cross-sectional survey Convenience sample	171 women Age range 18–56	Male partners' `IP use associated with sexual objectification, internal beauty standards, eating disorder symptomatology and body surveillance	Included
11	Cyberpornography: time use, perceived addiction, sexual functioning, and sexual satisfaction by Blais-Lecours et al., (2016). Canada	Cross-sectional survey Convenience sample	832 participants Age range 18-78	IP use directly associated with lower sexual satisfaction and stress	Included
12	Masculine norms, peer group, pornography, facebook, and men's sexual objectification of women by Mikorski, R., & Szymanski, D. (2016). USA	Cross-sectional survey Convenience sample	329 male participants Age range18-31	Higher levels of IP use emerged as unique predictor of body evaluation of women	Included
13	Male partners' perceived pornography use and women's relational and psychological health: The roles of trust, attitudes, and investment by Dunn et al., (2015). USA	Cross-sectional survey Convenience sample	359 female participants	Women's reports of male partners' IP use related to less relationship satisfaction and more psychological distress	Included
14	Internet pornography and relationship quality: A longitudinal study of within and between partner effects of adjustment, sexual satisfaction and sexually explicit internet material among newly-weds by Muusses et al., (2015). The Netherlands	5-wave longitudinal study one-year intervals	140 newlywed couples participated	IP use has negative consequences for husbands and wives	Included
15	Is pornography use associated with anti-woman sexual aggression? re-examining the confluence model with third variable considerations by Baer et al., (2015). London, England	Cross-sectional survey Convenience sample	183 male participants Age range 18–71	Men more likely to report sexual coercion and consume violent sexual media when they frequently used IP	Included
16	Adolescents' sexual media use and willingness to engage in casual sex: differential relations and underlying processes by Peter et al., (2017) The Netherlands	3-wave longitudinal study	1,467 adolescents Age range 13–17	Exposure to IP directly predicted willingness to engage in casual sex	Included
17	'It's always just there in your face': young people's views on porn by Higgs, et al., (2015). Australia	33 Qualitative interviews Purposive sampling	33 participants Age range 15–20	Link between IP exposure and young men's sexual expectations and young women's pressure to conform to what is being viewed. IP reinforces a sexual script promoting gender inequality and male subordination over women	Included
18	Pornography, alcohol, and male sexual dominance by Steffen et al., (2015). USA	Cross-sectional survey Convenience sample	384 male participants Average age 32	Men's desire to engage in sexual coercion, hair pulling, spanking a partner and other violent sexual behaviours linked to frequent IP exposure	Included
19	No harm in looking, right? men's pornography consumption, body image, and well-being by Tylka, T. L. (2015). USA	Cross-sectional survey Convenience sample	359 male participants Age range 18-47	IP is linked to muscularity and body fat dissatisfaction through internalization of the mesomorphic ideal	Included

studies were identified. Papers which did not fit the search limits were not included. The search strategy is reported in Table 1.

Search Results

Searching the databases retrieved 25 papers which fit the inclusion and exclusion criteria. Three more articles were included by searching the reference lists of retrieved articles from 2017. After reading the full texts, 10 articles were removed because they did not report findings specifically related to sexual attitudes or behaviours. The remaining 19 articles were summarised in Table 2 during the search process. They included 1 qualitative study, 1 mixed methods study, 11 quantitative cross-sectional surveys and 5 quantitative longitudinal studies, there were no duplicate articles.

Quality appraisal of the literature

The qualitative and mixed methods papers were included after review of the Critical Appraisal Skills program (CASP) Qualitative Checklist, retrieved from http://www.casp-uk.net/casp-tools-checklists. 11 articles reporting on cross-sectional surveys were assessed using the Oxford Centre for Evidence-based Medicine (OCEM) – Levels of Evidence, retrieved from http://www.cebm.net/oxford-centre-evidence-based-medicine-levels-evidence-march-2009/. All 11 articles were attributed OCEM level 4 and included for review. The 5 remaining quantitative longitudinal studies were reviewed using the CASP Cohort Study Checklist, retrieved from http://www.casp-uk.net/casp-tools-checklists, all 5 papers were included for analysis. (See Table 2 left)

Results

Prevalence and gender difference

The main result identified across the literature was IP as a gender issue. There was a significant difference between male and female IP use. Men are far more likely to use IP and use it frequently (Aghtaie et al., 2016; Bertoldo, Foresta & Pizzol, 2016, Bickham et al., 2015; Blais-lecours et al., 2016; Butler et al., 2017; Doornwaard et al., 2015; Kasper, Milam and Short, 2015; Tylka, 2015). A survey of 257 adults by Kasper et al., (2015) reported that 96% of male participants had used IP while only 68% of females had and a study by Blais-lecours et al., (2016) of 832 adults reported similar findings of 90.2% of males and 51% of females. A European study of school children between 14 and 17 years of age found an even wider gender difference with 59% of boys consuming IP and only 8% of girls (Aghtaie et al., 2016). Other studies supported these findings with male participants significantly correlated with more IP use than females (Bickham et al., 2015; Butler et al., 2017; Doornwaard et al., 2015). Consistent high rates of male IP were also reported in all-male studies with Bertoldo et al., (2016) reporting 77.9% and Tylka (2015) reporting 83.2%. Men were also found to access IP more frequently and spend more time watching it (Kasper et al., 2015). IP use and frequency of use were not the only gender difference identified in the literature; there is substantial evidence to suggest that IP use has different effects on male and female sexual attitudes and behaviours (Alderson & Resch, 2014; Kroon Van Diest & Tylka, 2015; Dunn, Feltman & Szymanski, 2015).

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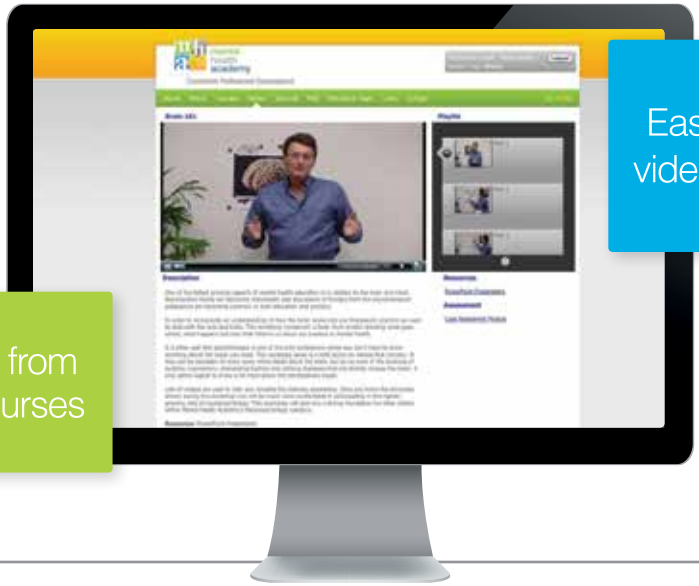

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The purpose of this course is to acquaint you with the basic principles of Psychosynthesis: its assumptions, core constructs, and understandings about what makes a being human, and what, therefore, may be the best means of facilitating that being's growth toward its fullest potentials.

Understanding Will

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

Overview of the Principal Personality Tests

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

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Brief Counseling: The Basic Skills

In this video John Littrell (Colorado State University) shows how to teach brief counselling from a microskills framework. You will learn how to search out positives and solutions early in the session; how to structure a five-stage brief interview; how to ask questions that make a difference; and how to manage difficult clients.

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Effect on male sexual attitudes and behaviour

There is evidence to suggest IP use has significant effects on male sexual attitudes around gender, body image, permissive sexual scripts and pro-sexual violence attitudes (Aghtaie et al., 2016; Baer, Kohut & Fisher, 2015; Bickham et al., 2015; Higgs et al., 2015; Mikorski & Szymanski, 2016; Tylka, 2016). Males who watch IP are more likely to hold negative gender attitudes, resorting to traditional gender scripts, blaming women for leading men on sexually and believing men are more important than women (Aghtaie et al., 2016). Two other studies confirmed IP reinforces gender attitudes of men's power and subordination over women (Higgs et al., 2015; Mikorski & Szymanski, 2016).

IP use is related to more permissive sexual scripts (socially constructed sexual roles that people play out when having sex) including riskier sexual behaviours, multiple sexual partners, sexual aggression and casual sex (Bickham et al., 2015; Braithwaite et al., 2015; Higgs et al., 2015). Permissive sexual scripts are also linked to male attitudes towards sexual violence (Higgs et al., 2015). IP use is positively correlated with the endorsement of sexual violence and an increase in hostile masculinity and sexual aggression (Baer et al., 2015; Bickham et al., 2015). Consumption of violent IP was a strong predictor of pro-sexual violence attitudes (Baer et al., 2015).

IP's influence on male sexual attitudes is linked to male sexual behaviours, including parallel increases in sexual violence perpetration and riskier sexual behaviours. IP use was significantly associated with male perpetration of sexual coercion (Aghtaie et al., 2015; Baer et al., 2015; Steffen et al., 2015). Exposure to violent IP was positively associated with sexual violence perpetration (sexual assault, harassment, and rape), especially correlated with sexual harassment (Thompson & Ybarra, 2017). Men who frequently consume IP are more likely to engage in dominant and violent sexual behaviours including, hair pulling, spanking a partner hard enough to leave a mark, facial ejaculation and confinement (tying a partner up or restricting their movement) (Steffen et al., 2015). Mikorski and Szymanski (2016) demonstrated that male IP users were more likely to make unwanted sexual advances toward females. Other studies showed a link between IP and riskier sexual behaviours, for example IP users were significantly more likely to have sent sexual messages or images over the internet (Aghtaie et al., 2016), engage in casual sexual encounters (Braithwaite et al., 2015; Peter, Vandenbosch & Van Oosten, 2017) and engage with a higher number of sexual partners (Braithwaite et al., 2015).

Male body image dissatisfaction is significantly affected by IP, linked to comparisons of muscularity, body fat and the perceived ideal mesomorphic body of male IP actors, leading to decreased body appreciation and increased body monitoring (Tylka, 2015). Increasing IP use was also correlated with significant increases in male's negative evaluation of female body image (Mikorski & Szymanski, 2016).

Female sexual attitudes and behaviours and male partners IP use

Female IP use was low in all studies, and its effect on sexual attitudes and behaviours was less pronounced than the effect on male participants. Studies also reported mixed findings, with Bickham et al., (2015) reporting IP use had no significant impact on female sexual attitudes or behaviours and Braithwaite et al., (2015) reporting more frequent IP use is associated with riskier sexual behaviours including casual sex and multiple sexual partners. However, numerous studies reported that female's male partners IP use significantly affected their sexual attitudes and behaviours, impacting relationship satisfaction, mental health, body image, sexual satisfaction and pressure to conform (Alderson & Resch, 2014; Bickham et al., 2015; Kroon Van Diest & Tykla, 2015; Dunn et al., 2015; Higgs et al., 2015).

Females who experienced dishonesty about male partners IP use reported lower relationship satisfaction and increased distress (Alderson & Resch, 2014). Over 50% of women are bothered by their partners IP use, with male partners IP use uniquely associated with reports of sexual objectification, internalisation of cultural beauty standards and body surveillance (Kroon Van Diest & Tylka, 2015). Females' reports of male partners IP use were related to less relationship satisfaction and trust and more psychological distress (Dunn, Feltman & Szymanski, 2015). Women reported feeling discomfort and disgust with IP and resented being exposed to sexist and abusive sexual scenes promoting values that reinforce men's subordination of women (Higgs et al., 2015).

Effects across genders

Several studies reported effects on both male and female sexual attitudes and behaviours (Butler et al., 2017; Thompson & Ybarra, 2017; Braithwaite et al., 2015; Doornwaard et al., 2015; Muusses, Kerkhof & Finkenauer, 2015; Peter et al., 2017). Musses et al., (2015) reported IP use has more negative than positive consequences for husbands and wives. There was evidence in the literature for a significant positive association between IP and loneliness (Butler et al., 2017), and hours spent using IP was linked to participants narcissism level, with IP users rating higher on measures of narcissism than non-users (Kasper et al., 2015). Frequent users reported perceiving IP as significantly more realistic and instructive than non-users, this is significant considering the content previously discussed (Doornwaard et al., 2015). Frequent use was also associated with riskier sexual behaviours (Braithwaite et al., 2015), and predicted willingness to engage in casual sex (Peter et al., 2017). Finally, exposure to violent IP was associated with the emergence of sexual violence perpetration in both males and females (Thompson & Ybrra, 2017).

Discussion

Gaps in the literature and recommendations

One of the limitations of the reviewed literature is the lack of cohesion in defining internet pornography. Although this study used the term Internet pornography or IP, the collected research used many different titles and names

for IP, the three most common being sexually explicit online media (SEOM), sexually explicit internet material (SEIM) and internet pornography (IP). The first recommendation is to have a consistent title for this topic in future research. Upon review, perhaps SEOM is more encompassing as it can include online movies, advertisements, and games that include sexually explicit scenes. However, the limitation of this definition is the broadness of the category which introduces other variables. Further research needs to explore alternative titles.

IP use is a grave issue for mental and sexual health, and research should continue studying its effect on individuals. This review acknowledges that because of the diversity of the consequences of IP on sexual attitudes and behaviours more specific literature reviews must be conducted to explore the research around male IP use separately to the effects of male partners IP use on female partners. This review did not explore the effect on the LGBTI population, this is also a critical area for future research.

Interestingly the investigation found no articles using randomised controlled trials (RCT) on this topic in the past three years. Although, the study recognises the difficulty of establishing an RCT in the male population as finding a control group who have not used IP is very difficult as the percentage of users is so high. Measuring the reduction of IP use during a longitudinal study may be a suitable alternative and its potential should be explored.

Conclusion

The critical synthesis of the literature establishes IP's overarching adverse effect on sexual attitudes and behaviours over the past three years across North American, European and Australian populations. The research indicates IP's consistent association with male patriarchal and dominance attitudes, permissive sexual scripts, riskier sexual behaviours and less relationship satisfaction and more distress.

There is a clear gender difference in the use and effects of using IP. Effects are greater for men, especially for frequent users who watch IP with violence and male patriarchal and dominance themes. However, female partners of male users are directly affected with many negative consequences to their sexual attitudes and self-belief. These effects combine to affect relationships with both genders reporting less relationship satisfaction and more distress. These findings reinforce the need for increased awareness of the effect of IP. Counsellors must address co-occurring problems in male individuals who are regular users and be on the lookout for IP as an underlying issue in relationship distress and dissatisfaction.

The scope of this literature review does not cover interventions or treatments for matters arising from IP. The prevalence and extent of effects on sexual attitudes and behaviours leads to a recommendation for counsellors to explore literature around IP especially if they have a client presenting with similar issues identified in this review. Counsellors should be aware that clients IP use is a significant factor and can lead to pro-violence attitudes and behaviours, negative gender norms and relationship dissatisfaction and distress. The final message of this review is; IP use is a gender issue appearing to cause harm and suffering to people and their relationships and could be explored through individual or couple counselling.

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Biography

OLIVER DAVID BROOKE

Experience

Oliver is an ACA student member completing a Master of Counselling at Murdoch University. He has an undergraduate degree in Psychology from Curtin University and has been working in the social sector for the past 5 years. Including, mentoring young Aboriginal men in Karratha and Northam, Western Australia (WA) with the Clontarf Foundation and volunteering and fundraising for Borderless Friendship Foundation (BFF) in Northern Thailand and Perth WA. He was a BFF committee member in 2014. Oliver's passion lies in delivering effective grass roots programs to make positive change in people's lives. He currently works for Relationships Australia as a group facilitator in their domestic violence program. Oliver uses an integrated counselling approach built on a person-centred foundation.

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Qualifications

Master of Counselling

Murdoch University (2017 – present)

Estimated completion in November 2018

Bachelor of Science (Psychology)

Curtin University of Technology (2010 – 2012)

Professional History

Relationships Australia

Joondalup, Western Australia

September 2017 – Present

Group Facilitator - Domestic Violence

Borderless Friendship Foundation

Northern Thailand and Perth, Western Australia

July 2012 - Present

Volunteer, Fundraiser and Past Committee Member

Clontarf Foundation

Karratha and Northam, Western Australia

March 2013 – December 2014

Operations Officer

PROFESSIONAL MEMBERSHIP

ACA Student member 2017

PACFA Student member 2017

VICKI COPE

Associate Professor Vicki Cope, RN, RM, BA, GDip(Ed), GDip(Nsg), MHSc(Nsg), PhD, has over 30 years' experience in healthcare with qualifications in education, nursing and midwifery. Vicki is currently the Academic Chair teaching research principles within the School of Health Professions at Murdoch University. Her research has focused on resilience and publications have concerned professional health leadership, patient safety, nursing management and professionalism. Associate Professor Cope encourages and supports students with the interpretation of research findings, report writing and writing for publication.

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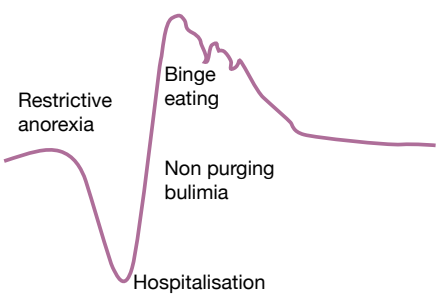
PEER REVIEWED ARTICLE

Illuminating the Eating Disorder landscape to support recovery

By Michelle Sparkes

"No-one has a view from nowhere."
–Vikki Pitcher

I love this quote. We all have a way of "seeing," a window on our world and the people we meet and work with that is drawn from 'somewhere.' My way of seeing and working with eating disorders and disordered eating (ED/DE) presentations is drawn from my professional experience as a physiotherapist and counsellor and my personal experience as a long term recovered survivor of anorexia, EDNOS and binge-eating. I did a journey through my teen and early adult years that looked like this:



Every picture tells a story and no two stories are the same but if I could sum up in one sentence what I believe an eating disorder is about I would say this: Eating disorders/disordered eating problems reflect an attempt to deal with emotional pain and conflict (challenging self and life experience), and they usually begin quite innocently with food restrictions and a simple desire to feel better about ourselves.

I don't pretend to have all the answers and I continue to learn from every person I meet, but one thing I know is that when you are lost, in the dark, or spinning your wheels in the eating disorder landscape, it helps to have a MAP to illuminate where you're at, why you struggle (the nature of the problem) and what you can do to begin to move forward.

I didn't have such a 'map' when I travelled through my eating disorder in the late 70s/early 80s and it cost me dearly in terms of time, health and opportunity. It also made me passionate to help others not do the same. In this article I want to share with you a 'map' I developed in the late 90s to help us consider how an eating disorder functions and how this might assist you in your work with individuals struggling in the ED space.

What is an Eating Disorder

According to the National Eating Disorder Collaboration, an eating disorder is a serious mental illness associated with significant physical complications characterised by disturbed eating behaviours, distorted beliefs, and extreme concerns about weight, shape, eating, and body image.

This excellent description helps us see the problem but not the elements that create or drive it. It is generally agreed that eating disorders are caused by a complex combination of genetic, biochemical, psychological, cultural and environmental factors. I find the following simple observation helpful when considering the individual (who struggles with disordered eating) in the context of his/her interior and exterior environment.

The most widely recognized risk factor in the development of an eating disorder is restrictive dieting, and this is commonly preceded by low self-esteem, poor body image &/or an external locus of control (a sense that we are not in the driving seat of our life). Other factors are mentioned in the literature (perfectionism, heightened sensitivity to criticism etc) but I submit these are all different ways of saying a

person feels in some way "not okay" &/or "not safe/secure" in their skin or environment. The core problem at the heart of disordered eating I believe is anxiety and insecurity. Studies confirm a strong correlation between anxiety and eating disorders with some researchers suggesting anorexia may be better classified as an anxiety disorder. My personal story illustrates this connection well.

A story to illustrate

When I was hospitalised with anorexia at the age of 15 I was completely driven by fear, guilt, and an accusing, annihilating voice that said I did not deserve to exist. My anorexia did not start here. It started three years earlier, age 12, in my first year of high school. At that time a number of factors were coming together that contributed to my feeling anxious and insecure in my adolescent skin.

Some of the SURFACE factors that were coming into play for me in early adolescence included:

- putting on pubertal weight – I had never had a weight problem but I began to put on weight with puberty and there was something about the high school culture that let me know that 'being big' was not cool. All the girls in my high school were dieting to avoid being 'big.'
- experiencing peer rejection – I had a fall out with my friends in the second year of high school and this led me to feeling less confident about myself. I started to question what made me "okay?" How could I be 'in' one minute and 'out' the next?
- getting chased by a man who had been masturbating while watching me and my younger sister at the beach the day before. This affected my sense of safety and security - on one hand I wanted to be attractive to the opposite sex, but on the other hand, there was a sense of danger and powerlessness attached to it. This left me feeling conflicted about my blossoming sexuality.
- becoming more aware of the world at large – the media focused issues of my adolescence included the threat of nuclear war, communism and the proliferation and use of drugs (even amongst my school friends) - things that made me feel a little uncertain about the world I was growing up into. When I think of the issues young people face today with global warming, the threat of terrorism, the rate of change with technology, financial stress (seeing their parents grappling with this), the hyper-sexualization and 'pornification' of our culture, I'm not surprised that we are seeing younger and younger children struggling with anxiety and insecurity played out in food/weight and body "control" issues.

DEEPER DOWN (and more 'core' to the development of my anorexia):

- I was concerned about parental stress, particularly my mothers - I could see and she would say things that indicated to me that she was stressed and struggling to cope with the challenges of raising five kids.
- As the middle child of five, I was perfectly positioned (in my adolescence) to hear her cries for help and 'catch the ball' - my older brother and sister were out and about; my younger brother and sister were more dependent and unaware but *I was right there in the kitchen after school* watching mum juggle a myriad of demands and hearing her say things like "*you don't care how hard I have to work*," and "*you'll be the end of me,*" or "*you'll be sorry when I'm gone*." The truth was I did care. I could see mum needed support. I found out years later that she had watched the father she loved die of a heart attack due to work-related stress when she was a young woman. My father was in a stressful job at the time and I believe mum was trying to protect him from the stress she faced at home (based on her own personal history). It's an important aside because our stories do not happen in isolation; the way a parent or loved one responds to us may be more reflective of their own history than our immediate circumstances.
- I was already primed by my sensitive personality, and by something that had happened earlier in my life (I was holding myself responsible for someone drowning when I was 6 years old) to 'catch the ball.' It's a long story and you can read more about it in Illuminating Anorexia, but suffice to say, when I saw mum struggling to cope with the stress of raising five children, I felt like I needed to lift my game and be a better kid so that my mum wouldn't leave or possibly die. I thought if I could just be 'good enough' I could stop bad things happening (this was also a reflection of the religious ideas I was taking on board at the time).

Figure 1 Miche's Model: The eating disorder 'solution' to pain (an overview)

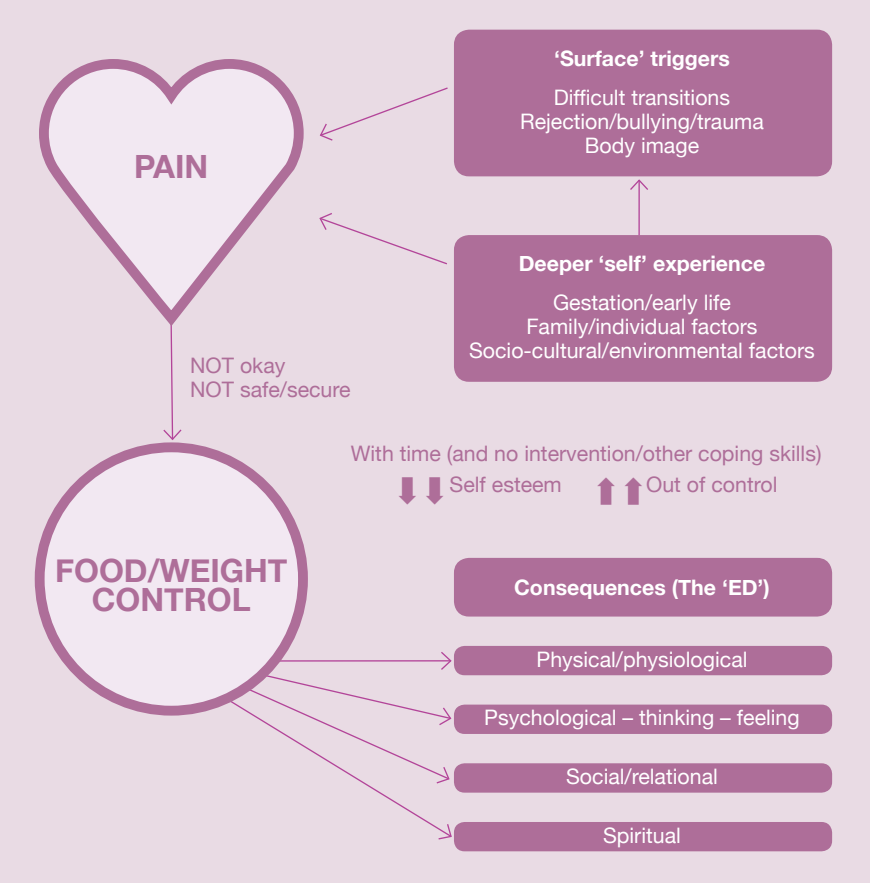
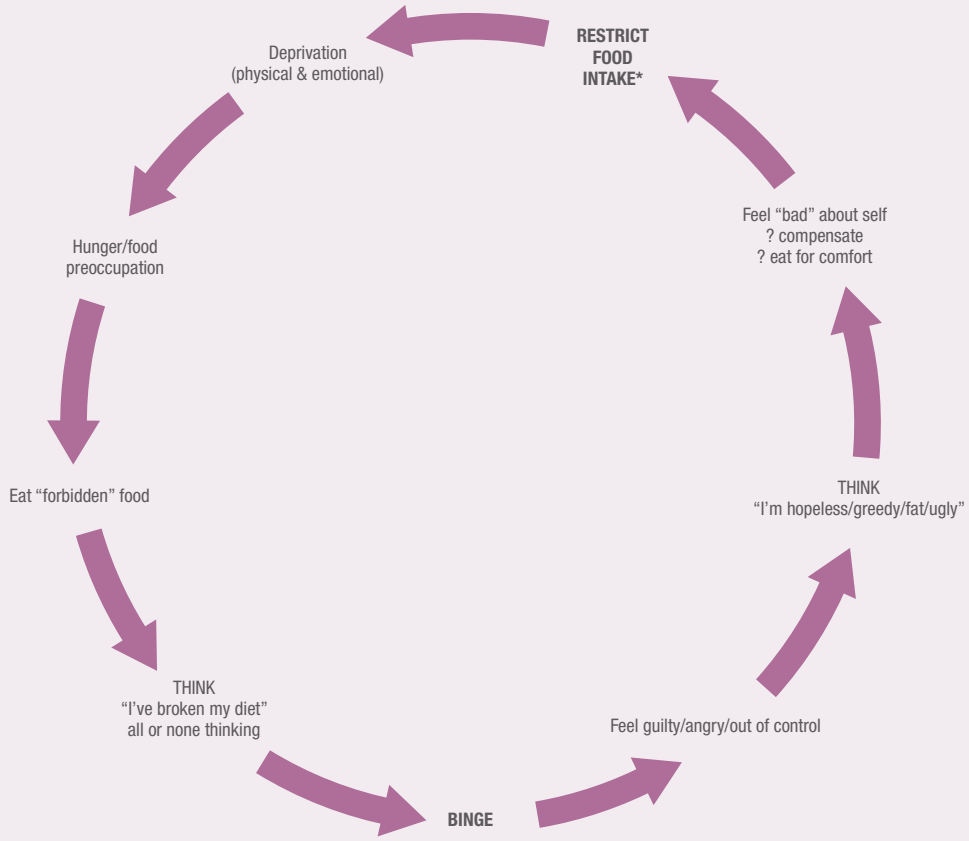


Figure 2 Restrictive dieting and disordered eating have unintended consequences



The bottom line for me is that in developing anorexia, I was trying to be 'good enough' to keep myself 'safe.' Anxiety fuelled my food control 'solution' and my food control solution compounded my anxiety. Over time they created the problem of my eating disorder.

A model (or map) to elucidate

I developed the 'map' or model in the late 90s to elucidate this process (see page 29).

Controlling food as a 'solution'

Controlling food and body/weight is an understandable way to deal with feelings of body/self anxiety and insecurity because it gives us a tangible way to make ourselves feel more acceptable (according to social norms), competent and in control. Initially it seems to work and we may receive a lot of positive reinforcement from family, friends and the culture at large (for being 'successful', exercising more 'discipline,' making 'healthier' food choices etc), BUT if we continue to rely on this strategy to deal with the ongoing challenges and stressors of life, our 'solution' can quickly spiral out of control and create the problem of disordered eating or an eating disorder. Diets don't work. Research shows that when we restrict our food intake the body lowers its metabolism and increases its ability to absorb calories from food; the mind becomes preoccupied with food and the drive to eat. This is a great mechanism for surviving a famine, but a disaster when you're surrounded by food and determined not to eat. To override our hunger, we develop rules about when and what we should eat and we rely on these rules to feel safe. As we continue to restrict food,, thinking becomes rigid and we categorise our food choices and behaviours in simple terms of good and bad, black-and-white. Self-esteem becomes increasingly dependent upon our ability to stay in control. Unfortunately "diet" thinking and behaviour sets us up to lose control and plummet into self-loathing. We find ourselves spinning our wheels on the diet/binge treadmill.

Restrictive dieting and disordered eating have unintended consequences

1. Physically - strain is placed on all body organs and systems through repeated or prolonged starving, restricting, bingeing, purging and over-exercising
2. Psychologically – thinking becomes more rigid, black-and-white (polarized) and irrational; feelings become more anxious, irritable and depressed. This is not only a result of changing biochemistry but also an emotional response to the fact that our 'solution' is not working. If we don't know what else to do, we will become more anxious and depressed
3. Socially/relationally – we isolate and withdraw – not only because of behaviours which others may judge and we may feel ashamed of, but if we're not feeling good inside ourselves we are likely to push other people away.
4. Spiritually – I believe we give away our power when we let the 'diet master' tell us whether or not we're making the grade. We find ourselves bowing the knee to a lie that says, you're not good enough, ***you're not worthy, you don't deserve***... and this lie

As long as we think controlling food is a solution to our problems, we will continue to spin our wheels on the diet/binge treadmill losing time, health and opportunity.

and the fear that drives it grows, progressively, the longer we play the game. In my experience and that of many anorectics I've spoken with this fear can become truly life controlling as we find ourselves fighting (literally) for the right to take up space.

Freedom from disordered eating

Freedom from disordered eating comes as we cease food restrictions and nurture body and soul. The first step on our road to freedom requires us to SEE that our current disordered eating behaviours, although originally well-intentioned, will never take us where we want to go. They will never bring us the inner peace and self acceptance we crave. This SEEing empowers us to reconsider our options; to make new choices; to let go of outmoded, unhelpful behaviours and beliefs and to find new ways to move forward.

As long as we think controlling food is a solution to our problems, we will continue to spin our wheels on the diet/binge treadmill losing time, health and opportunity.

I did this for around 15 years because I could not SEE why I struggled or what I needed to do to get free. I didn't know how to identify and feed the real hunger. I didn't know how to process the pain locked up inside me; to find new ways to manage my emotions and express myself; to anchor my worth, value and security into more substantial foundations.

I've created an online program called the 4x4 Freedom Express to help individuals do just this. It's based on the 'map' I've shared here and a model of healing that you can access from my website. I've utilised the digital space to make it accessible, flexible and affordable. It comprises 4 keys with 4 components, and over 6 hours of video teaching and training materials to help individuals develop the knowledge and skills to get off the eating disorder treadmill and head towards freedom. It is best done with the support of a counsellor or therapist but I recognise that not everyone has access to such support. It requires at a minimum that participants agree to seek and maintain medical oversight while participating in the program.

The feedback from a recent pilot program has been very encouraging. The first of the 4 keys ("Adjust your Vision") is available to trial for free at https://michellesparkes.com/freedomexpress I believe counsellors and health professionals armed with this knowledge can help individuals struggling in the eating disorder space SEE why they struggle and what they can do to begin to get unstuck and move forward.

I welcome your feedback and questions.
michelle@michellesparkes.com

Biography

MICHELLE SPARKES

Experience

Director of Essential Health Concepts, Founder of Women Worth their Weight, Producer & Host of Illuminating Anorexia, Eating, Self & Body Issues Podcast, Author of Illuminating Anorexia and Creator of the 4x4 Freedom Express, Michelle is a physiotherapist and counsellor with a passion to help people recover from eating disorders and disordered eating concerns.

PEER REVIEWED ARTICLE

How do Australians find counsellors and navigate the work within private practice? Implications for professionals.

By Dr. Rebecca M. Gray, Dr. Timothy R. Broady and Paula Mance

Abstract

In Australia, clients in public health settings or the social services sector are directed to counsellors through invitation or formal referrals. But how do Australians find and select counsellors in private practice? And how do counsellors manage and negotiate their work with clients outside of these settings? Study findings demonstrate the considerable time and effort undertaken to promote and manage their practices, and the high levels of concern counsellors have about the business aspects of their work.

The findings of the public facing survey indicate that the majority of participants had considered counselling, but only half had attended in the past three years and a quarter had never attended counselling.

A professional referral or a web search were the most popular methods for finding a counsellor, and women were more likely to initiate a search. There were also gender differences in how confident respondents perceived themselves to be in asking questions about the counselling process, with men reporting that they felt more confident in knowing what to ask. Ultimately, the majority of people who had tried counselling felt that the experience was worthwhile after the first session. This paper, then, contributes to what is known about the ways in which Australians find counsellors in private practice, and how professionals negotiate the work alongside practical tasks, like appointments, cancellations and fees.

Key Words

Counselling; psychotherapy; help-seeking; client engagement; client preferences

Introduction

In Australia, clients in public health settings or the social services sector are directed to counsellors and psychologists through informal suggestions or formal referrals. International research into help-seeking has established various factors which increase or hinder client help-seeking and engagement. Indeed, services and community based organisations have adjusted their promotional outputs and service provision to better attract and engage different members of the community, increasing access to those who need it, and those who need it most (Boag-Munroe & Evangelou, 2012). Moreover, these organisations have referral pathways in place, as well as targeted funding and paid positions to establish or maintain referral pathways and enhance client access to services and support (Yates, Erofeyeff & Gray, 2015). There is little to support members of the public who want to initiate their own counselling or therapy, however, particularly those outside the health, family law or social services sectors. Similarly, private practitioners must promote their services, and manage appointments, cancellations and fees with little to guide them about best practice or policy.

In Australia, information about counsellors is currently available via a set of directories or professional websites, and these are uncoordinated and patchy. At this time, little is known about how many potential clients view or use these websites, or the rate of conversion from viewing information to initiating treatment. Moreover, there is a lack of information about how many counsellors or psychologists are working in private practice in Australia, their level of training or clinical governance, or how they attract clients and manage appointments. While published research documents high level information about client help-seeking, there is a lack of detailed, local information about what clients actually do when they want to access counselling, and how they navigate the nuts and bolts of therapy.

In order to meet these gaps in knowledge, we undertook two surveys,

first with members of the Australian public who were visiting Relationships Australia websites, and then a longer survey which targeted professionals. This paper reports on the findings of these two surveys, and sheds light on the contemporary business practices of private practitioners. In doing so, we provide feedback from potential clients about how they source and select counsellors, and from professional counsellors about how much time they spend attempting to attract clients, outlining their diverse practices relating to their bookings, client cancellations and the extent to which they follow up unpaid fees for no-shows. This has the potential to inform counsellors managing their own practices, the peak bodies overseeing these professionals, and describes the nature of practice based counselling in contemporary Australia.

Literature Review

Published research on client engagement and termination is dominated by the debate between the therapeutic working alliance for enabling client outcomes (Sprenkle, Davis, & Lebow, 2009; Bischoff & Sprenkle, 1993), versus those who wish to establish which common factors predetermine best practice (Imel & Wampold, 2008). Research methods for evaluating client engagement have been criticised due to the lack of cohesive definitions (Bischoff & Sprenkle, 1993) and small sample sizes (Wang et al., 2006), but recurring themes are evident, and we summarise these to contextualise our aims and findings.

What is known about client behaviours in sourcing and selecting private practitioners?

There is a significant gap in research which explores how members of the public source, and select, counsellors and psychotherapists who work in private practice. Published reports aim to support professionals working in health and allied health settings to make good quality referrals to counselling professionals based in community settings, such as work by Crane and colleagues (2013). When clients are directed to an intervention, or mandated to attend, their preference about the style or training of the professional is not generally factored in. Recent reviews have demonstrated that clients who receive therapy based on their preferences are less likely to dropout, more likely to develop a therapeutic working alliance with their counsellor, and demonstrate better outcomes at the end of therapy (McLeod, 2015). Ultimately, what has been written tends to focus on what happens once the client arrives at their first session, not how they came to find or select this professional.

What has been examined tends to explore two main themes: the role that gender plays in affecting help seeking behaviours; and differing motivational levels between clients, in relationship counselling. Published reports about couple and family therapy suggest it is important for the professional to engage the "less committed" client, these commonly being men, who are understood to be less committed to therapy and more likely to cease sessions (Adams, 2007). Indeed, men of every age, nationality, and ethnic background seek less professional help than women. This is particularly the case for psychiatric and counselling services, and some have argued that this is due to men being less likely to recognise and label non-specific feelings of distress as emotional problems (Addis & Mahalik, 2003). Rather than wholly tying these dynamics to gender, however, writers have argued that masculine role socialisation leads to differences in help-seeking between men and women (Addis & Mahalik, 2003). Men's help-seeking behaviours are structured by social norms of what is known as hegemonic →

masculinity (Connell, 2005) and poses specific challenges for seeking mental health support (Mansfield, Addis, & Mahalik, 2003). This information is useful in helping professionals understand the needs of potential clients, but research has not sufficiently accounted for what clients actually do when sourcing professionals, and what they need when making a selection. This is particularly the case for members of the public who are attempting to initiate counselling outside of a formal referral context.

Factors which hinder attendance and continuation

In relation to counselling and psychotherapy, factors hindering attendance and continuation relate to three main areas: client factors, which include lifestyle and behaviours (Boag-Munroe & Evangelou, 2012) or expectations of therapy (Anker, Duncan & Sparks, 2011); process factors, such as, location (Australian Government Dept of Families, 2011; Wang et al, 2006) or in session behaviours (Anker, Duncan, & Sparks, 2011); and therapist factors, such as, gender or training (Bischoff & Sprenkle, 1993). These affect the frequency with which clients initiate counselling, as well as the likelihood that they will continue. For clients, socio-economic status and income levels appear to be the most significant barrier to attendance and continuation in therapy (Boag-Munroe & Evangelou, 2012; Katz, Spooner, & Valentine, 2006; Bischoff & Sprenkle, 1993). Indeed, some argue that therapy best aligns with middle class values and lifestyles (Bischoff & Sprenkle, 1993).

Prior to the first therapy session, research indicates that the referral source correlates with attendance and continuation and that those who self-direct to therapy are more likely to continue (Pekarik, 1992). Parents are particularly challenged in attending therapy, as childcare plays a significant role in enabling attendance (Allgood & Crane, 1991). Indeed, Wang et al. (2006) have noted that barriers exponentially increase for families as they expand. The cultural backgrounds of the therapist and client are important, and dropout is more likely to occur where these diverge (Wang et al., 2006; Bischoff & Sprenkle, 1993). Finally, as outlined above, gender also plays a role, and some have noted that men might perceive counselling as a "feminising" process that threatens their masculine identity (Englar-Carson & Shepherd, 2005).

Published research, then, highlights the role of gender, socio-economic and cultural factors in enabling or hindering the initiation and uptake of counselling. There is a lack of information, however, about the more practical aspects of establishing and maintaining a private practice. In what follows, we outline some of these aspects and discuss how business imperatives intersect with the establishment of counselling.

Method

Study design and ethics

Both surveys were administered online, through web-based invitations. The community survey used six closed questions to prompt "yes/no" and other short responses. Participants were visitors to the Relationships Australia webpages, across the federation, for one month (June 2016). Website visitors were invited to take part through a pop up screen which asked: "Would you like to take part in a survey about choosing counsellors?" Questions asked for basic demographics (gender and age); whether respondents had ever considered counselling; how respondents conduct research to find a counsellor; whether they got the information they needed to find the right counsellor; and how confident they feel to ask questions to gain the information they needed. The short survey generated over two thousand responses (n=2191), and was designed to be completed in two minutes. Survey responses were anonymous and a full report is available on the Relationships Australia National Website (Mance, 2016).

The survey for professionals was longer and took up to 30 minutes to complete, being a mixture of closed and open questions. The target group for this survey was professional counsellors and therapists in private practice. This survey attracted 143 responses. Questions were designed to trigger responses about time they spent promoting their private practice; their level of concern about attracting and retaining clients; modalities and skill sets; how they approach the discussion of modalities and their approach; areas of expertise; any presenting issues that they would not work with; screening dynamics; experience and length of service; booking and fee management; and cancellations. The survey was anonymous, but respondents were invited to provide contact details, so they may be involved in focus groups at a later date. A web-based, online data collection tool (SurveyMonkey) was used to collect the responses and generate the data. Approval for the conduct of the study was provided by the Relationships Australia NSW Ethics Committee.

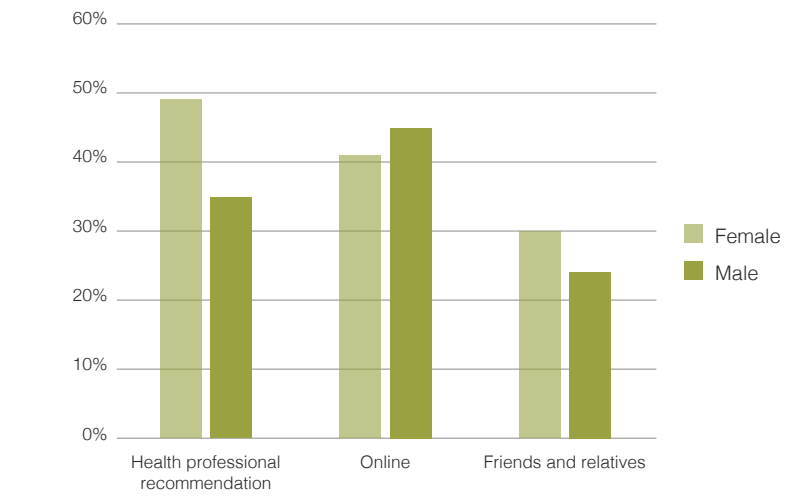
Once approval was gained, the recruitment invitation was circulated among the Relationships Australia NSW workforce via a staff email distribution list, the RANSW social media platforms, and a range of peak bodies including the Australia Association of Social Workers; the Australian Association of Family Therapy; and the Psychotherapy and Counselling Federation of Australia. Snowball recruitment was undertaken informally as participants were invited to forward the survey link to their peers and colleagues.

Analysis and Verification

Analysis involved categorising the responses using quantities, frequencies, and, in the case of narrative data, thematically. Preliminary analysis used the SurveyMonkey reporting mechanisms, and the narrative answers were aggregated and coded using MS Word. This process adopted the qualitative approach Interpretive Description (Thorne, 2006) as the sensitizing framework, as it aims to include the analyst's professional experiences and fore-knowledge of the topic at hand. Therefore, pushing the conclusions beyond description towards interpretation, and thus better suited to applied research projects. We focused on the overarching question: "What are the client-engagement needs of counsellors and psychologists working in private practice, in contemporary Australia?"

Preliminary findings were summarised and shared with a group of key stakeholders, including RANSW senior staff members, mental health and counselling sector specialists, and customer experience experts. These presentations described findings and checked, through discussion, for congruence with the professional wisdom of key stakeholders, and notable gaps in

Figure 1 Most popular sources of finding a counsellor - gender comparison



the information or any discordance in the interpretation of findings. The aim was to reach consensus about the implications for professionals, and to verify the recommendations made.

Community participant profile

2,191 people responded to the Relationships Australia National online survey, and the majority identified as female (75%). More women than men responded across all age groups, and almost ninety percent were between 20-59 years. Women aged between 30-39 years were the most prominent participants (n=500), and this reflects the demographic profile seen in previous online surveys, and remains consistent with our knowledge of who is accessing the Relationships Australia website.

Professional participant profile

143 professionals took part in the long survey and the majority identified as women (82%) compared to 25 men (18%). One respondent identified as non-binary. The majority were older than forty years (88%) and thirty per cent were older than sixty years. This reflects the RANSW workforce, and what we know of the demographic profile of private practitioners in Australia. The sample was also professionally experienced, with the majority having worked for more than ten years (60%), and many for more than twenty years (30%).

Findings

Community and potential client responses

The RANAT report (Mance, 2016) indicates that while more than eighty percent of respondents reported that they had considered counselling, but not all were currently attending, and approximately a quarter had never attended counselling. However, 53% of women and 48% of men had attended counselling in the past three years.

When asked how they conduct research to find a counsellor, recommendations from a health professional and online research were most popular. Women were most likely to report that they rely on recommendations from a health professional (49%) or online research (41%), whereas men were more likely to use online research (45%) than a recommendation from a health professional (35%). Friends and relatives were also a popular choice for recommendations (24% of men and 30% of women). Only 8% would source promotional materials, such as brochures and flyers. Women were more likely than men to conduct research from multiple sources.

Most popular sources of finding a counsellor - gender comparison

When asked about the availability of information needed to select a counsellor, nearly half (49%) reported that this was available to them (Figure 1). Women reported being less confident than men about what questions to ask a counsellor to determine whether they had found the right professional. Indeed, a large proportion of women (48%) and men (41%) reported that they did not know what to ask their counsellor, and only twenty percent of all respondents knew what to ask. This suggests that there is low literacy relating to counselling and therapeutic processes in the Australian community and that most do not know how to negotiate this process at the establishment phase. More needs to be done to educate the public about what is to be expected in counselling and therapy, in order to improve their opportunities to get what they want and need in counselling and psychotherapy.

Having said this, half of the survey respondents (50%), who had attended counselling, reported that after that first session they felt they had chosen the right person. A third (29%), however, were unsure. Finally, the majority of respondents who had seen a counsellor felt it was worthwhile (71%) and only a minority felt that it was not a worthwhile experience (14%). Given that previous experience in counselling predicts rates at which people return and continue to attend (Pekarik, 1992), it is probable that a positive experience will bolster this behaviour. More research is needed, however, as to whether clients shop around and initiate counselling again, at a later date.

Professional responses

Promotion and Client Engagement

When asked how important it is to attract new clients, most indicated that it was important (34%) or very important (35%) (Figure 2). Only twelve percent of respondents do not feel they need to work to attract new clients. Most are working to attract new clients on a monthly (32%) or weekly (22%) basis. In terms of the frequency with which respondents are attracting new clients, most do so, on a monthly (30%) or fortnightly (24%) basis. Twenty percent of respondents reported that they are attracting new clients on only a quarterly or less than quarterly basis (Figure 3). Sourcing and attracting new clients seems to be time-consuming, with most spending 1-5 hours in a month on →

Figure 2 Importance of attracting new clients

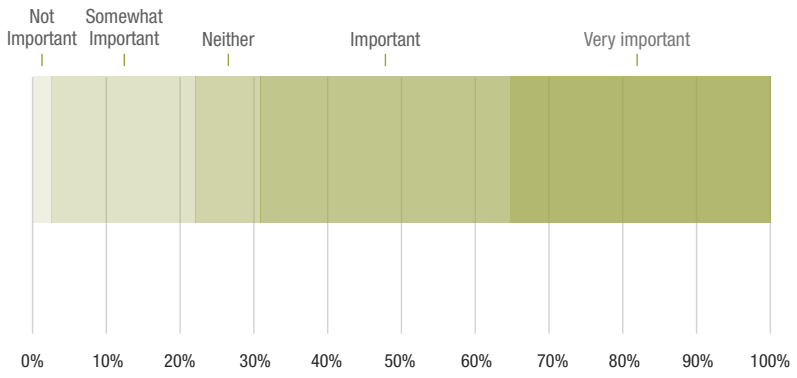


Figure 3 How regularly new clients are attracted

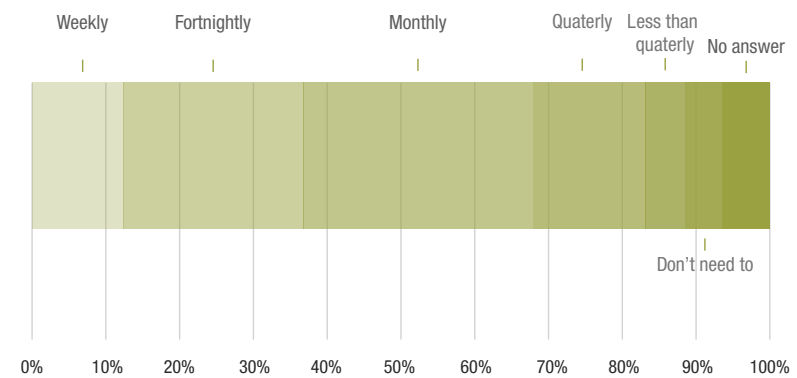
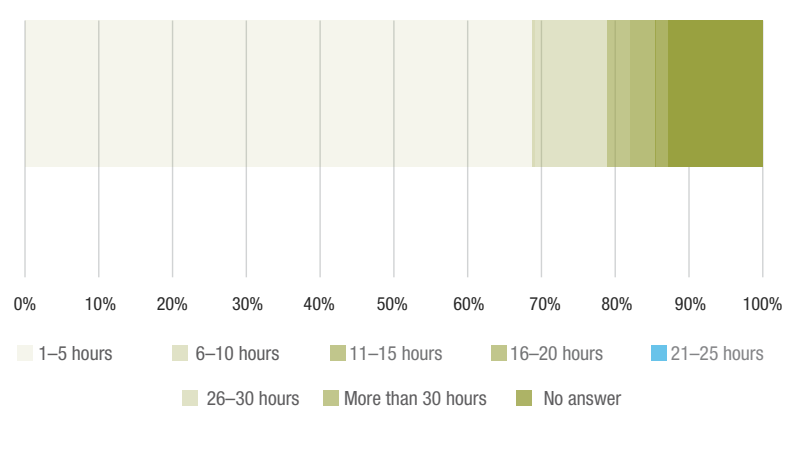


Figure 4 Time spent attracting new clients each month



sourcing activities (70%) and nearly 10% spending up to ten hours doing this every month. For 7% of our sample, this work takes two days per month (Figure 4). The rates were similar for time spent promoting and marketing their practices, in that two thirds of respondents spend between 1-5 hours per month undertaking this task. There were also similar rates for screening clients before the first session, and 74% spend between 1-5 hours per month on this work. Indeed, the majority of respondents (65%) indicated that there were presenting issues that they would not work with, which hints at reasons for the importance of screening.

New clients

Sixty percent of respondents felt that getting new clients is a moderate (30%) or high concern (30%), as well as getting the "right" clients (60%). This refers to clients for whom there is a treatment-fit, in that their needs match the expertise and training of the practitioner. However, getting new clients was a slightly higher concern for respondents, than getting the "right" clients. Respondents also indicated moderate or high levels of concern about retaining clients (50%) as well as marketing their practice (57%). Most were not concerned about the need to educate clients in the practitioners' preferred modality (50%), but for about a quarter of respondents, this was a moderate or high concern.

Booking and fee management

Most of the respondents handle their own bookings (93%) with only 7% using a receptionist for this task. When asked how frequently they experience a "no-show" (defined as an appointment in which the client does not arrive, and fails to notify the practitioner about this), respondents indicated that this was moderately frequent, with 12% experiencing weekly no-shows, 7% fortnightly no-shows, and 18% having monthly no-shows. This suggests that unused sessions are affecting approximately 10% of practitioners' income and resourcing on any given week. While half impose a fee for no-shows, collection of this fee is rare (27%) or never happens (10%), but a quarter of respondents are able to collect these fees often or always.

Cancellations seem to be slightly more frequent than no-shows (Figure 5), with just over a third of respondents indicating that they experience a cancellation frequently, that is, on a weekly (20%) or fortnightly (14%) basis. Over a third of

respondents experience a cancellation on a monthly basis (34%). Most respondents have a cancellation policy (80%) and most of these policies (73%) stipulate that a fee will be charged in the event that a client provides insufficient warning (less than 24hours) or does not show for an appointment. There is, however, a lack of consistency in the rates at which these fees are collected, and only 11% of respondents reported that they "always" collect fees for cancelled at short notice appointments, with just over a third reporting that they never (14%) or rarely (26%) collect fees (Figure 6).

Cancellations

When asked how they collect fees for cancellations, many respondents do so at the next session (41%) but others navigate this through collecting full fee payment in advance of the session (9%) or partial fee in advance of the session (12%). Only 3% use a receptionist to follow up with fee payment. As such, the vast majority of respondents are negotiating and managing their own fees, and collection of fees, directly from clients.

Modalities and mechanisms

Participants were asked about use of ICT platforms in providing service, and most provide telephone counselling options as an alternative to face-to-face sessions (69%). E-counselling was also popular, and included Skype and other video-conferencing platforms (38%), but only 5% are using email-counselling to meet the needs of their clients. Having said this, there was overlap within these responses, with many using more than one technological alternative to face-to-face counselling, and 39% reporting no use of any of these mechanisms. Therefore, those offering alternative mechanisms are more likely to use more than one option, while many are not offering any alternative and only work face-to-face.

Participants were asked: "What type of therapist do you identify as?" and most selected Counsellor (38%), followed by Accredited Social Worker (25%), Psychotherapist (25%) and the remaining selected a form of endorsed Psychology, such as Clinical or Counselling Psychologist (13%), as their profession. This reflects the recruitment pathways of the survey, via the websites of AASW, AAFT and PACFA, but nevertheless provides a wide range of perspectives based on professional affiliation. Almost all had a private practice (90%) and more than half also work part time in a community setting (53%), with a few listing Health, Community Health, Telephone Helplines and School or University settings, as providing an alternative source of income. When asked about their length of service in private practice, nearly ten percent of respondents declined to answer, but of the 117 that did, most had maintained a practice for longer than six years (60%) and many for more than ten years (30%).

In terms of client specialisations, adults (88%) and older adults (39%) were the most frequently selected client age, and more than one third also work with teenagers and adolescents (38%), and nearly a quarter with children (22%). More than two thirds of respondents indicated that they work with couples (64%) and nearly half work with families (49%). This is likely to be an over-representation of professional profiles, caused by recruiting from the RANSW workforce, which specialises in couple and family therapy, and is not used to represent the preferred specialisations of Australian counsellors and psychotherapists working today.

The survey also provided a long list of modalities used, and respondents were invited to tick all that apply. The most frequently selected options included: Cognitive Behavioural Therapy (58%); Family Systems Therapy (45%); Person-Centred Therapy (Rogerian Therapy) (42%); Solution Focused Brief Therapy (42%); Emotion Focused Therapy (41%); Anger Management (33%); Acceptance and Commitment Therapy (32%); Mindfulness Cognitive →

Figure 5 Regularity of experiencing cancellations and no shows

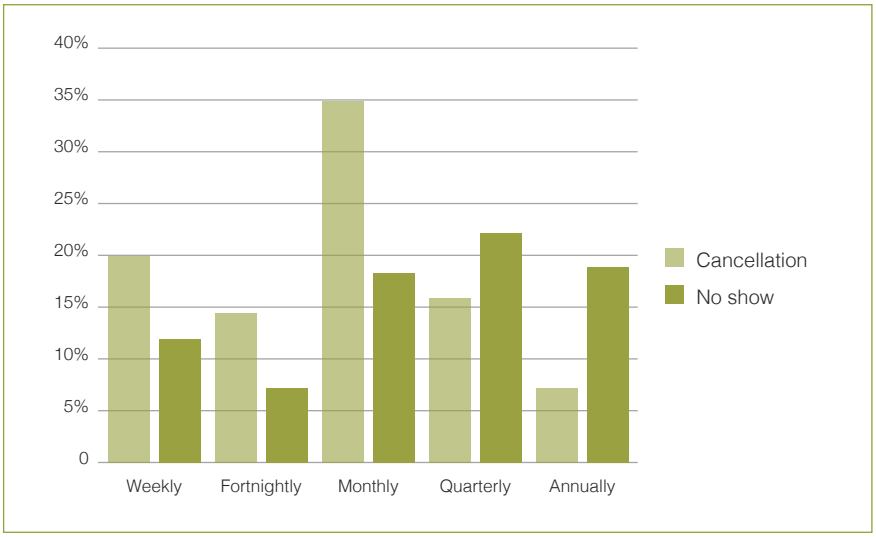
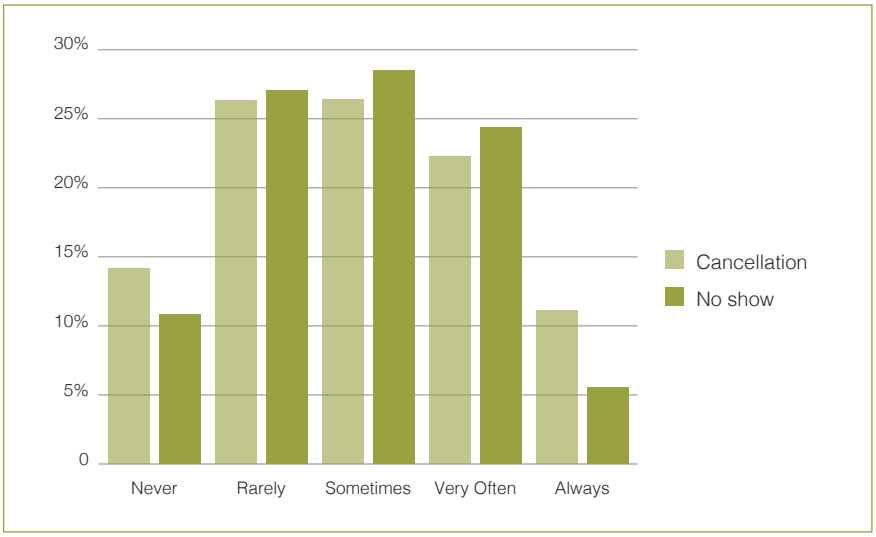


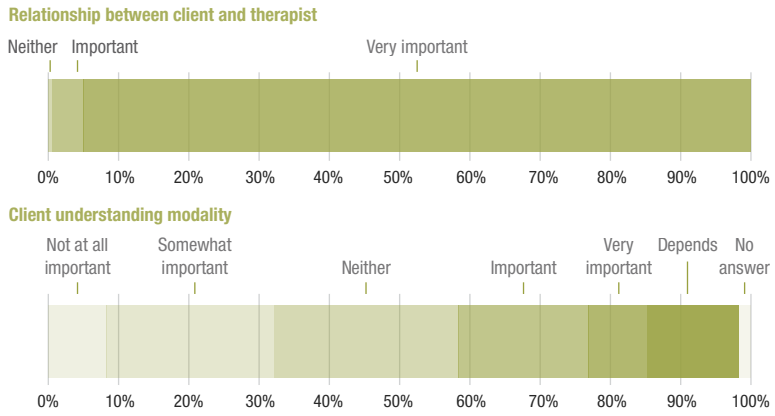
Figure 6 Frequency of collecting fees for cancellations and no shows



Therapy (32%); Gestalt Therapy (30%); the Gottman Method (30%); Systems Therapy (28%); Interpersonal Therapy (25%); Psychodynamic Therapy (24%); Transactional Analysis (17%). Most respondents reported that they use more than one modality with a client, either "very often" (51%) or "always" (19%). When asked whether more than one modality might be used in a single session, most reported that this happens only "sometimes" (52%) and fewer respondents reported that this happens "very often" (33%) or "always" (6%).

The vast majority of respondents reported that they cite the relationship between the client and the therapist as important in determining therapeutic client outcomes (95%), and no one chose the "not at all important" option. This was considered more important than the client understanding the modality being used in session, and only 18% felt this was "Important" and 8% "Very Important" (Figure 7).

Figure 7 Importance of client-therapist relationship and client understanding modality



Importance of client-therapist relationship and client understanding modality

This question was followed by an open field which invited narrative responses to the question: Can you please explain why it is important to understand the modality being used? Recurring themes in these responses suggest that respondents describe the modality to increase clients' understanding of the nature of the work, and that this enhances the clients' sense of trust in their practitioner, and sense of safety during the sessions.

This is consistent with meaning making during the open response sections, for example:

It helps them get/understand what you are doing and builds trust in the process.

Creates safety and explains how I might work with them. I'm not sure they need to understand it but it is important that they have some knowledge about the modality in order to agree to participate.

It helps client understand what is going on in the process of therapy. It makes the process more transparent to build the trust in between the therapist and the client. The clients are more informed and be able to provide feedback whether the modality works for them or not.

In describing the process, and the particular modality that the practitioner uses, the respondents also aim to allay client fears about what might happen, through fostering self-efficacy and motivation in the client:

So they can apply it to future situations, also if we need to draw on it again, they understand what it is we are doing.

Some modalities are intended to develop self-awareness in the client so they need to have a rationale for proceeding with this, for example, becoming more focused on their reactions rather than another's to become the focus of their own observations to determine whether they have interest in doing anything other than what they are currently doing that may be unhelpful, and to realize what they are up against in their efforts to change.

Indeed, many respondents perceived explaining their model establishes their credibility as a professional, but also provides an opportunity for the client to ask questions and indicate what they prefer or do not like:

I find psychoeducation helps them by giving a rationale and enabling them to engage in the process and feel more confident that there's a method.

It is important for a client to understand the modality being used during assessment and collecting data. So that client understands the reason counsellors asking questions.

I believe it is respectful to explain that there are various methods of therapy available and to offer a brief explanation if the client seeks clarification. Clients are often well informed, or misinformed, before therapy. They have a right to ask questions.

Moreover, respondents felt that negotiating the use of modalities focused the work, and generated a more transparent understanding of the clients' goals, while also enabling them to understand what would happen in session:

I find it helps the client to put a border around the experience and it grounds some of the work we do in theory and ideas.

It can help them to apply the homework or see where the therapy is going to achieve goals.

This increased awareness not only provided an opportunity for clients and practitioners to align their values and strengthen their therapeutic alliance, but would enable the client to retain awareness and be able to use the methods once the work of counselling and psychotherapy was complete.

To empower them in understanding the evidence base, and why it is indicated for their presentation, and particular circumstances. To locate the therapy among other options and to get informed consent.

It enables them to better understand the goals and outcomes and it is also empowering and allows for the opportunity to get feedback from the client about whether the modality is a good fit.

Clients sometimes prefer to know what kind of modality their therapist is using and it allows them to understand the process and interventions more fully. This information allows them to also do their own research and be proactive in the therapy process.

These excerpts illuminate the importance of trust, relational alignment and the role of negotiation about the work, and how this empowers and engages the client to the process, for these participants. In contrast to key findings from published research, however, these professionals seemed to perceive that describing their modality achieved these ends, rather than the in session behaviours they exhibit such as respectfulness, warmth or presence. It is possible, therefore, that describing their modality is being misinterpreted as an engagement technique and too great an emphasis is being placed on the training and philosophy of the practice, rather than how the process plays out within the relational dynamics of therapy.

Discussion

Acknowledging the deductive nature of the surveys, these data provide information about what clients want when locating counselling support, and the perceived value of counselling for those who attended. There are slight differences in how men and women navigate this process, and women seem to be slightly more likely to initiate and source counselling, whereas they report being less confident than men in knowing what to ask the counsellor, in order to determine if they have found the right professional. A large proportion of those who had experienced counselling, however, felt that they had the right person after the first session. This study provides recent and local information about the perceptions of members of the public, when sourcing counselling and therapy from private practitioners, and speaks to the importance of referral pathways between health services and professionals. Given that respondents tend to look for counsellor information online, and that few use flyers, it is possible that passive brochure displays are becoming redundant.

The survey which targeted professionals gathered responses from a wide range of experienced and highly trained counsellors and therapists. Findings indicate that attracting and retaining clients can be time-consuming for many private practitioners, and reported that they were concerned about marketing their practice and attracting new clients. Participants seem to handle cancellation policies, fee management and follow up differently.

Moreover, practice relating to collecting fees for cancellations and no-shows is inconsistent with cancellation policies, and many do not retrieve fees from clients who fail to show up for appointments.

This speaks to a need to develop better and more consistent clinical governance guide for cancellations and fee management within the private practice field, in Australia. More consistency could support the professionalization of the field and enable more clarity, and less confusion, for clients, as well as better financial security for private practitioners.

Professionals reported using a combination of mechanisms to provide their services, such as telephone, e-counselling and video-conferencing. They also offer a wide range of modalities, and many offer multiple models. While most indicated that educating the client about the modality is less important than establishing a therapeutic professional relationship, recurring themes across the narrative responses suggest that professionals take the opportunity to describe their modality to the client. In doing this, respondents described it as necessary for improving outcomes by helping clients better understand what to expect. Respondents also perceived that increased knowledge about the upcoming process will increase clients' self-efficacy during therapy, their trust in their counsellor, and the likelihood that the client will sustain changes once their therapeutic episode is complete. These responses imply some discordance between the information that clients seek, when they initiate counselling, and what the professional perceives as important to discuss. While it is possible that the framing of the open questions has led to this contradiction, this finding is consistent with other research which indicates that professionals exhibit too great a focus on modalities and new models, despite this not correlating with client outcomes (Snyder & Halford,

2012). Future studies would be wise to seek more detailed information about what professionals could do to help clients understand the process, and how to engage with it, and then any correlation this has with client behaviours and outcomes.

Ultimately, we note that many Australians are not sure what to expect in counselling, and what to ask to know they had found the right person. For private practitioners, support is needed to help them spend their administrative and commercial time more efficiently, both for the benefit of their business, and in order to improve their access and experience for clients. As Benson, McGinn & Christensen (2012) suggest, in session behaviours are important to clients, but we need to do more to support members of the public find and navigate counselling in private practice.

LIMITATIONS

Using existing digital platforms to reach the community and professionals, for these surveys, was a convenient and swift mechanism for recruiting participants. We were not able to strategically sample respondents, however, and do not suggest that the findings are conclusive. We also note that the majority of community respondents identified as women, therefore our findings are subject to a reporting bias. Nevertheless, the surveys provide information about the perceptions and behaviours of both potential clients and professionals as they embark on sourcing and selecting each other for counselling, with a view to providing practical information to guide the sector. The findings in this paper, therefore, are not definitive and require replicating, but they contribute to what is known about the ways in which counselling is initiated in private practice, and what professionals can do to improve this.

Acknowledgements

The authors gratefully acknowledge the contributions of the professionals and community members who contributed their time to the surveys.

Disclaimer

The researchers are employed by Relationships Australia NSW and worked independently to analyse the survey responses, and derive this set of recommendations. This paper aims to inform ACA readers on how professionals attract and engage clients, and in no way supports, or argues against, any particular business practices. As such, no conflict of interest is declared.

Biography

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Dr. Timothy R. Broady, Relationships Australia New South Wales
Paula Mance, Relationships Australia National Office

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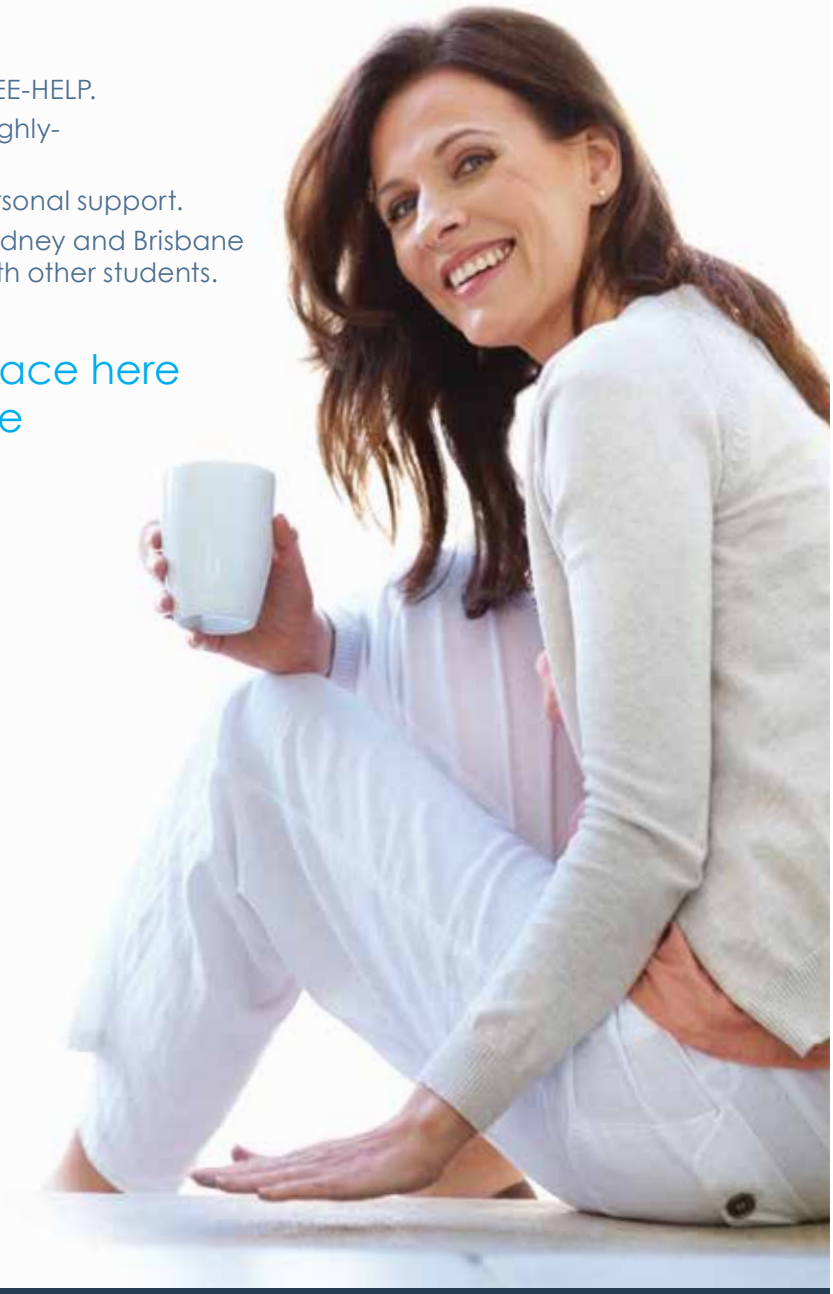

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A STORY ABOUT JAKE

Spence, Robbie., (2017). *A story about Jake*. Brisbane, AU.

Review by Judith R Boyland
Clinical Counsellor, Professional Supervisor, Behaviour Consultant, Life Coach

PhD Candidate, Master Education, Diploma Professional Counselling

Honorary Life Member Australian Counselling Association Inc.

"Even in the midst of a complete emotional meltdown, sometimes the only thing a child wants is for his feelings to be acknowledged".
For Jake, his meltdown stems from the difficulties he is experiencing as he tries to tackle his reading homework. From a global perspective, A Story About Jake highlights the significance of a child's having calm and understanding support when not coping with the challenges of living in a world where there is an expectation to perform to standardised levels of achievement. While Jake is having difficulty with his reading task, Jake's story prompts us to consider that whenever someone we love is having difficulty that sends them into meltdown, the first step towards resolution is connection and acknowledgment of feelings.

While the focus of *A story about Jake* is supporting a child who sees the printed word through a lens clouded of Dyslexia, there is also scope for using this story of the power of acknowledgment as a resource in many and varied situations. Scenarios where A story about Jake would prove to be a most useful resource are when supporting the emotional well-being of children who may be prone to the occasional meltdown or when supporting children who might be confronted by the experience of trying to deal with and manage learning difficulties.

A story about Jake is designed as a practical resource package for parents, counsellors, psychologists, school chaplains, guidance counsellors and other professionals who work with children in a supporting role. The package comprises a fully illustrated text, complete with a colouring-in reproduction of the illustrations, talk cards, confidence cards and a journal page.

Also available is an online event titled "coaching parents to support the emotional wellbeing of children with learning difficulties". This event has ACAInc accreditation and attracts two (2) OPD points for ACAInc members.

A story about Jake is available as a pdf download or hard copy along with extra cool resources. To purchase A story about Jake, visit www.storyaboutjake.com To register for the online course, go to www.storyaboutjake.com/online-pd The author and developer of *A story about Jake* is a primary school guidance counsellor, clinical counsellor, psychotherapist and professional supervisor who specialises in supporting children, those who support children and those who support those who support children. Robbie is a member of Australian Counselling Association Inc, Member of ACA College of Clinical Counsellors and ACA College of Creative Arts Therapies. A great story and a great resource with so many applications.

WINDMILL THERAPY: YOUR GUIDE TO BETTER HEALTH

Anne Moir-Bussy and Joseph Kok-Keung Wong

Review by Kaye Laemmle
Bac. Soc. Sci. Couns; M.A.C.A.

I had the opportunity to see this book at the ACA conference in Sydney and was interested in the concept and exercises

What I discovered is an easy to read text that makes sense of the exercises and their benefits to an individual's life

The information on restoring the body-mind through these simple exercises was interesting and finding extra energy is always a benefit no matter how you live your life.

The acid test for anything with movement is how easy the exercises are to implement into your daily life as well as how hard they are to perform. As a disabled person the need to maintain movement is very important but some of the exercises given are difficult normally

What I found in this book is the exercises are easy to do (except the floor ones I do cheat and do them on my bed) and I have found them easy to incorporate into my daily life. What I also like is that you are not being asked to build up the exercises to a 100 like others I have been advised to follow. The hand and voice exercises have been very beneficial and the exercises are illustrated well and easy to follow. I strongly recommend this book, it is a gem for overall wellbeing. Thank you Anne and Joseph for writing it..

To purchase *Windmill Therapy: Your Guide to Better Health*, contact Ann Moir-Bussy by email: annmb.ab@gmail.com

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Anne-Marie Houston	BUNDABERG	0467 900 224	Upon Enquiry	FTF
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Yvette Marion Johnstone	MURRUMBA DOWNS	07 3496 2861	$70	FTF/GRP/WEB
Jay Ellul	MANLY WEST	0415 613 447	$120	FTF/PH/GRP/WEB
David Kliese	SIPPY DOWNS/ SUNSHINE COAST	07 5476 8122	Indiv $80, Grp $40 (2 hours)	FTF/GRP/PH
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Gary Noble	LOGANHOLME DC	0439 909 434	Upon Enquiry	FTF
Steven Josef Novak	BUDERIM	0431 925 771	N/A	FTF
Virginia Roesner	KAWUNGAN	0743 24667	$110 (Students - $60)	FTF, GRP, SKP
Deborah Stevens	KINGAROY	0411 661 098	Upon Enquiry	FTF
Julianne Cutcliffe	SPRINGFIELD	0425 623 400	$50 Students $60 professionals	FTF/ GRP/ WEB
Jodie Logovik	HERVEY BAY	0434 060 877	Upon Enquiry	FTF/PH
Robbie Spence	GREENSLOPES	0435 732 650	Upon Enquiry	F/F
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Christine Boulter	COOLUM BEACH	0417 602 448	Upon Enquiry	FTF
Brian Ruhle	URANGAN	0401 602 601	Upon Enquiry	FTF
Christine Perry	BUNDABERG	0412 604 701	$70	FTF/WEB
Judy Boyland	REDLAND BAY	0413 358 234	UPON ENQUIRY	FTF/GRP/PH/WEB
Yildiz Sethi	WAKERLEY	07 3390 8039	Indiv $90, Grp $45	FTF/GRP/PH/WEB
Christine Cresswell	ORMEAU HILLS	0439 852 364	Upon enquiry	F/F; GRP; PH; WEB
Jennifer Bye	VICTORIA POINT	0418 880 460	Upon Enquiry	FTF
Nancy Grand	SURFERS PARADISE	0408 450 045	Upon Enquiry	FTF
Maartje (Boyo) Barter	WAKERLEY	0421 575 446	Upon Enquiry	FTF
Lynn Woods	CALOUNDRA	0408 710 300	Indiv - $110; Group - $60 per person	FTF/GRP
Heidi Edwards	GYMPIE	0466 267 509	$99	FTF/WEB
Diane Newman	BUNDABERG WEST	0416 715 053	Upon Enquiry	FTF/PH
Bernice Botha	ORMEAU	0449 611 521	Gp:$50p/h Idv:$90p/h Stu:$75p/h	FTF,Ph,Grp,Skp
Catherine Dodemont	NEWMARKET	0413 623 162	Upon Enquiry	FTF/PH/WEB

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QUEENSLAND *CONTINUED*				
Jenifer Joy Jensen	KURANDA	0414 262 040	Upon Enquiry	FTF
Menny Monahan	KIPPA-RING	0419 750 539	$100.00	FTF/PH/WEB
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
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
Kate Oosthuizen	WORONGARY	0411 469 222	Upon Enquiry	FTF/WEB
Frances Taylor	REDLAND BAY	0415 959 267 or 07 3206 7855	Upon Enquiry	FTF
Maryanne Lee	WOODY POINT	0421 623 105	Negotiable	FTF/PH/GRP/WEB
Tracey Milson	ARUNDEL	0408 614 062	Upon Enquiry	FTF
Monika Wilson	MALENY	0413 962 899	$100 P/P	FTF, PH
Penelope Richards	CHAPEL HILL	0409 284 904	Upon Enquiry	FTF
Neil Roger Mellor	PELICAN WATERS	0409 338 427	Upon Enquiry	FTF
Carol Thackray	ALGESTER	0432 594 889	Ind. $80 : Group $50	FTF/PH/GRP
William James Sidney	LOGANHOLME	0411 821 755 Or 07 3388 0197	Upon Enquiry	FTF/PH/GRP
Roslyn Price	REDLAND BAY	0401 266 170	80/hr for practitioners $80/hr for students	FTF/PH/GRP/WEB
Lyn Patman	BROWNS PLAINS	0415 385 064	Upon Enquiry	FTF
Ann Moir-Bussy	SIPPY DOWNS	07 5476 9625 or 0400 474 425	Upon Enquiry	FTF/GRP/PH/WEB
Bernadette Maree Wright	ALBANY CREEK	07 3137 1582, 0419 218 062	Indiv. $120 Group $50	FTF/PH/GRP/WEB
Christine Castro	ALGESTER	0478 507 991	Upon Enquiry	FTF
Iain Bowman	ASHGROVE	0402 446 947	Upon Enquiry	FTF/PH/GRP/WEB
SOUTH AUSTRALIA				
Ellen Turner	HACKHAM WEST	0411 556 593	Upon Enquiry	FTF
Annie Cornish	HENLEY BEACH	0407 390 677	Upon Enquiry	FTF
Deborah Green	BLACKWOOD	0474 262 119	Indiv $75: Groups $45	FTF/GRP/WEB
Maxine Litchfield	GAWLER WEST	0438 500 307	Upon Enquiry	FTF
Kerry Turvey	TANUNDA	0423 329 823	Upon Enquiry	FTF
Beverley Dales	GOLDEN GROVE	0413 303 576	$25 PP	FTF/PH
Carol Kerrigan	ENGLFIELD	0410 567 479	Upon Enquiry	FTF
Susan Turrell	BLAKEVIEW	0404 066 433	55	FTF/GRP/WEB
Niki Gelekis	MAGILL	0405 822 566	$90 (ind)	F/F: PH: NET
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon Enquiry	FTF
L'hibou Hornung	NAIRNE: PARKSIDE	0409 616 532	$80	F/F,PH,GRP,WEB
Barry White	Port Adelaide 5015	0488 777 459	Upon Enquiry	FTF/PH
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

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SOUTH AUSTRALIA *CONTINUED*				
Carolyn Grace	ADELAIDE	0401 337 448	Upon Enquiry	FTF/PH/WEB
Rachael Cassell	TORRENSVILLE	0434 570 992	$80 1 hour : $120 1.5 hours	FTF
Shelley Murphy	BROOKLYN PARK	08 8443 5165; 0407 435 169	Ind. $80ph; Group - 2hrs - $40	FTF/PH/GRP/WEB
Richard Hughes	WILLUNGA	0409 282 211	Negotiable	FTF/PH/WEB
Adrienne Jeffries	STONYFELL	08 8332 5407	Upon Enquiry	FTF/PH/WEB
Laura Wardleworth	ANGASTON	0417 087 696	Upon Enquiry	FTF
Dr Nadine Pelling	ABERFOYLE PARK	0402 598 580	$100.00	FTF, INDIV, WEB
Annemarie Klingenberg	WOODCROFT; MURRAY BRIDGE	0458 851 379	$65 - $75 per hour	F/F; PH; WEB
Anthony Gray	ATHELSTONE	08 8336 6770/ 0437 817 370	Upon Enquiry	FTF
Pamela Mitchell	WATERFALL GULLY	0418 835 767	Upon Enquiry	FTF
Maxine Kikkert	MT BARKER	0457 358 874 (w) 0438254 255 (h)	$80; $60 (disc); GRP $30	FTF/GRP/PH/WEB
Chaplain Ken Schmidt	MAWSON LAKES	0400 398 005	$80/hr	F/F; GRP; WEB
Allyson Ions	ADELAIDE	0411 446 631	on application	On Enquiry
Emily Lim	ADELAIDE	0439 547 610; 08 8331 3111	on application	F/F
TASMANIA				
Michael Beaumont-Connop	NEWSTEAD	0429 905 386	$60	FTF/PH/WEB
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
VICTORIA				
Sheryl Judith Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Keith John Hulstaert	BELGRAVE	0409 546 549	Upon Enquiry	FTF
Jennifer Reynolds	LOWER TEMPLESTOWE	0425 714 677	Upon Enquiry	FTF
Jacquie Wise	ALBERT PARK	03 9690 8159 or 0439 969 081	By Negotiation	FTF, PH, WEB, GRP
Molly Carlile	INVERLOCH	0419 579 960	Upon Enquiry	FTF
Bridget Pannell	MELBOURNE	0423 040 718	Upon Enquiry	FTF/PH/GRP/WEB
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Anna Atkin	CHETLENHAM	0403 174 390	Upon Enquiry	FTF
Lehi Cerna	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB
Batul Fatima Gulani	MELBOURNE	0422 851 536	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
Bettina Revens	NEWPORT/ WILLIAMSTOWN	(03) 9397 7075: 0432 708 019	$120 indiv	FTF/PH
Dorothy Dullege	RINGWOOD NORTH	0433 246 848	Upon enquiry	FTF/PH/GRP/WEB
Danielle Aitken	SOUTH GIPPSLAND/ MELBOURNE METRO	0409 332 052	Upon Enquiry	FTF/GRP/PH/WEB
Belinda Hulstrom	WILLIAMSTOWN	04714 331 457	Upon Enquiry	FTF

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VICTORIA *CONTINUED*				
Angeline Crossin	ASCOT VALE/ESSENDON	0451 010 750	$100 F/F, $90 Skye,$50 Group, $70 Students	FTF/GRP/WEB
Petra de Kleijn	TATURA	0413 824 073	Upon Enquiry	FTF/PH/WEB
Catherine Ethel Noy	MORWELL	0477 159 168	$80	F/F, PH, GRP, WEB
Carolyn Geer	BENTLEIGH	0419 572 970	Upon enquiry	FTF
Gaye Hart	BITTERN	0409 174 128	Upon Enquiry	FTF
Natalie Wild	BORONIA	0415 544 325	Upon Enquiry	FTF
Lynne Rolfe	BERWICK	03 9768 9902	Upon Enquiry	FTF
Marie Bajada	BALLARAT	0409 954 703	Upon Enquiry	FTF
Barbara Matheson	MELBOURNE	03 9703 2920 or 0412 977 553	Upon Enquiry	FTF
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF
Sandra Hatton	KEW	0425 722 311	Indiv. $80/hour; sml group $80/2hours	FTF/GRP
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Nancye Cottrell	LYSTERFIELD	0424 739 891	$50/hr Disc $40/hr	FTF/PH/GRP
Peter F. O'Toole	CAROLINE SPRINGS	0410 330 865	Ind.$80, Group $40	F/F; PH; GRP
Graham Hocking	PARK ORCHARDS	0419 572 023	Upon Enquiry	FTF
Patricia Reilly	MOUNT MARTHA/ GARDENVALE	0401 963 099	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
Debra Darbyshire	BERWICK	0437 735 807	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
Sandra Robinson	MANSFIELD/BENALLA	0403 175 555	$110 individual 1 hour session. $50 - group per he	FTF/WEB
Matt Glover	CROYDON HILLS/EAST DONCASTER	0478 651 951	Conc: $70, Full: $90 Group: $30/hour	FTF/PH/GRP/WEB
Heather Bunting	GLEN IRIS	0421 908 424	Upon Enquiry; special rates for students	FTF/PH/GRP/WEB
Jeff Pemberton	BALLARAT	0422 375 899	80	FTF/PH
Kim Billington	SANDRINGHAM/STKILDA/ ARMIDALE/MENTONE	0488 284 023	$110 : 2hr group $60	FTF/PH/GRP/WEB
Tabitha Veness	FERNTREE GULLY	0400 924 891	Upon Enquiry	FTF
Claire Sargent	CANTERBURY	0409 438 514	Upon Enquiry	FTF
Karli Anne Dettman	Blackburn	0403 922 245 text only	$100	FTF/GRP/WEB
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF/WEB
Linda Davis	LEONGATHA/GIPPSLAND	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
Sara Edwards	DINGLEY	0407 774 663	Upon Enquiry	FTF/WEB
Charlene Pereira	RINGWOOD/YARRAGLEN/ MELBOURNE	03 9999 7482; 0403 099 303	Ind $140; $90 P/T practitioners; Group on aplication	FTF/PH/GRP/WEB

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VICTORIA *CONTINUED*				
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
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
Andrew Reay	MOORABBIN	0433 273 799	Upon Enquiry	FTF
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
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon Enquiry	FTF, GRP, WEB
Stephen O'Kane	BLACKBURN	0433 143 211	Negotiable	FTF, GRP
Sharon S Erten	SOUTH MORANG	0400 345 045	FTF $80/GRP $40/ WEB&PH $60	FTF/PH/GRP/WED
Helen Wayland	ST KILDA	0412 443 899	$75 Indiv	FTF/PH/GRP/WEB
Sandra Brown	FRANKSTON/MOUNT ELIZA	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF
Keren Ludski	MALVERN	03 9500 8381 Or 0418 897 894	Upon Enquiry	FTF/PH/WEB
Lynda M Carlyle	EAST MELBOURNE/ SPRINGVALE SOUTH/ RIPPON LEA	0425 728 676	$135 per hour	FTF/PH/WEB
Paul Montalto	FAIRFIELD, FITZROY NORTH, BENALLA	0415 315 431	Upon Enquiry	FTF
Derek Goodlake	SANDRINGHAM	0403 045 800	$110	FTF/PH/WEB
David Mitchelmore	CARRUM	0414 795 398	$80/hr : Students $50/hr	F/F; WEB
Gayle Stapleton	BERWICK	0459 075 284	100 p/h Negotiable	FTF/PH/GRP/WEB
Lisa Derham	CAMBERWELL	0402 759 286	Upon Enquiry	FTF/WEB
Sandra Clough	TRARALGON	0412 230 181	Upon Enquiry	FTF, PH,GRP, WEB
Kaye Allison Jones	CAMBERWELL	0417 387 500	Upon Enquiry	FTF
Michelle Wood	MANSFIELD	0497 037 436		FTF/ PH/GRP/WEB
Judith Beaumont	MORNINGTON	0412 925 700	Upon Enquiry	FTF/PH/GRP/WEB
Mihajlo Glamcevski	ARDEER	0412 847 228	Upon Enquiry	FTF
Marguerite Middling	NORTH BALARAT	0438 744 217	Upon Enquiry	FTF
Rosie Barbara	SYDENHIAM/WYNDHAM	0433 277 771	Ind:$110/Grp:$50 each min of 4 hours	FTF/PH/GRP/WEB
Simon Philip Brown	WATSONIA	03 9434 4161	Upon enquiry	FTF/PH/GRP
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
Judith Ayre	BENTLEIGH	0417 105 444	Upon Enquiry	FTF
Melissa Harte	PAKENHAM/SOUTH YARRA	0407 427 172	$132 to $143	FTF
Jenny Anne Field	UPPER FERNTREE GULLY	0404 492 011	On Request	FTF, PH, GRP, SKYP
Joanne Ablett	PHILLIP ISLAND/ MELBOURNE METRO	0417 078 792	$120	FTF/GRP/PH/WEB

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VICTORIA *CONTINUED*				
Michael Woolsey	SEAFORD/FRANKSTON	0419 545 260 Or 03 9786 8006	Upon Enquiry	FTF
Cheryl Taylor	PORT MELBOURNE	0421 261 050	Upon Enquiry	FTF
Linda Spencer	STAWELL	0407 783 131	$80 ind; Grp -$50/person (2 or more)	F/F; PH; GRP; WEB
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Rosemary Petschack	DIAMOND CREEK	0407 530 636	80 p/h	FTF/PH
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Rosie Barbara	SYDENHIAM/WYNDHAM	0433 277 771	Ind:$110/Grp:$50 each min of 4 hours	FTF/PH/GRP/WEB
Simon Philip Brown	WATSONIA	03 9434 4161	Upon enquiry	FTF/PH/GRP
Patricia Dawson	CARLTON NORTH	0424 515 124	Grp $60 1 1/2 to 2 hrs, Indiv $80	FTF/GRP/PH/WEB
Judith Ayre	BENTLEIGH	0417 105 444	Upon Enquiry	FTF
Melissa Harte	PAKENHAM/ SOUTH YARRA	0407 427 172	$132 to $143	FTF
Jenny Anne Field	UPPER FERNTREE GULLY	0404 492 011	On Request	FTF, PH, GRP, SKYP
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
Linda Spencer	STAWELL	0407 783 131	$80 ind; Grp -$50/person (2 or more)	F/F; PH; GRP; WEB
Roselyn (Lyn) Ruth Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Rosemary Petschack	DIAMOND CREEK	0407 530 636	80 p/h	FTF/PH
Zoe Broomhead	RINGWOOD	0402 475 333	Upon Enquiry	FTF
Gina Salvagno	DONCASTER/ TEMPLESTONE/BALWYN	(03) 9812 7520 or 0430 157 857	$120 p/h $100 - students enroled in counseling	FTF/PH/WEB
Tra-ill Dowie	PORT FAIRY	0439 494 633	Upon Enquiry	FTF
Jenni Harris	KEW	0406 943 526	$90 per 3 hr session Small group only	FTF
John Dunn	COLAC SW AREA/ MT GAMBIER	03 5232 2918	By Negotiation	FTF/GRP/WEB
Sophie Lea	MORNINGTON PENINSULA	0437 704 611	Individual $100/hour	FTF, PH, WEB
Brian Whiter	CARLTON, MOORABBIN	0411 308 078	$100	FTF
WESTERN AUSTRALIA				
Karen Heather Civello	BRIDGETOWN	0419 493 649	Upon Enquiry	FTF
David Fisk	NORTH LAKE	0412 781 865	$100 (neg) upon enquiry	FTF/GRP/WEB
Cindy Cranswick	FREMANTLE	0408 656 300	Upon Enquiry	FTF
Jenna Trainor	BEDFORD	0431 817 807	Upon Enquiry	FTF, PH, GRP, SKP
Renee Schultz	MOSMAN PARK	0458 125 26	Upon enquiry	F/F; PH; GRP; WEB
Salome Mbenjele	TAPPING	0450 103 282	Upon Enquiry	FTF/PH/WEB
Narelle Williams	MIDLAND, PERTH	0429 000 830	Individual $100 : Students $85	FTF/WEB
Merrilyn Hughes	CANNING VALE	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB

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WESTERN AUSTRALIA *CONTINUED*				
Victoria Laws	NORTH PERTH	0415 604 847	Upon Enquiry; student rates available	FTF/GRP/WEB
Lynette Cannon	CAREY PARK	0429 876 525	Upon Enquiry	FTF
Ken Bartlett	CLOVERDALE	0458 982 803	$75 (individual)	F/F
Anne Arrowsmith	MANDURAH	0458 525 039	Ind $140 Student $120	FTF/PH/WEB
Genevieve Armson	CARLISLE	0412 292 999	Upon Enquiry	FTF, GRP, PH, WEB
Eva Lenz	FREMANTLE/COOGEE	08 9418 1439 Or 0409 405 585	$85 concession $65	FTF/PH/GRP/WEB
Allison Lord	CLARKSON	0403 357 656	Upon Enquiry	FTF/PH/GRP
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
Trudy McKenna	NEDLANDS	0438 551 210	$120 (NEG) Upon Enquiry	FTF/PH/GRP/WEB
Heather Williams	ROCKINGHAM	0407 900 973	Ind - $100; Group - $50	FF; PH; GRP; WEB
Ligia Emmel Barnett	GERALDTON	0419 954 984	$80.00	FTF/PH
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
Julie Hall	YANCHEP/BUTLER/ JINDALEE/JOONDALUP	0416 898 034	$100	FTF, PH, 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.
Alan Furlong	WINTHROP	0457 324 464	Upon Enquiry	FTF
John Dallimore	FREMANTLE	0437 087 119	Upon Enquiry	FREMANTLE
Clare Robbins	KALAMUNDA	(08) 9293 4668: 0408 548 838	$95 individual; $75 Group per person	FTF/GRP
David Peter Wall	MUNDARING	0417 939 784	Upon Enquiry	FTF
Dr Patricia Sherwood	PERTH/BUNBURY	0417 977 085 or 08 9731 5022	$120	FTF/PH/WEB
INTERNATIONAL				
Contact	**Country**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
Roderick Boon Leng Chua	SINGAPORE	+65 9118 4687	Upon Enquiry	FTF
Robert Tai Lee Lieh	SINGAPORE	65-96318622	95	FTF/PH
Eugene Chong	SINGAPORE	+65 6397 1547	Upon Enquiry	FTF
Indumathi Balasubramanian	SINGAPORE		Upon Enquiry	FTF
Nadia Rahimtoola	SINGAPORE	+65 9647 1864	Upon Enquiry	FTF
Ellis Lee	SINGAPORE	N/A	Upon Enquiry	FTF
Cecilia Lee Ching Hoon	SINGAPORE	+65 9029 6543	upon enquiry	FTF
Emilia Yee	SINGAPORE	+65 9183 5007	upon enquiry	FTF
Kwang Mong Sim	SINGAPORE	N/A	Upon Enquiry	FTF
Saik Hoong Tham	SINGAPORE	+65 8567 0508	Upon Enquiry	FTF
Prem Kumar Shanmugam	SINGAPORE	N/A	Upon Enquiry	FTF
David Kan Kum Fatt	SINGAPORE	+65 9770 3568	Upon Enquiry	FTF
Su Keng Gan	SINGAPORE	+65 6289 6679	Upon Enquiry	FTF
Abigail Lee	SINGAPORE	N/A	Upon Enquiry	FTF
Jeffrey Gim Tee Po	SINGAPORE	+65 9618 8153	$100.00	FTF/GRP/PH/WEB

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INTERNATIONAL				
Contact	**Country**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
Yuk King Lau	HONG KONG	N/A	Upon Enquiry	FTF
Frank King Wai Leung	HONG KONG	+852 3762 2255	Upon Enquiry	FTF
Viviana Cheng	HONG KONG	+852 9156 1810	Upon Enquiry	FTF
Mei Han Leung	HONG KONG	N/A	N/A	FTF
Lap Kwan Tse	HONG KONG	+852 9089 3089	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
Winnie Wing Ying Lee	HONG KONG	N/A	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	BRIGHTON/HONG KONG	+65 9186 8952 Or 0447 262 130	Upon Enquiry	FTF/GRP/WEB
Natalie Chantagul	BANGKOK/MALAYSIA	N/A	Upon Enquiry	FTF
Joyce Chan	HONG KONG	(+852) 92507002	$AU90, HKD 550	WEB
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SUBMISSION GUIDELINES

Want to be published?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

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

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

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

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

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

Editorial policy

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

Previously published articles

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

Articles for peer review (refereed)

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

Conditions

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

Deadline

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

AIPC

Gain Entry Into An ACA Professional College

With An ACA Accredited Specialty Vocational Graduate Diploma

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

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

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

Get Direct Entry Into A Professional College

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

Flexible And Cost Effective

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

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

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

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

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

Sydney	1800 677 697	Brisbane	1800 353 643	Reg QLD	1800 359 565
Melbourne	1800 622 489	Adelaide	1800 246 324	Gold Coast	1800 625 329
Perth	1800 246 381	Reg NSW	1800 625 329	NT/Tasmania	1800 353 643