# COUNSELLING AUSTRALIA

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## Going it alone – Safe and effective private practice

## Integrating creative and expressive therapies

## Positive disintegration and triumphant transformation

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# International connections

## *By Philip Armstrong*

On 4th of May 2018 an historic meeting took place in Atlanta. The meeting was between the American Counseling Association and the Australian Counselling Association. The meeting saw a formal signing of a Memorandum of Understanding outlining a formal partnership between the two associations to host the 6th Asia Pacific Rim Confederation of Counsellors conference in Brisbane Australia at the Hilton Hotel on 27th to 29th of September 2019.

The signing was attended by the current President of American Counseling Association (Dr Gerrard Lawson), the incoming President (Dr Simone Lambert), Australian Counselling Association CEO (Dr Philip Armstrong) and President (Simon Clarke). Dr Lawson and Armstrong were the signatories of the document. The signing was witnessed by a contingent of CEOs and Presidents from the British Association for Counsellors and Psychotherapists and Irish Association for Counsellors and Psychotherapists. This is the first partnership between the two ACA's to host a conference. The conference will see delegates from all over the world attend with presentations from Australasia, the America's, Europe, Africa and the Middle East.

This will be biggest coming together of counsellors and psychotherapists to Australia from all over the world since 2006. The last time such a gathering took place was in 2006 when ACA partnered with the Australian Guidance and Counselling Association to host the International Association of Counsellors conference in Brisbane. A call for abstracts and presentations will be sent out in the next few weeks.

For further information on sponsorships or presenting email danielle@theaca.net.au

Left - Dr Gerrard Lawson
Right - Dr Philip Armstrong

Left - Dr Gerrard Lawson
Right - Dr Philip Armstrong

Left to right - Dr Simone Lambert, Dr Gerrard Lawson, Mr Simon Clarke and Dr Philip Armstrong

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# Technology Update

## *With Dr Angela Lewis*

I recently put together a presentation on social media for a local council. As part of this we looked at some of the major social networking apps (by apps we mean applications so these programs can be used on a computer or mobile devices); so I thought that might be a good place to start in this issue.

The top three social media apps by user remains steady with Facebook still the most popular. Facebook is generally used by people to maintain social connections to those they know in real life such as family, friends and co-workers; although it is also well used by business to support their brands. Facebook allows the user to share content such as text, online links to articles and sights and post videos and photos. People from all walks of life and all age groups use Facebook and it is generally expected that as a user you interact by posting comments, photos, news etc., with your friend circle.

In second place is the public micro-blogging network of Twitter which tends to be favoured for breaking news, current affairs and politics – though of course it can still be used to tell the world you are eating a doughnut or are bored at work. While Twitter users can post links, video and photos, it tends to be used more so for text based posts and comments. Twitter is accepted to be a public forum and as such people follow strangers (along with those they are acquainted with) and tend not to share highly personal, identifiable data. Twitter is generally not considered a popular option by young adults or teenagers. There is no real requirement to post on Twitter and many people simply use it as a way to keep up to date with news and current affairs by following interesting people and organisations; as such it could suit someone who prefers little social interaction.

Third in line is LinkedIn, which is the social network for professionals, who utilise it for making connections to advance and showcase their careers. People who join LinkedIn generally link to others who they have met or know through their professional lives. A typical LinkedIn profile reads somewhat like a CV and the user is expected to provide some information on their qualifications and job history. LinkedIn not only lets the user promote themselves in the workplace, but provides a forum when seeking or applying for jobs.

### How safe are you being online?

Which brings me to this point; it is easy to get carried away with sharing information online, particularly on sites such as Facebook, as we tend to think of this as an audience of friends not foes (as a side note, I am sure most of you would also have read some of the recent media reports in regard to the on-selling of private information that users have supplied to Facebook).

However…not all your friends may have positioned their security settings to within their circle of friends and may well be sharing their information publicly and/or with people who are strangers to you– which means that if you make comments or share something with a Facebook friend to their page and this person has set their privacy to 'public' for all posting, then whatever you posted to that page can automatically be seen by anyone, anywhere. A good example of how privacy may be unwittingly breached is my ticket to Priscilla, Queen of the Desert (which was great by the way).

When I shared a photo of my ticket with my Facebook friends I ensured that my thumb obscured both the seat allocation and which session I was attending – and I posted it after I had seen the show, not while I was there. Why? Because even though I generally trust my friends and my settings are secure, had I shared the version on the right, then potentially 'the world' would know what I was doing and when – because I have no way of knowing who of my friends is sharing information publicly and/or with others who I do not know personally – so this situation means I had no control around where these details ended up and with whom. So if I had shown the ticket freely while sitting at the theatre, I would have unwittingly made it known exactly where I was on that day and where to find me should someone feel like robbing or accosting me – and depending on who in my circle knows where I live, that ticket would be an open invitation to my home being empty given I was at the theatre. The same goes for airline tickets, yes it is tempting to show off your ticket Europe, but as far as I'm concerned, you may as well leave your doors and windows open while you are away!

So, without being alarmist, I suggest you fully acquaint yourself with all the options around security when using Facebook, just go to **Settings** then locate the **Privacy** icon and ensure you are in control of your own privacy and security. If you are unsure of what to select and why, please do some homework and Google articles, tips and tricks around being safe online.

### Some Common Terms Used on Social Media

**Add friend:** allow someone to access your Facebook page, which by default gives you access to theirs.
**Block:** when you no longer want someone to see what you are posting (e.g. writing about, uploading etc to your social media account) or be contactable you via the app. As a general rule the blocked person will not be notified that you have taken this action.
**Comment:** to write something either as a remark or response to something another person has posted to a social media site.
**Connection:** similar to Friend in Facebook, this is someone who you are professionally connected with.
**Direct message:** a one to one message (referred to as a DM) sent on Twitter and that is only visible to the two people exchanging the message. See also Private Message.

**Feed/news feed:** what others have written or uploaded to your chosen social media site is shown in your feed and is the way you can read or view what others have posted. You will also see ads in your feed when using all free social media sites.
**Friend:** someone who you have allowed to access your Facebook page and you theirs.
**Follow:** used mostly by Twitter and Instagram, to follow someone means that when they put something on their Twitter or Instagram it will appear in your feed when you use that app.
**Hashtag #:** e.g. #cats, will show you a list of tweets where the writer put the hashtag symbol next to 'cats' to indicate the tweet is about…cats! Used extensively by **Instagram and Twitter.**
**Pin:** Pins consist of an image or video posted to Pinterest. Pins also include information specifying the board in which it is pinned, the source (either uploaded or taken from the web).
**Private message:** a more general term for any communication (such as direct message) which is not seen publicly but remains with the writer and receiver of the message.
**Profile:** a chosen description of you used to identify yourself on on social media sites (e.g. "my name is Maggie and I love donuts, sunny weather and giraffes. I hate Donald Trump and my tweets can be contentious")
**Post:** to post is write something for others to read on a social media site, or to upload a photo or video.
**Retweet:** when you publish (repeat) someone else's tweet in its entirety to your Twitter feed.
**Subscribe:** if you like a particular YouTube channel then clicking the Subscribe button means you will be kept up to date with recent uploads from that particular YouTube channel.
**Troll:** An Internet troll is a member of an online social community who deliberately tries to disrupt, attack, offend or generally cause trouble within the community. So to 'troll' is to undertake that activity.
**Tweet:** when you write (or post) on Twitter it is called a tweet, with tweets currently to limited to 280 characters.

## How to speak Millennial

Your average Millennial was born sometime between 1982 and 2000 and along with those aged either side, this tends to be the generation which lives and breathes the world of social media for business, play and communication. Not surprisingly they have created their own informal shorthand when communicating online – here's a few to help the rest of us translate their lexicon!
**AF** – used to indicate something is quite extreme. "I'm feeling tired AF today".
**BAE** – acronym for "before all others", signifying your special person or best friend. E.g: "He is totally my BAE".
**Cooked** – to describe when something was very exciting.
**Ceebs** – shorthand for "I can't be bothered".
**Dead** – used to show you find something very funny, e.g. "I'm dying with laughter" is replaced with the single word dead.
**K** – why type okay when you can simply use one letter?
**Lolz** – a hybrid of LOL (the old laughing out loud to signify you find something funny), Lolz indicates you find something really funny "oh the Lolz".
**On fleek** – originally used to describe perfect makeup and style, it is used for describing a situation or person you consider to be flawlessly stylish.
**Thirsty** – used to describe someone who is trying hard for approval online, e.g. a friend who posts multiple pictures of their holiday day after day, would be described as "a bit thirsty".
**V** – similar to K for okay, I mean, why type a long word like 'very' when you can just use V…

## Email Subscription Management App

I recently came across an app called Unrollme, which helps manage subscription emails and facilitates unsubscribing from mailing lists you are no longer interested in or forgot subscribing to (yep, that's me!).

This app will also roll up all subscription emails so you get them all in one daily email or as digest, which saves cluttering up your inbox.

Of course please do your own due diligence, as for this to work you need to give the app permission to read, send, delete and manage your email. I tried it on my Google account and it worked a treat, but I wasn't comfortable giving the app those privileges on my primary account – much as I'd like to get rid of the pesky subscription emails!
Find it at https://unrollme or do a Google search for it.
As is always the case, all website addresses were correct at time of submission and neither the ACA nor Angela Lewis receives any payment or gratuity for publication of the website addresses presented here.

PEER REVIEWED ARTICLE

# Going it alone

*By Sally Brown*

**For many counsellors, private practice is their only option if they are to earn a living. What do you need to know to do it safely and effectively? Sally Brown finds out from those who have made it work**

According to the 2017 British Association for Counselling and Psychotherapy (BACP) members survey, half of us work in private practice. For many, it's a positive choice – a chance to control when, how and with whom we work. But for counsellors struggling to find a paid job after qualifying, going into private practice may be their only alternative to taking a voluntary, unpaid role, or leaving the profession altogether. In the same survey, 49% of BACP members said finding paid work was their biggest challenge.

So what do counsellors need to know in order to make a success out of private practice from the start? We asked successful private practitioners what they wished they had known when they first started out.

## Specialise to stand out

It's tempting to tick every box on the 'areas of counselling covered' section of your directory listing, in the hope that it will bring you more clients. But many of the most successful practitioners have found that the opposite is true, and that specialising is the key to attracting clients. 'Ninety-five per cent of the work I now do is on anxiety,' says James Rye, who works in private practice in Norfolk and is author of Setting Up and Running a Therapy Business (Karnac, 2016). 'Once I recognised the demand, I set out to become as expert as I could in it. If I were starting out now, I would consider specialising in working with children under 11, as that seems to be a growing area of demand.'

Central London- and Surrey-based counsellor Joanne Benfield believes that choosing to specialise as a sex and relationships therapist was the key to her success in private practice. 'After qualifying with an MA in counselling and psychotherapy, I realised there was a huge number of counsellors working in my five-mile radius that I would be competing with. But there weren't many specialising in sex and relationship therapy, and I knew there was a growing demand for it. It was also an area of interest for me, so it seemed to make sense to specialise.'

Birmingham-based counsellor Martin Hogg chose to specialise in anger management, offering workshops and courses, as well as one-to-one sessions. 'A well-intentioned therapist early on in my training told me to forget all my past experience and think about starting as a counsellor with a clean sheet. But I say, draw on what you have experienced in your life to inform your specialism. When I was doing my counselling placement, I was asked to engage with a group of young men, which involved anger management work. It really clicked with me. Prior to becoming a therapist, I spent 20 years in the hospitality industry, running pubs and clubs, and a lot of that work was about managing behaviour and resolving conflict.'

## Keep training

Once you have identified a potential specialism, it's essential to get further training in it. Benfield invested in a post-qualification diploma in psychosexual and relationship therapy, as well as attending relevant talks and workshops. 'Part of my motivation was to meet other practitioners in this field,' she says. A chance meeting at one event with a publisher looking to commission a book on sex and relationships (this became Benfield's book Three in a Bed: conversations with a sex therapist, published by HarperCollins) ignited her career. 'It had always been my dream to move to the south of France and write a book. When I was offered the book contract, I did some research, moved to Monaco, and set up a private practice there while I worked on the book.'

Adding specialist training after qualifying was also crucial for Rabina Akhtar, who works in private practice in Peterborough. 'It's obvious from my profile picture that I am a Muslim, so I assumed I had an automatic specialism and the clients would come to me, but I was wrong. I didn't get a single Muslim client until I invested in specific training, then offered my services for a reduced fee to an organisation that worked with the Muslim community. It's almost as if I needed to grow within myself before the clients came. I also learned a lot about the needs of the community – don't assume you know everything just because you have experience in an area.

'You should look at your three-year general counselling qualification as a base level on which to build, not something that qualifies you to work with everyone who walks through the door, no matter what they present with. And don't mis-sell yourself – you're not only mis-selling yourself, you're mis-selling counselling as a service.'

## Portfolio working

To be in a position to be selective about clients, you may need another source of income, and 37% of BACP members in the 2017 survey said they have a portfolio career that includes non-counselling work. Rye says he 'couldn't have survived' without the income from his part-time job as a trainer. 'I don't know anyone who goes straight into earning £25-£35k a year in private practice,' he says. 'I had been in teaching for many years and was fortunate to get a part-time job that was mornings only, which allowed me to build up a counselling practice in the afternoons and evenings and gave me the financial security I needed to allow my practice to grow gradually.'

Starting with one or two days a week of counselling, combined with another role, can help you gain experience in a contained way. 'Having another revenue stream, especially initially, is crucial, as it allows you to take the number of clients that is right for you, rather than how many you need to pay the bills,' says Hilda Burke, a private practitioner in north London. 'There is a tipping point where your caseload impacts on the quality of your work. I realised that a full practice is not the same as a successful one. There was a point when I was taking as many clients as I could, but I also had a high turnover rate – clients didn't stay. Now, I take on fewer clients, but they stay for longer.

'I think it's about the quality of the attention they receive from me. I boost my income with writing and consultancy work for PR companies on mental health issues. I would advise all new practitioners to think about ancillary revenue streams that relate to the work of counselling but are not client-facing, such as training, speaking or writing.'

## Money, money, money

As well as establishing what the right number of clients is for you, there is the question of what to charge them. 'When you first start out, it's easy to think that any low fee is better than working on a voluntary basis, but as I got more experienced, I realised that clients who aren't prepared to invest in themselves financially often aren't prepared to commit to coming regularly,' says Akhtar.

You need to consider what your service is worth, says Rye. 'I started out with this wonderful idea that I would charge people a 1000th of their income, so if you were earning £70,000 a year, you paid £70 a session, or if you earned £10,000, you paid £10. I soon found out that, apparently, everyone earned £10,000 a year. You shouldn't be embarrassed about putting a significant price on the skill you offer. If your work helps one man refrain from taking his life and bereaving his young family, or helps one woman stop abusing alcohol and keeps her with her partner and children, think of the financial and emotional cost you have helped others avoid. Wising up to that was part of my growth.'

Getting your pricing right may be a trial and error process, says Rye. 'The advantage of working in private practice is that you are free to both make and change decisions. You don't have to decide on one figure and then stick with it, regardless of the effect.'

## Location, location, location

Your choice of location can also influence what you charge, as Chloe Langan found when she moved her practice from Kent to Inverness. 'I had to do a lot of thinking about pricing when I moved. You can't ignore the local economy,' she says.

The change in geographical location also shaped the way she worked. 'In Kent, I was working in an urban, densely populated environment, and I moved to an area where the population was sparse and very spread out. That meant some of my clients travelled two hours to get to me from Skye or Wick and were at the mercy of the weather. I had to change my thinking about boundaries – I can't be as rigid about sticking to timing as I was in Kent.'

There is also the decision of whether to work from home, or from an external location. Renting a room in a building used by other counsellors can provide contact

and informal peer support from more experienced practitioners. It's an added expense, but one that is tax deductible, and it separates your work and personal life. 'If there isn't anything suitable available, consider getting together with a group of local counsellors and renting rooms together,' says Akhtar.

But for many practitioners, working from home is more convenient. 'When I first started, I thought I would look more "professional" if I also worked from a room off Harley Street, and thought this might be attractive to more clients,' says Surrey-based Rachel Shattock Dawson. 'What I found was that London workers are reluctant to contract to a regular weekly appointment in office hours, and at the same time they were not always in a mindset to come straight from work. Or they would cancel at the last minute because a meeting ran late or whatever, and I would be left sitting on my own in an expensive room in central London at night, having travelled an hour to get there. My practice really took off when I moved it into a room in my home. It seems that for my clients "low key, local and homely" has more appeal than "inner city and sophisticated".'

Rye has always worked from home, even though it could be tricky when he first started out and his teenage children were at home. 'It meant giving them money to go out at times,' he says. 'But working from home gave me flexibility, especially when I was starting out. If my client appointments were spread out, I wasn't sitting in an empty room waiting for someone who might not turn up, and I could get on with other things between appointments. I have always made it clear that I work from an office at home, so clients know before they turn up. Many clients say they prefer the informality of it.'

## Peer power

The downside of working from home, however, is the potential for isolation, which Shattock Dawson staves off through extra peer supervision and support. 'I make a point of regularly meeting other therapists for coffee, lunch or whatever, and I also do three hours of peer supervision every month,' she says. 'There can sometimes be an element of censoring in clinical supervision, but peer supervision tends to be more open and honest. We also discuss the practicalities of private practice, like what marketing works best, and how to adapt the household around client needs.'

An important element of contact with other local practitioners is that you get to know counsellors to refer clients on to, says Bristol-based counsellor and supervisor Els van Ooijen. 'We have a responsibility to work within our capabilities, and that means we should be referring on clients that we are not confident we can work with effectively. The best way to find who to refer to is to meet and talk to local practitioners.'

Doing a few hours of voluntary work can also be a good way to connect with peers, says Rye. 'When I started out, I was managing the counselling for a local charity for a few hours a week on a voluntary basis, which protected me from isolation. It also provided me with free training and CPD. Joining or setting up a monthly counsellors' reading group is another good way of ensuring you have regular contact with other practitioners.'

## Supervision and mentoring

Another source of support is supervision. It's essential to find the right supervisor when you start out in private practice, which may not be your training supervisor. 'If people are going to go into private practice, they really need to have a supervisor who is steeped in private practice, and has a lot of experience,' says van Ooijen. 'If you have never been in private practice, how do you know what it is like, and the kind of things to think about? It's limiting to think supervision is only about talking about clients – it should be everything that a practitioner needs in order to give the best service to the clients. For some of my counsellors, it can mean booking an extra session where we deal with the business side.'

For other practitioners, finding a

mentor who can advise on the logistics of building a private practice works well. Burke stumbled across her mentor at a friend's wedding in the Caribbean. 'One of the guests was a very successful analyst running a private practice in New York. We started talking and I told her I was just starting out. She was very straight-talking, and said, "You have to approach it as a business right from the start." I feel lucky that she remains an unofficial mentor.'

An alternative is to identify a successful local practitioner and ask if you can pay for an hour of their time for advice, says Akhtar. 'I find you always pay more attention to advice you have to pay for!'

## Smart marketing

Once you feel ready to get going, your challenge is to help the right clients find you. 'The biggest mistake that counsellors make is that they think they are selling counselling,' says Hogg, who runs one-day marketing courses for counsellors. 'What you are actually marketing is what counselling can do for people. With the exception of trainees, no client is coming for an "experience" of counselling. They are coming because they want to relieve the pain of their bereavement, their anxiety, their depression, or move towards a better relationship with their partner or children. But counsellors will set up a website that says, "My name is John, I am an integrative counsellor and I studied at the Institute of Counselling, and I have a diploma in whatever." A successful website speaks about the client – what they will get from coming to you, in language they can relate to.'

Rye agrees: 'Just because you are qualified and list your qualifications in a directory profile, and say how supportive you are and that you offer a safe space to talk, it doesn't mean that clients will come to you. You have to learn how to market yourself.'

There are a growing number of marketing courses available for counsellors, and you can also learn a lot from looking at the websites and directory entries of successful practitioners. But it can be a trial and error process, says Akhtar. 'I set up in 2011, but it took me until 2012 to get my act together about marketing myself. It is easy to think, "Well, I've done the training and I'm qualified, so now clients will come to me." As a result, my first year was very quiet. And it's only in the last two years that it has really grown, and now I can choose the hours I want to work.'

## Treat it like a business

Whether you have ended up in private practice by choice or by default, you can't ignore the fact that you are running a business, and that is not for everybody. 'Would-be private practitioners would do well to be realistic about their personal strengths and weaknesses,' says Rye. 'Apart from the professional difficulties of working with clients in an isolated context, there are the personal qualities that are needed to overcome other difficulties.'

'This really is a business venture that you are embarking on, and you have to regard it as such,' agrees Mervyn Wynne-Jones, Deputy Chair of BACP Private Practice. 'There are expectations of you, not only from your clients and your professional body, but also from external bodies such as HMRC and the Information Commissioner's Office.' Rye recommends considering a business-skills course: 'It was one of the best things I did when I was starting out.'

It undoubtedly pays to do your research, and make use of all available resources, before taking the leap into private practice. Flying solo is not for everyone, and it may take time to get it right, but when you do, it can offer what we all want from our working life – flexibility, autonomy and a sense of purpose.

Sally Brown is a counsellor and coach in private practice (sallybrowntherapy.com), a freelance journalist, and Executive Specialist for Communication for BACP Coaching.

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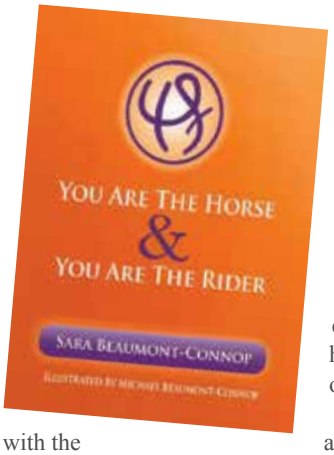
# You Are The Horse & You Are The Rider

**Author Sara Beaumont-Connop**

**Reviewed by Philip Armstrong,** FACA




This book very much reflects my own belief that you cannot separate mental health from physical health. Ones own well being very much determines to a large degree one's own resiliency in regards to mental health.

The book takes its title from the holistic idea that as the Rider we take care for making the choices for our physical manifestation of who we are. The Horse is the organic mirror image that we present to the world we inhabit. The theory the author explains "is the idea that when the two parallel developmental paths are joined through a process, I call centauring, a third sphere of experience occurs and this is the controversial or contentious aspect. It's really the human application of General Systems Theory, the simple idea that the whole is greater than the sum of the parts, that we have within us an energy designed for our use which manifests in a transcendental manner; quite simply creativity."

This well thought out, and written book starts out with the author telling the story behind the inspiration that led to the book, an ability to understand and synthesise the physical and its impact on mental health. The book runs in a logical sequence starting with the importance of understanding the history of psychological thought with a quick rundown on important theorists and how they have influenced the author through to the importance of the child and how early experiences impact on the development of our inner child. The book moves through several spectrums discussing issues such as defences and adversity through to the importance of food.

The chapter on food is a must if you want to understand the connection between eating, our minds and self and how this is exploited for commercial interests and the price that we can pay emotionally. The book ends with the last few Chapters discussing the concept of planning a head for the body or a body for the head and finishing with the third nature, a duality of your mind and body, your Horse and Rider energies. Throughout, the book constantly refers back to the importance of childhood experiences and how each concept impacts on our development.

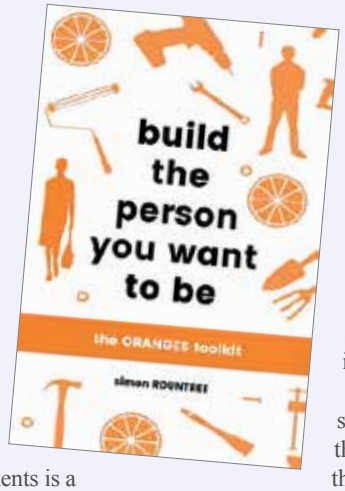
The book uses the analogy of the horse and rider as it moves through each concept. Movement from one concept to the other is made simple and seamlessly through the use of storytelling and a character named Crystal whose stories help demonstrate the use of concepts within the theory of General Systems. A major strength of the book is the rich use of pictures, drawings, tables, illustrations and diagrams that help to demonstrate ideas reflect concepts and put together ideas.

If ever a book was written that clearly and strongly demonstrates the need for those in the helping profession to understand the significant overlap of the self, psychology, nutrition and exercise then this is it. The author's use of the General Systems Theory to explain this is, in my opinion, is a revelation.

## Build the person you want to be: the ORANGES toolkit.

**Rowntree, Simon, (2018). Exisle Publishing**

**Reviewed by Nancy Grand**
Solution-Focused Therapist, Wellbeing Coach and Clinical Supervisor




This is a practical "how to" book whose purpose is to provide the reader with tools to foster greater resilience and mental wellbeing. The ORANGES toolkit upon which the book is based is used by the Australian national children's cancer organisation, Camp Quality, where the author holds the position of CEO.

While there is nothing ground-breaking or revolutionary in this book, it is a competent collection of gathered wisdom gleaned from a variety of positive psychology resources and backed up by appropriate references. For those who like acronyms (and they are certainly effective tools for working with children in particular), this book will not disappoint.

The primary acronym, ORANGES, refers to seven key elements for increasing positive emotions and mental wellbeing. The key elements are Optimism, Resilience, Attitude, Now (mindfulness), Gratitude, Energy and Strengths, all concepts that will be familiar to mental health practitioners. There are also the Four As of emotional management and resilience: awareness, acceptance, adjustment and action. Within these elements is a table of strategies incorporating practical activities to change your emotions. The author recommends a number of strategies under the categories of brain, body, environment, and relationships, and suggests that the reader supplement these lists with relevant activities and keep the written list handy for times when a change is needed. As with any self-help book, the effectiveness of these strategies depends on putting them into action, a point the author is keen to emphasise.

The author spends some time describing the work of psychologist and researcher Carol Dweck, whose "growth mindset" work is very popular in educational circles and provides a practical and optimistic approach to developing intelligence.

There is also a segment investigating the evidence relating to the benefits of gratitude, and some interesting suggestions for incorporating it in our daily lives. And, there is an interesting take on the "four strength" categories.

If you are a practitioner and are looking for a way to review your knowledge and maybe find references to authors or research that you haven't explored before this is a useful read. But most of all, it would be a little gem for the lay person looking for a broad and simple exploration of positive psychology in action.

australian centre for grief and bereavement

# Australian Grief and Bereavement Conference 2018

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## 6 - 10 AUGUST 2018

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The Dougy Centre for Grieving Children and Families, USA

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### Dr Wendy Lichtenthal

Memorial Sloan Kettering Cancer Centre, USA

***When Those Who Need It Most Use It Least: Facilitating Grief Support for Those at Greatest Risk***

### Dr Birgit Wagner

MSB Medical School, Berlin

***Coping with bereavement online? An Overview of web-based interventions for the bereaved***

### Professor Richard Bryant AC

University of New South Wales, Australia

***Prolonged Grief Disorder: What We Know and What We Don't***

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ANU College of Asia and the Pacific, Australia

***Mourning mass death: Australian grief and bereavement in and after World War I***

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PEER REVIEWED ARTICLE

# Haemodialysis Patients' Perception of NKF Education Rehabilitation Programme

*By Job Loei and James Chong*
*The National Kidney Foundation (NKF)*

## Abstract

This qualitative study served as a programme evaluation to determine how the National Kidney Foundation's (NKF) patients with end-stage renal disease (ESRD) benefitted from their Education Rehabilitation Programme, which consisted of Education @ DC and Back-2-School Workshops. A focus group consisting of 12 Patient Advocates was formed to discuss the effectiveness of the programme. The results were interpreted using Interpretative Phenomenological Analysis (IPA). It was concluded that the programme was a good initiative to engage nurses to provide rehabilitation programme for patients through education, as the knowledge taught was useful and important to the patients. The programme also had a positive impact on the patients' behaviour and lifestyle habits. Further quantitative studies could be conducted to achieve more conclusive results about the effectiveness and impacts of the programme. Key variables may include as the patients' perceived impact of ESRD education, and the perceived and actual impact of education on patients' physical health.

Keywords: rehabilitation, education, haemodialysis, end-stage renal disease (ESRD)

Patients with end-stage renal disease (ESRD) have several severe limitations: low physical fitness (Bennett et al., 2010), psychological problems (Khalil, Lennie, & Frazier, 2010), and poor quality of life (QOL; Yang et al., 2015)). The National Kidney Foundation (NKF) aimed to tackle these limitations based on Life Options Rehabilitation Program's "5 E's" of renal rehabilitation (i.e., encouragement, education, exercise, employment and evaluation; Life Options Rehabilitation Advisory Council (LORAC), 1998), which enables patients to improve their overall well-being (Jehan, Lobna, & Enshrah, 2012).

The current research was a qualitative post-programme evaluation of the Education Rehabilitation Programme, conducted by NKF from 4 October 2016 to 8 October 2017, and consisted of two programs: Education @ Dialysis Centre (DC) and Back-2-School Workshop. Education @ DC was a program conducted at NKF's dialysis centres across Singapore, whereby education modules were disseminated by trained nurses to haemodialysis ESRD patients. It aimed to educate patients regarding mental illnesses, insomnia, ways to living a healthy and active lifestyle, and community resources that were available for the patients' engagement. Back-2-School Workshops were held quarterly at the NKF Auditorium for haemodialysis (HD) and peritoneal dialysis (PD) patients and their caregivers. It promoted lifelong learning, a gateway for a healthier and more enriching life, and aimed to improve the health of patients through the education of personal grooming, nutrition and diet, insomnia, and medication. Comprehensively, the Education Rehabilitation Programme aimed to empower and equip renal patients with knowledge of ESRD and skills for self-reliance (Tsay & Hung, 2004), thereby increasing their self-efficacy and allowing them to partake greater responsible for their own self-care (Lingerfelt & Thornton, 2011). Thus, the programme may also subsequently reduce stress on the patients' caregivers and communal support.

Therefore, this qualitative study aimed to serve as a programme evaluation on three aspects: (1) the benefits of the programmes on NKF haemodialysis patients, (2) the elements of the programme that had benefitted these patients, (3) the kind of impact the programme might have had on the patients' behaviour and lifestyle habits. Additionally, we sought to provide suggestions for key variables in future quantitative studies.

## Method

### Education Rehabilitation Programme Education @ DC

#### Procedure and participants

The Education @ DC programme lasted for a year, with an education module rolled out every three months. There were four education modules in total, disseminated by the nurses in sequential order. nurses who had undergone prior training as educators provided one-to-one module education sessions with patients during their dialysis session. Ethical approval for this study was granted by NKF (Singapore) Management team has approved this study after a series of review by the allied health team. Participants were haemodialysis (HD) patients at the NKF clinic who completed all four education modules in sequential order, and gave verbal consent to participate in the programme. Exclusion criteria for participants consisted of patients who had a mental disability or illness (e.g., dementia or delirium), as the programme would not be effective for them because

*The programme also had a positive impact on the patients' behaviour and lifestyle habits.*

of factors like low learnability and self-efficacy. The completion rate of the programme was 63.7% (based on 3,420 patients).

## Materials

There were four education modules which were disseminated in sequential order during the Education @ DC programme.

Firstly, the Beautiful Mind education module promoted patients to look after their mental health, as the journey battling a long-term illness like kidney failure is challenging. Patients may harbour worries and stress about the impact ESRD has on their life, their family and finances, which may lead to anxiety and depression. Hence, this booklet helped patients to understand and identify the signs of anxiety and depression, and guided them in self-care while nurses and counsellors continued to support them. The booklet was divided into two sections, discussing anxiety and depression respectively. In the first section, it identified what anxiety is to the patients. Patients are assured that it is normal to be overwhelmed by stress, and are advised to seek help should excessive stress cause them anxiety problems. This section also identified common causes of anxiety in kidney patients, such as feelings of being a burden to family, disease progression, financial worries, side effects of treatment, and uncertainty about the future. Additionally, physical and mental symptoms of anxiety were listed for the patients' reference. Patients are cautioned that different people may experience different kinds of symptoms of anxiety, and side effects of dialysis may be similar to anxiety symptoms; though patients are encouraged to alert their nurse any time they experience any of these symptoms. Finally, tips were given to patients on how to manage anxiety, like having positive thoughts, reducing caffeine intake, turning to loved ones and members of their community (i.e., nurses, counsellors and healthcare professionals) for support and comfort, and practicing a breathing exercise that was explained in detail in the booklet.

In the second section, the definition of depression was explained, and the possible causes of depression for ESRD patients were listed, such as the prevalence of life events (e.g., unemployment or losing a loved one) and the onset of life-threatening or chronic illness. Patients were given a checklist of symptoms to recognise depression, and were recommended to seek help if they experienced five or more symptoms. In this booklet were tips on how to manage depression, one of which was acknowledging that it is not easy to get assistance for depression due to feelings of shame or fear of familial judgment and disapproval. Patients were encouraged to continue engaging in meaningful activities and receiving proper forms of help. Hotlines for the patients' reference were included in the last page, including organisations that provides counselling and mental health treatment.

Secondly, the Quality Sleep education module educated patients on ways to cope with insomnia. It stressed that sleep is fundamental in recovery and well-being, which many kidney patients lack due to insomnia; which could lead to sleep disorders and low QOL. This module delved into insomnia by explaining insomnia and its ill effects; and provided possible explanations as to why a patient may be experiencing insomnia, such as body aches as a side effect of dialysis, mental issues, substance abuse and smoking, poor diet, inadequate dialysis causing discomfort due to a build-up of waste in a patient's blood, or excess fluid in the person's body, causing chest discomfort and breathlessness. The booklet advised patients to discover if they have insomnia by visiting a doctor, who may diagnose patients based on their medical and sleep history. It also advised on ways to manage insomnia through good sleep hygiene practices, which their nurses could help them with. It also encouraged patients to keep a sleep diary that helps with identifying their sleep patterns and understanding possible reasons for bad quality sleep, which may hence assist nurses in the creation of a suitable intervention plan for the patient. Helplines for organisations dealing with mental


health issues and sleep disorders were listed in the last page.

Thirdly, the Healthy Lifestyle education module promoted patients to maintain an active life of work, quality time with family and friends, and physical activity through changes in diet and lifestyle choices. The module started off by pinpointing various hindrances that may prevent patients from leading an active lifestyle, like emotional stress (i.e., depression, and feelings of loneliness and hopelessness), family matters (i.e., strained and distanced relationships), mobility issues, medical conditions, a lack of company, and feelings of tiredness after dialysis. The module then provided solutions to these problems – first being exercise, which could help to control diseases and improve emotional and mental health. Steps to begin exercise and ideas for activities (including exercise videos and activities provided by NKF) were listed. Patients are simultaneously advised to seek help from their doctors, nurses or exercise specialists on deciding on their exercise plan before they begin. Secondly, education on nutrition and diet were highlighted to patients. The booklet explained that malnutrition is common among patients due to a lack of protein and energy stored in their bodies, which is an effect of dialysis. Patients were warned that malnutrition may lead to a higher risk of infections, longer hospital stays, constant fatigue, and a lower QOL. They are then advised to seek help from their dietician, nurses, and medical social workers if they suspect that they face malnutrition. To further prevent malnutrition and weight loss, they were advised to eat adequate nutritious food relative to their lifestyle and medical condition. A rough guide of the recommended protein intake for patients of different weights was written in detail in the subsequent section, along with a list of high-quality protein foods that may fulfil their needs. Additional dietary reminders for patients included controlling their fluid intake, taking phosphate binders regularly with their meals, and limiting their salt intake. The purpose of phosphate binders was also explained to patients, which encouraged patients to be more disciplined in taking them according to their doctor's prescription. Thirdly, the module suggested that patients spend more time with their family and friends, who could be pillars of support during dialysis. They are made aware that nurses could provide suggestions for places of leisure and dining that are affordable and accessible. Finally, patients were encouraged to pick up a new interest, as it would facilitate lifelong learning that may enrich their lives, and provide new opportunities for patients to make new friends. Ways on how a patient could start on a new interest were also listed, such as considering what they enjoy or are interested in, or even considering good causes that they could contribute to. Ideas for the types of activities a patient could participate in were also given, for example, courses that are provided by their local community centres which could improve their skills and knowledge, outings, or volunteer work (e.g., NKF's Patient Advocacy Programme). Ending off the booklet were helpful numbers of organisations that patients could contact for employment and employability advice, or information on courses and outings they could join.

Finally, the Living Smart education module was produced to encourage patients to seek help and be smart in engaging community resources for support. It began by explaining to patients the importance of seeking help, such as learning coping skills, easing anxiety, knowing modes of access to resources, relieving familial stress, alleviating


*...the Healthy Lifestyle education module promoted patients to maintain an active life of work, quality time with family and friends, and physical activity through changes in diet and lifestyle choices.*

excessive worries that would otherwise lead to negative thoughts and behaviours, interfering with their desired lifestyle and increasing their desire for substance abuse. Living Smart helped patients to identify the three challenges that they could seek help for – psychological challenges (i.e., mental health and emotional stress), social challenges (i.e., need for financial assistance and family matters), and physical challenges (i.e., rehabilitation needs, mobility issues and medical assistance). The module recommended NKF as the patient's first line of support, with its various services that it provides for the holistic care of its patients and their family. Patients were made aware that NKF provides psychosocial support and counselling by a team of medical social workers and counsellors, and is readily available to assist in overcoming a patient's psychological and social challenges. Patients were also told that peer support through patient advocacy is another service which NKF provides, through which encouragement and comfort can be shared by fellow patients during their rehabilitation. Additionally, patients were notified that NKF's dietician may provide diet and nutrition advice to patients, to improve the patient's self-efficacy in having a better diet and preparing healthier meals. Also stated were NKF's occupational therapists which are available to guide patients with disabilities to improve their physical functioning and mobility in their homes and outdoors. Finally, patients were enlightened on NKF's weekly exercise classes and videos, developed by their exercise specialists, which is provided as a secondary form of treatment. This is because exercising may help patients to strengthen their hearts and muscles, which could allow them to overcome their physical challenges. Moreover, it is beneficial in helping them lose excess water. The last section of Living Smart expanded on other organisations which could provide psychological help and financial aid; and provided hotlines for social assistance, psychiatric emergencies, crisis support, care services and legal support.

### Back-2-School Workshop

There were 300 participants per workshop, who were haemodialysis and peritoneal dialysis patients and their caregivers. The workshops were advertised through posters, and patients registered through their nurses on a first-come-first-serve basis if interested.

Four Back-2-School Workshops were held quarterly at the NKF Auditorium. The first workshop, titled Personal Grooming, was conducted by an image consultant, and focused on educating patients to boost one's confidence and appearance. Topics focused on grooming and dressing tips according to individuals' hairstyle, face and body shapes. The second workshop, titled NKF MasterChef, was a cooking competition conducted by NKF's in-house dietitian, and it focused on improving patients' knowledge on nutrition and the importance of having a healthy diet. The third workshop, titled Working Towards Quality Sleep, discussed insomnia and ways to combat the problem. The fourth and final workshop, titled Medication & Its Effects, encouraged patients to take an active participation in understanding their own health and medication that they are prescribed.

## Post-Programme Evaluation

### Participants and Procedure

An hour-long focus group discussion was conducted to determine the effectiveness of the Education Rehabilitation Programme. The researchers acted as facilitators for the focus group. NKF's Community Support Services team purposefully selected 12 NKF Haemodialysis patients, under the patient advocacy programme, from 11 dialysis centres across Singapore, average age of 58 years old, six males and six females. These participants reflected the age group of the main patient population and were undergoing haemodialysis at the time of the focus group.

Before discussion, participants were briefed on the purpose of the study, and verbal informed consent was given by participants.

### Data analysis

Interpretative phenomenological analysis (IPA) is a psychological qualitative approach which aims to provide detailed examinations of personal lived experience in the given context, and makes sense of the given phenomenon. It produces an account of lived experience in its own terms rather than one prescribed by pre-existing theoretical preconceptions. IPA is a particularly useful methodology for examining topics which are complex, ambiguous and emotionally laden. It is a good for a group study between three and 15 participants.

The main facilitator gathered qualitative data from participants during the focus group using flexible and open-ended questions on participants' experiences of the education programme. Detailed verbatim transcript was recorded and transcript by the co-facilitator. Three main themes that were brought up during the focus group were identified.

### Results and Discussion

There were three main points were brought up in during the focus group discussion – the usefulness and importance of the educational programme, the delivery of the education materials, and having a patient-led programme.

Firstly, the Educational Rehabilitation Programme was useful and important to the patients. There was a consensus among participants that sufficient information was provided during Education @ DC and in the Back-2-School Workshops. Participants also agreed that the programme was essential for patients who originally had little to no awareness of the topics covered. The knowledge gained from the programme had been applicable to the patients – helping them in their improvement of sleep quality, engaging in meaningful conversation with healthcare professionals (e.g. their doctors, nurses and dieticians), and personalising their rehabilitation treatment. It also assisted them with customising their medical treatment, effectively increasing their

protein intake (after learning about the importance of maintaining muscle mass), and looking forward in life and proactively seeking help when needed (e.g. seeking help from an occupational therapist regarding their mental well-being).

To value-add in the applicability of the educational programme, patients suggested that a pocket-sized FAQ booklet containing of a brief summary of knowledge could be dispensed during the programme for convenient referencing on the go. On another note, although the Back-2-School Workshop had been a good platform to engage patients, it was limited to a maximum of 300 beneficiaries per session (including haemodialysis and peritoneal dialysis patient's family and friends) due to the venue's holding capacity. Also, it may have been inconvenient for patients with poor mobility to travel to the venues.

Secondly, participants suggested that the delivery of materials in Education @ DC could be improved. Adequate training had not been given to the nurses and the consistency of trainings remained an issue despite having a standardised curriculum and briefing for them. Moreover, nurses in clinics that concurrently catered to a large number of patients were too busy to provide effective one-to-one sessions with each patient. Thus, some nurses decided that patients who were intellectually capable of understanding the materials on their own did not require one-to-one sessions, and simply handed the education modules to them. As a result, these patients were unmotivated to read the education modules as they did not see the importance in doing so.

Furthermore, there had been a language barrier between several patients and nurses. As most nurses at NKF's dialysis centres are foreign nurses. Thus, these nurses had difficulty in conversing with patients when expressing ideas and clarifying terms from the education modules to non-Chinese patients (e.g., Malay and Indian patients). Other language barriers were present with special populations of patients, such as Punjabi patients and patients of the pioneer generation who uses their mother tongue (i.e., Chinese dialects, Malay, Tamil, Hindu etc.). Therefore, these challenges had caused nurses to face difficulties in providing in-depth education to the patients during Education @ DC. To increase the effectiveness of comprehension for the non-English and pioneer patients, the focus group suggested to produce educational booklets in languages other than the ones already available (e.g., Malay, Tamil, etc.). However, NKF feels that it would not be cost effective to produce and print extra booklets on a large-scale basis.

Thirdly, participants ideated on a patient-led programme that would allow Patient Volunteers to be trained as Education Facilitators to conduct the Education @ DC programme instead of nurses. This would decrease the workloads of the busy nurses, and allow patients to have longer and more in-depth one-to-one education sessions. This would also allow for better educator-patient interaction, as fellow patients would be better able to genuinely relate and empathise with each other. Hence, patients would have a higher willingness to take the advice of educators, as they feel connected and understood by these Patient Advocates, as compared to professionals such as doctors and nurses who have not been through their situation. Thus, it could tackle problems where patients refuse to listen to the nurses' and doctors' advice. Additionally, Patient Advocates may better relate to other ESRD patients as they have a similar cultural background, compared to the foreign nurses who are unfamiliar with the country's culture. Thus, they would be able to better translate certain concepts to patients in their own colloquial language, and share self-care tips that they have gained through experience with their fellow patient (which will be more relatable to patients as compared to advice given by professionals which are highly theoretical). Furthermore, Patient Volunteers can solve the problem of a language barrier between nurses and patients, as they are able to speak the local language. They could conduct one-to-one sessions with the special population of patients that do not converse in English or Mandarin, and therefore increase the effectivity and patient understanding in the education sessions.

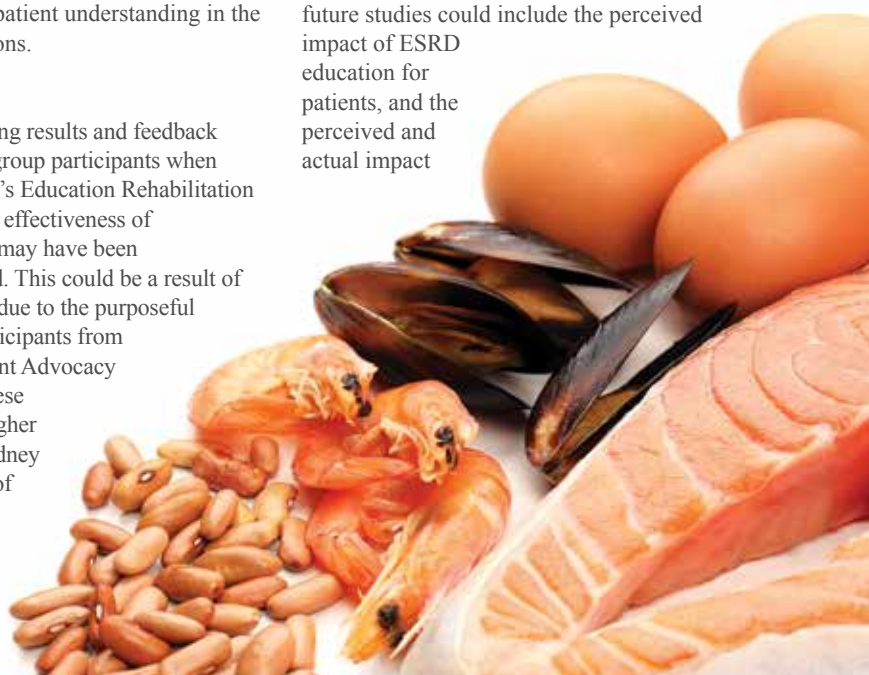
## Limitations

Despite promising results and feedback from the focus group participants when evaluating NKF's Education Rehabilitation Programme, the effectiveness of the programme may have been overexaggerated. This could be a result of a selection bias due to the purposeful selection of participants from the NKF's Patient Advocacy programme. These patients have higher scores on the kidney disease quality of life (KDQOL) measure – a health survey that assessed the quality of life of a patient with kidney disease (Hays, Kallich, Mapes, Coons, & Carter, 1994), meaning that they have an improved overall well-being as compared to the general population of ESRD patients. They also have better physical health than the general population. These are possible reasons as to why they are able to volunteer as advocates and engage in community work. Thus, they may overlook problems that patients with worse overall well-being and lower mobility may face, and portray an overexaggerated depiction of the magnitude of positive impact of the programme on haemodialysis patients with ESRD.

Furthermore, researchers question if there had been miscommunication and misconceptions with the delivery of research questions during the focus groups. Researchers noticed that some participants had been confused with questions given by the facilitators, and some had provided answers that were not relevant to the questions. Thus, we suggest that a pilot test could be done in the future to practice the delivery of research questions and prevent these errors in the actual testing phase.

## Future Studies

Quantitative research could be conducted to achieve more conclusive results about the effectiveness of the Education Rehabilitation programme and understand more about its impacts as well. Quantitative studies will have a larger sample size, thus they will have higher power in determining the validity (i.e., by finding out what we should be testing) and reliability (i.e., by having concrete quantitative results to support current research) of the Education Rehabilitation Programme. Possible key variables of future studies could include the perceived impact of ESRD education for patients, and the perceived and actual impact

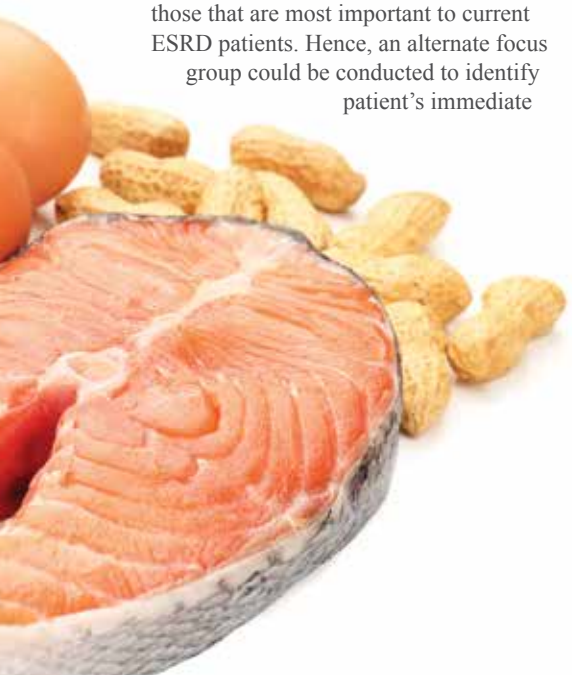


of education on patients' physical health. However, further qualitative studies will firstly be needed to determine other key variables for these quantitative studies.

Additionally, qualitative research on nurses' perception of NKF's Education Rehabilitation Programme could be done to increase the effectiveness of the Education @ DC programme. This could identify areas of the training programme that are lacking or are not successful and identify the nurses' thoughts on the Volunteer Educators.

Cultural considerations must also be noted when using the KDQOL, a Western instrument, to determine Singaporean ESRD patients' overall well-being. Chow and Tam (2014) explained that standard items on KDQOL may differ in application across countries. Thus, the KDQOL should be revised to fit the Singaporean context. Also, the relationship between KDQOL and education rehabilitation in local context could be explored further.

It may also be necessary to review the Education Rehabilitation Programme syllabus. There currently exists a lack of control with regards to the consistency of delivery in Education @ DC, in terms of quality of delivery and patient education, styles of delivery across nurses, and centre culture across Singapore. We do acknowledge that methods of delivery differ in effectiveness across centres. Thus, further research need to be done to determine what method of delivery works best in each centre, and how we should standardise syllabus delivery by nurses across centres. Another concern is that the Education @ DC's education modules were produced by researchers. Therefore, the perspective may not match the patients', and the information provided may not be highly valid. It is not certain whether the topics covered are those that are most important to current ESRD patients. Hence, an alternate focus group could be conducted to identify patient's immediate needs. Additionally, an increase in patients' knowledge does not necessarily create a positive change in their well-being if no action is done. Thus, we have to come up with ways to ensure that patients are enforcing the knowledge that are taught to them during the programme. However, it should be noted that the review of the syllabus should not compromise on the quality and consistency of the content.



*The education provided to haemodialysis patients was useful and important to them, and was essential for patients who had little awareness about insomnia, comorbid mental illnesses, dietary and physical health, and ESRD medication.*

## Conclusion

Results prove that this new education programme was a good initiative to engage nurses to provide rehabilitation programme for patients through education. The education provided to haemodialysis patients was useful and important to them, and was essential for patients who had little awareness about insomnia, comorbid mental illnesses, dietary and physical health, and ESRD medication. The programme also had a positive impact on the patients' behaviour and lifestyle habits. Explicably, it helped in the improvement of sleep quality, proactive engagement in their rehabilitation process, and gave them a forward-looking perspective. Further quantitative studies could be conducted to achieve more conclusive results about the effectiveness of the Education Rehabilitation programme and understand more about its impacts as well. Key variables may include as the patients' perceived impact of ESRD education, and the perceived and actual impact of education on patients' physical health.

## REFERENCES


Bennett, P. N., Breugelmans, L., Barnard, R., Agius, M., Chan, D., Fraser, D., . . . & Potter, L. (2010). Sustaining a hemodialysis exercise program: A review. *Seminars in dialysis*, 23(1), 62-73. doi: 10.1111/j.1525-139X.2009.00652.x

Chow, S. K. Y., & Tam, B. M. L. (2014). Is the kidney disease quality of life-36 (KDQOL-36) a valid instrument for Chinese dialysis patients? *BMC Nephrology*, 15(199). doi:10.1186/1471-2369-15-199

Hays, R. D., Kallich, J. D., Mapes, D. L., Coons, S. J., & Carter, W. B. (1994). Development of the Kidney Disease Quality of Life (KDQOL™) Instrument. *Quality of Life Research*, 3(5), 329-338. http://www.jstor.org.libproxy1.nus.edu.sg/stable/4034432.

Jehan, S. A. S., Lobna, M. G. A., & Enshrah, R. M. (2012). Effect of tailored counselling for patients undergoing hemodialysis upon their self-care. *Life Science Journal*, 9(4), 2463-2471.

Judd, E., & Calhoun, D. A. (2015). Management of hypertension in CKD: Beyond the guidelines. *Advances in Chronic Kidney Disease*, 22(2), 116-122. doi:10.1053/j.ackd.2014.12.001

Khalil, A. A., Lennie, T. A., & Frazier, S. K. (2010). Understanding the negative effects of depressive symptoms in patients with ESRD receiving hemodialysis. *Nephrology Nursing Journal*, 37(3). 289.

Life Options Rehabilitation Advisory Council (LORAC) (1998). Unit self-assessment manual for renal rehabilitation. *Madison WI: Medical Education Institute*.

Lingerfelt, K. L., & Thornton, K. (2011). An educational project for patients on hemodialysis to promote self-management behaviors of end stage renal disease. *Nephrology Nursing Journal*, 38(6), 483-488.

Tsay, S.-L., & Hung, L.-O. (2004). Empowerment of patients with end-stage renal disease - a randomized controlled trial. International *Journal of Nursing Studies*, 41(1), 59-65. doi: :10.1016/S0020-7489(03)00095-6

Wingard, R. (2005). Patient education and the nursing process: Meeting the patient's needs. *Nephrology Nursing Journal*, 32(2), 211.

Yang, F., Griva, K., Lau, T., Vathsala, A., Lee, E., Ng, H. J., . . . Luo, N. (2015). Health-related quality of life of Asian patients with end-stage renal disease (ESRD) in Singapore. *Quality of Life Research*, 24(9), 2163-2171.

PEER REVIEWED ARTICLE

# Integrating creative and expressive therapies within clinical supervision to foster supervisee personal and professional development:

## A review of the literature

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Creativity is the process of bringing something new into being. It brings to our awareness what was previously hidden and points to new life

(Rollo May, 1975, p.39)

### Introduction

Over the past ten years there has been a growing interest in the use and effectiveness of creative and expressive therapies within counselling (Bulchalter, 2009; Moreno, 2014; Purswell & Stulmaker, 2015). According to Degges-White and Davis, (2017) the expressive arts have the power to transcend and connect to parts of the self that traditional talk approaches may not be capable of. Through the use of mediums such as art, music, dance/movement, drama, poetry, creative writing, play and sandtray, and by focusing on the process of self-expression rather than the aesthetic merits of the art itself (Malchiodi, 2012), therapists can assist clients to draw on inner feelings and the unconscious to facilitate a more comprehensive form of self-expression and deeper levels of insight (Degges-White & Davis, 2017).

Less well understood, however, are the ways in which creative and expressive therapies may contribute to a counselling supervisee's personal and professional development. Bernard and Luke's (2015) ten-year analysis of the literature on clinical supervision, for example, revealed that the use of expressive therapies within supervision is an 'emerging' practice warranting further attention and research. In light of this, a narrative review of the literature was undertaken to illuminate not only the contributions that integrating creative and expressive therapies within supervision might make to a supervisee's personal and professional development but also to highlight the gaps in the current knowledge base with regard to this 'emerging' practice.

By way of orientation, definitions of key terms relating to narrative literature reviews, creative and expressive therapies, clinical supervision, and the personal and professional learning needs of the supervisee are provided, followed by an outline of key search terms, and data retrieval methods. The key themes identified within the literature are then examined with reference to the research question, "In what ways does the integration of creative and expressive therapies in clinical supervision foster a counselling supervisee's personal and professional learning needs?" Discussion of the findings, together with gaps in the current knowledge base and recommendations for future research are then presented.

### Definition of Terms

#### NARRATIVE LITERATURE REVIEW

A comprehensive synthesis of existing works that often discuss theory and context with the aim of provoking thought and controversy (Green, Johnson, & Adams, 2006).

#### CREATIVE AND EXPRESSIVE THERAPIES

According to the Australian New Zealand Arts Therapy Association the arts therapies are a form of psychotherapy utilising creative modalities, including visual art-making, drama, and dance/movement, within a therapeutic relationship to improve and inform physical, mental and emotional well-being (ANZATA, 2017).

For the purpose of this review, therefore, creative and expressive therapies will refer to a variety of modalities used in a psychotherapeutic context to improve and inform the physical, psychological and social wellbeing of the client and may include, but are not limited to, the use of toys, art materials, drawing, painting, clay, role playing, psychodrama, dance, sand tray and symbol work, either individually or in combination (ANZATA, 2017; Purswell & Stulmaker, 2015).

#### CLINICAL SUPERVISION

Conceptualising clinical supervision has become increasingly complicated due to the multiple definitions available that emphasise its different aspects and functions including the nature of the relationship; the knowledge, skills, attitudes and values necessary for competence; approaches to assessment; and the value of reflective practice (Falender & Shafranske, 2014; Milne, 2009). This complexity has also been noted by Martin, Copley and Tyack (2014) who argue that the term clinical supervision is "problematic" due

to the existence of multiple interpretations linked to historical uses of the word, dynamic changes and relevance to different cultural groups. In response to these difficulties, a call for consensus in the definition has been made in an effort to capture the diverse perspectives and varieties of supervision which continue to emerge (Falender & Shafranske, 2014; Milne, 2009).

In light of the current lack of definitional consensus, for the purpose of this literature review, clinical supervision will be defined as a professional relationship involving a dynamic of encouraging supervisee development and autonomy, relationship building, protection of the client and enhancement of client and supervisee outcomes (Falender & Shafranske, 2014).

### PERSONAL DEVELOPMENT NEEDS OF THE SUPERVISEE

For the purpose of this review, personal development needs of the supervisee will include those relating to biases, beliefs, attitudes, life experiences, personality, interpersonal styles, diversity and countertransference (Falender & Shafranske, 2014).

### PROFESSIONAL DEVELOPMENT NEEDS OF THE SUPERVISEE

Professional development needs, within this review, will refer directly to discussions between the supervisor and supervisee around professional development issues such as case load, clinical issues and staff relationships (Martin, Copley & Tyack, 2014).

## Methods

The literature used in this review was obtained by searching the following electronic databases: CAUL Taylor & Francis Journals, Cinahl Complete, ProQuest PsycARTICLES and Wiley Online Library. The search was limited to peer-reviewed, Australian and international journal articles and textbooks which specifically referred to the integration of creative and expressive therapies in either individual or group clinical supervision, were written in English and had been published between 2000 and 2017. After applying the search terms and inclusion criteria, nineteen peer-reviewed journal articles and three textbooks were retrieved.

## Findings

Analysis of the nineteen literature sources revealed six key themes relating to the use of creative and expressive therapies in supervision: left and right brain integration, supervision models that support creative approaches, the importance of the supervisory alliance, increased personal and professional development, enhanced case conceptualisation and ethical considerations. Each of these themes is explored in greater detail below.

### THEME ONE: LEFT AND RIGHT BRAIN INTEGRATION

The theory of left and right brain functioning asserts that the two hemispheres of the brain are each responsible for different functions (Schuk & Wood, 2011). Whilst the left hemisphere is associated with tasks involving logic, linear, calculative and sequential thinking, the right hemisphere focuses on processing emotions, intuition, creativity and emotional literacy (Schuk & Wood, 2011).

In his book, "Creative Supervision", Lahad (2000) highlights the fact that, traditionally, counsellor supervision has neglected to integrate the right brain's creativity, focusing instead upon the left brain's rational and verbally-based logic and reasoning in the supervision process. In complete contrast to this approach, Lahad (2000) calls for the integration of both the left and right brain in supervision, arguing that the integration of the 'other fifty percent' offers greater flexibility in relating to the diverse beliefs, values, affect, social, imaginative, cognitive and physiological needs of a supervisee than do more traditional methods. To this end, Lahad (2000) advocates for the use of metaphor, stories, images, expressive materials, drawing, letter writing, colours and shapes within the supervisory process.

Williams (2000) also espouses the integration of right brain creative approaches within supervision. In his 1995 publication, "Visual and Active Supervision", he highlights the fact that using right brain visual methods works to both illuminate complex relationships from the supervisee's point of view and promote experiential and metaphoric learning in ways that traditional left brain verbal methods fail to do (Williams, 1995).

Schuk and Wood (2011) likewise encourage supervisors to integrate both sides of the brain in their work with supervisees. They assert that most people have a dominant side of the brain when perceiving the world which can be drawn on in supervision in the context of the supervisee's learning styles. Whilst left brain dominance draws people to logic, reason, calculation and mathematics, right side dominance features emotion, intuition, creativity and emotional literacy. By integrating left and right brain approaches within supervision, the authors argue that the supervisor can challenge a supervisee to move beyond their preferred dominant learning style which, whilst potentially uncomfortable and requiring negotiation, can open up new possibilities and experiences of personal and professional development for the supervisee. Liberati and Agbisit (2016) concur, stating that by incorporating left and right brain processing in supervision the supervisee's understanding of inter and intrapersonal relationships and their personal growth can effectively be broadened and accelerated.

An approach to supervision which favours an integration between lineal (left brain) and non-lineal (right brain) approaches, is also supported by Hecker and Kottler, (2002) (as cited in Graham, Scholl, Smith-Adcock & Wittman, 2014) whose qualitative case study of

three creative approaches to supervision revealed that the use of purely lineal, traditional methods in supervision was not always effective in promoting counsellor development and case conceptualisation.

Despite evidence within the literature that the integration of left and right brain (or linear and non-linear) approaches to supervision are best placed to respond to the diverse ways in which supervisees reflect, communicate, learn and develop, the use of verbally based, left brain supervision approaches in psychotherapy and counselling continues to dominate. In seeking to understand this dominance, Chesner and Zografou (2014) draw attention to Moreno's (1940) concept of "cultural conserve", the tendency for habit and familiarity to deaden creativity and spontaneity, as a possible reason why supervisors may revert to familiar left brain linear methods in supervision irrespective of the benefits of adopting a right and left brain integrative approach.

## THEME TWO: SUPERVISION MODELS THAT SUPPORT CREATIVE APPROACHES

Within the literature relating to the integration of creative and expressive therapies in supervision, the importance of practicing within a theoretical foundation or model is noted. Chester and Zografou (2014), argue that the use of a model ensures that supervision remains relevant to the task and refrains from manifesting into a space for general exploration or personal counselling. To date, creative and expressive therapies have been predominantly applied in supervision in a person-centred approach where the supervisor provides an environment in which the quality of the relationship determines the outcomes (Corey, Haynes, Moulton & Muratori, 2010; Perryman, Anderson, Moss & Moss, 2016).

With regard to supervisory models, Bernard's Discrimination Model is commonly referenced as one which supports the integration of creative therapies within it (Bernard, 1979). This model focuses on the three supervisor roles of teacher, counsellor and consultant; and three foci which include intervention, conceptualisation, and personalisation (Bernard & Luke, 2015). Due to its flexibility and different foci and roles within supervision, this model has been found to be very useful for the integration of creative strategies such as sandtray, play therapy (Perryman et al, 2016) and metaphoric sculptures and drawings (Koltz, 2008).

Developmental models of supervision, which view counsellors in context of self and other awareness, from novice to advanced, have also been widely demonstrated as being able to match various creative and expressive therapies to a supervisee's needs in clinical supervision (Chesner & Zografou, 2014; Corey, et al., 2010; Guiffrida, Jordan, Saiz & Barnes, 2007; Koltz, 2008; Liberati & Agbisit 2016; Purswell & Stulmaker, 2015). Furthermore, the integration of Bernard's Discriminatory Model with a developmental one using play therapy has also been demonstrated to assist in drawing out the supervisee's innate knowledge by tactfully targeting both their ability and developmental stage via play and metaphor (Anderson, Perryman & Moss, 2016; Graham, Scholl, Smith-Adcock & Wittman, 2014).

Finally, the integration of Hawkins and Shohet's (2012) Seven Eyes of Supervision approach, Williams' (1995) Roles in supervision and Stoltenberg & McNeill's (2010) Integrated Developmental model has been demonstrated through case studies, to effectively incorporate psychodrama, action methods, symbol work and drawing in supervision (Chesner & Zografou, 2014). According to Chesner and Zografou (2014), the integration of creative and expressive therapies within these models assists the supervisor to respond to the emotional state of the supervisee including their personal distress, transference, countertransference and parallel process, whilst also attending to client case conceptualisation.

It is evident from the above that within the literature numerous supervision models have been demonstrated to support the use of creative and expressive therapies in supervision due to their flexibility and capacity to accommodate a range of diverse concepts and techniques (Chester & Zografrou, 2014; Koltz, 2008).

## THEME THREE: THE IMPORTANCE OF THE SUPERVISORY ALLIANCE

As with the therapeutic relationship, the quality of the relationship within supervision in determining good outcomes, regardless of the theoretical approach taken, has been widely acknowledged in the literature (Corey, et al., 2010; Falender & Shafranske, 2014; Leibovich & Zilcha-Mano, 2016; Martin et al, 2013; Schuk & Wood, 2011).

Furthermore, the essential need for supervisor competency and skills in forming the necessary preconditions for a solid supervisory alliance before any creative or expressive therapy is implemented has also been repeatedly referenced (Chester & Zografou, 2014; Leibovich & Zilcha-Mano, 2016; Liberati & Agbisit, 2016; Newsome, Henderson & Veach, 2005; Purswell & Stulmaker, 2015). This is due to the fact that creative and expressive therapies invite supervisees to engage in deep reflection about experiences where words alone would not be enough (Leibovich & Zilcha-Mano, 2016). Clearly such an invitation can only be made after a safe, trusting, non-judgemental supervisory alliance has been formed (Purswell & Stulmaker, 2015).

Whilst underscoring the importance of creating a strong supervisory alliance prior to the introduction of

creative and expressive therapies, the literature also acknowledges that the use of creative techniques such as visual metaphoric interventions can strengthen the supervisory alliance whilst nurturing the developmental needs of the supervisee (Perryman et al, 2016). This is because these techniques assist in the discovery of power differentials, member roles, strengths and growth in the supervisory relationship (Perryman et al, 2016; Purswell & Stulmaker, 2015).

### THEME FOUR: INCREASED PERSONAL AND PROFESSIONAL DEVELOPMENT

Consistently referenced in the literature is the means by which creative and expressive therapies are more likely than traditional approaches to lead to increased supervisee personal and professional development. In offering a reason for this, Purswell and Stulmaker (2015) argue that the use of creative and expressive therapies in supervision is a less threatening and quicker way of raising supervisee awareness and insight than the more traditional approaches. By working with the 'visceral and internal' as opposed to the 'cognitive and rational' components (Purswell & Stulmaker, 2015), supervisees gain deeper understandings about their relationships with clients; experience reduced resistance, particularly in group settings; have deeper connections with and expression of feelings; demonstrate increased empathy and client care; gain greater awareness about countertransference reactions; and increased abilities to track their personal growth and foster their own wellbeing (Deaver & Shiftlett, 2011; Liberati & Agbisit, 2016; Peabody, 2015; Schuk & Wood, 2011; Stark, Frels & Garza, 2011). Peabody (2015), reports on a case study that used Lego Supported Play (LSP) in clinical supervision, finding that the non-specific nature of the Lego bricks permitted supervisees, through 'metaphoric constructions', to effectively address their personal identity, foster self-awareness, resolve problems and raise awareness about interpersonal dynamics and narratives.

Anecdotal evidence also suggests that the use of metaphoric drawing activities (Fall & Sutton, 2004 cited in Guiffrida, Jordan, Saiz, & Barnes, 2007) and environmental metaphors (Valadez & Garcia, 1998 cited in Guiffrida et al, 2007) in supervision are particularly helpful in tracking supervisee development and the process of 'becoming a counsellor' by encouraging supervisees to look critically at their goals and link these to their unique learning experiences. Similarly, the use of sand tray within solution focused supervision has been noted to work well in shifting novice counsellors to a place of self-reference, rather than dependence on their supervisor's feedback (Stark, Frels, & Garza, 2011). Garza and Watts (2009 cited in Stark et al, 2011) argue that this is due to the fact that creative and symbolic therapies, such as sand tray, encourage an internal process of ownership by supervisees to discover their own thoughts, feelings and needs, whilst reinforcing existing and past strengths and resources.

Integrating expressive psycho-dramatic approaches within counselling supervision has also been found to work well at promoting counsellor identity development, self-efficacy, self- esteem, autonomy, self-awareness and holistic growth (Blatner et al, 2000 cited in Scholl & Smith-Aldcock, 2008). Scholl and Smith-Aldcock (2008) state that this is because these approaches work by facilitating a supervisee's creative and

spontaneous self-expression, revealing previously hidden or unknown aspects of the self. The emotional catharsis and new insights gained in the process are also believed to be integrated into supervisee behaviours and personality characteristics that promote supervisee growth (Scholl & Smith-Aldcock, 2008; Purswell & Stulmaker, 2015).

Working creatively in supervision with role plays and metaphoric interventions is also argued to be beneficial in eliciting insights into the dynamic of parallel process by affording the supervisee some distance to observe and reflect on this phenomenon from multiple perspectives (Chesner & Zografou, 2014; Schuk & Wood, 2011). Lahad (2000) proposes the use of letter writing to self, the client, or a person in the past or present, as being a highly effective means of addressing parallel process and personal factors in clinical supervision.

Finally, with regard to countertransference, Response Art has been noted to aid in the identification of countertransference reactions which would otherwise have gone unnoticed in traditional verbal supervision (Fish, 2012). Response Art works by exploring and physically handling complex clinical issues through various visual media which may include painting, sculpting, drawing or collage (Fish, 2012). Fish (2012) presents a case vignette in which a distressed supervisee, whose personal safety had been threatened by a client, was able to address her experience by creating a sculpture for self-reflection of both present and past issues whilst simultaneously addressing her self-care.

Overall, the literature demonstrates not only that a wide variety of creative and expressive therapies can be used effectively in clinical supervision to foster the personal and professional development of the supervisee but that these approaches permit dynamic engagement between the two.

## THEME FIVE: ENHANCED CASE CONCEPTUALISATION

The reviewed literature highlights how case conceptualisation is enhanced through the use of creative and expressive approaches within supervision. Numerous authors propose that this is because of the capacity of these approaches to address multiple learning styles, thereby fostering awareness and insights previously inaccessible through traditional linear approaches to supervision (Anderson, Perryman & Moss, 2016; Guiffrida et al, 2007; Liberati & Agbisit, 2016; Purswell & Stulmaker, 2015).

Ishiyama's (1988)(cited by Guiffrida et al, 2007) visual case conceptualisation method was one of the first creative approaches offered and is still referred to in the contemporary literature, having been credited for its capacity to shift supervisees from concrete verbal thinking to metaphorical visual thinking (Shiflett & Remley, 2014). This metaphoric approach, which involves generating an image and metaphors followed by the drawing of the case in group supervision, works by offering another lens through which to view the case, enabling supervisees to not only discover new aspects about their case but also informing future case directions and goal formulations (Guiffrida et al, 2007; Liberati & Agbisit, 2016).

Ishiyama's (1988)(cited by Guiffrida et al, 2007) study on metaphoric case conceptualisation found that working with metaphoric approaches was viewed by group participants as being superior to the traditional verbally-based approaches in eliciting deeper understandings about the client, the relationship and the counselling goals. In the same period, Amundson's (1988)(cited by Deaver & Shiflett, 2011) study on metaphoric case conceptualisation also found metaphoric creative approaches to be more effective than linear, verbal case processing. This may be due to the fact that metaphoric narratives and visual metaphors act as bridges to feelings and insights which enhance client case conceptualisation, intervention strategies and the therapeutic relationship (Deaver & Shiflett, 2011).

The use of sculpting and drawing in conceptualising cases has also been found to be effective in eliciting details beyond the obvious verbal facts of the case (Fish, 2012; Koltz, 2008). Koltz (2008) argues that these creative approaches are able to transform experiences of feeling 'stuck and unsure' into insightful patterns and themes whilst simultaneously eliciting the supervisee's personal feelings, reactions, behaviours, attitudes and uncovering any parallel processes.

Other creative approaches to fostering case conceptualisation skills revealed in the review include Phillip's (2010) use of poetry to work 'intuitively' with metaphor in self-supervision and Shiflett and Remley's (2014) use of metaphoric drawing techniques in group supervision. In addition to enhancing supervisee's case conceptualisation capacities, these approaches were able to manage countertransference reactions (Phillip, 2010), increase empathy and connection with the client instead of conducting a 'case synopsis' (Shiflett & Remley, 2014) and assist supervisees with noticing when clients presented their own metaphors (Shiflett & Remley, 2014).

These findings suggest that the use of metaphoric interventions enhances case conceptualisation by developing a shared language to conceptualise cases, helping supervisees think about clients through an alternate lens and enabling a deeper understanding of client and 'self as counsellor' (Liberati & Agbisit, 2016).

Regardless of the type of creative or expressive approach used, however, its success in relation to case conceptualisation is highly dependent on the supervisor's

skills and competency in facilitating and tailoring these approaches to a supervisee's developmental learning needs and their capacity to think abstractly and creatively (Chesner & Zografou, 2014; Guiffrida et al, 2007; Schuk & Wood, 2011).

### THEME SIX: ETHICAL CONSIDERATIONS

The review found that at the heart of working successfully with creative and expressive therapies in supervision is the supervisor's observance of engaging in ethical decision-making and behaviour. This is attributed to the obvious intimate nature of the deep insights that may be elicited from supervisees when creative and expressive therapies are used (Liberati & Agbisit, 2016; Mullen, Luke, & Drewes, 2007; Purswell & Stulmaker, 2015). Some key ethical considerations consistently found in this review and discussed below include: supervisor competency, the responsible use of supervisory power, sensitivity in practice, boundary violations and dual relationships, and maintaining confidentiality.

In practicing ethically, supervisors are encouraged to have training and firsthand experience in the use of creative or expressive therapies prior to implementing them as the success of these approaches is deemed to be related to a supervisor's skill and ease in presenting and processing the therapies in ways that resonate with the supervisee's learning needs (Chesner & Zografou, 2014; Deaver & Shiflett, 2011; Guiffrida et al, 2007; Liberati & Agbisit, 2016; Schuk & Wood, 2011). The ethical risk of using creative and expressive therapies mechanically, or in the absence of a clear theoretical supervisory purpose, is also of paramount importance, to prevent the practice of creative therapies becoming 'distractions', given the allure of being in a ludic space (Chesner & Zografou, 2014). The possibility of losing one's focus and aim in the session due to the playful nature of the creative approaches therefore requires constant consideration by the supervisor.

The second ethical consideration, the responsible use of power, requires the supervisor to be aware of power differentials which can act as a barrier to effective, creative supervision (Purswell & Stulmaker, 2015). Given the spontaneous and experiential nature of creative and expressive therapies, transparent guidelines are advised to alleviate any uncertainty, feelings of pressure, anxiety or discomfort towards the approaches that the supervisee might have and to ensure that consent in the process is obtained (Deaver & Shiflett, 2011; Newsome, Henderson & Veach, 2005; Purswell & Stulmaker, 2015; Schuk & Wood, 2011; Stark, Frels & Garza, 2011).

There is also a significant focus within the literature about the need for sensitivity in practice when integrating creative and expressive therapies, particularly with novice supervisees or those who have not had prior experience in working this way (Deaver & Shiflett, 2011). For these supervisees, exploring work or personal factors using such approaches may lead to fears of being judged or being seen as being incompetent and they may struggle with the use of such approaches at first (Deaver & Shiflett, 2011; Koltz, 2008; Peabody, 2015).

Supervisors also need to be mindful that the boundaries between counselling and supervision do not become blurred by attending to personal issues only when these interfere with the counsellor's work (Chesner & Zografou, 2014). This is pertinent in creative and expressive styles of supervision, where a supervisee can experience a deeper level of non-verbal processing of personal issues that may be affecting their client work (Purswell & Stulmaker, 2015). Although the 'person as therapist' is viewed as an integral component to explore in supervision, a supervisor's ability to be aware of boundary breaches and the dual relationships which may unintentionally form is of paramount importance and requires ongoing attention (Purswell & Stulmaker, 2015). Finally, with regard to confidentiality, particular emphasis within the literature is placed upon respecting and managing physical art in the same way as confidential supervisee file notes (Deaver & Shiflett, 2011).

In summary, ethical considerations are pertinent when working with creative and expressive therapies in supervision to ensure that the supervisee's personal and professional learning needs are met in a safe, clearly defined supervisory relationship with a competent and well-trained supervisor.

## Discussion and Future Recommendations

This review identified six key themes within the literature relating to the ways in which creative and expressive therapies in counselling supervision may foster a supervisee's personal and professional development. These themes were: left and right brain integration, supervision models that support creative approaches, the importance of the supervisory alliance, increased personal and professional development, enhanced case conceptualisation, and ethical considerations. The literature illustrates that integrating right brain, nonlinear therapies in clinical supervision with counsellors can enhance awareness and create personal and professional insights about experiences of self, others and the world which would otherwise go unnoticed in traditional, linear supervisory models (Deaver & Shiflett, 2011; Shiflett & Remley, 2014). However, it also demonstrates that the effectiveness and success of integrating creative and expressive therapies within supervision is contingent on the supervisor's skill, training and experience in these approaches, their capacity to form a strong supervisory alliance and their willingness to address any ethical issues that arise. Despite these identified benefits, there is also general consensus in the literature that traditional, left-brain, cognitively-based supervision continues to be prioritised in the counselling profession (Graham et al, 2014; Koltz, 2008; Lahad, 2000; Schuk & Wood, 2011).

A number of knowledge gaps within the existing literature that require further investigation were also identified during the review process. These include supervisor training requirements for facilitating creative clinical supervision and the evaluation of creative clinical supervision approaches (Bernard & Luke, 2015; Deaver & Shiflett, 2011; Newsome, Henderson & Veach, 2005); ways of integrating creative and expressive therapies in supervision; the level of supervisor competency required for its successful facilitation (Bernard & Luke, 2015; Liberati & Agbisit, 2016; Purswell & Stulmaker, 2015); the supervisor's capacity for selecting developmentally appropriate therapies (Deaver & Shiflett, 2011; Newsome, Henderson & Veach, 2005; Purswell & Stulmaker, 2015) and the pedagogical methods for transmitting skills to clinical supervisors in training (Bernard & Luke, 2015).

In this age of rapidly emerging technologies and professional reliance of online communication, further research is also required in the use of creative and expressive therapies within supervision using online technology (Liberati & Agbisit, 2016; Scholl & Smith-Aldcock, 2008). This is particularly relevant in an Australian context which features large geographic areas of rural and remote communities. Such research could continue to focus on evaluating its efficacies in supervisee development as well in facilitating creative

supervision in line with technology, in an ethical and effective way.

With regard to the methodology used within the research conducted to date, the literature reflects a predominance of qualitative approaches, for example, case studies and anecdotal accounts. This may be due to the constructivist framework which underlies creative approaches (Perryman et al, 2016). In light of this, Shiflett and Remley (2014) suggest that further research be undertaken using quantitative methodologies which can measure the differences between the utilisation or non-utilisation of art based methods in supervision. O'Leary (2014) expands upon Shiflett and Remley's (2014) suggestion, advocating for the use of mixed method approaches which will continue to generate rich qualitative data as well as evaluative data which is currently lacking in the field of creative clinical supervision. Perryman et al's (2016) call for quantitative longitudinal research which follows novice counsellors throughout their developmental stages to an advanced counsellor stage also appears to be valid and timely. Finally, the lack of retrieval of any Australian based journals within the current literature review highlights the need for further research to be undertaken in an Australian context.

## Conclusion

This narrative literature review has provided an overview of some of the most salient themes within the literature on the use of creative and expressive therapies in counsellor supervision and how they foster personal and professional development within the supervisee. Gaps within the current knowledge base that require further investigation have also be identified. It is hoped that, having read this review, counselling supervisors will be inspired to integrate creative approaches within the supervisory context.

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## REFERENCES

ANZATA. (2017, August 20). *About Arts Therapy* . Retrieved from Australian and New Zealand Arts Therapies Association (ANZATA) : https://www.anzata.org/About-Arts-Therapy

Bernard, J. M. (1979). Supervisor Training: A Discrimination Model. *Counsellor Education and Supervision*, 19(1), 60-68.

Bernard, J. M., & Luke , M. (2015). A Content Analysis of 10 years of Clinical Supervision Articales in Counselling. *The American Counselling Association*, 242-257. doi:10.1002/ceas.12024

Buchalter, S. I. (2009). *Art Therapy Techniques and Applications*. London: Jessica Kingsley .

Chesner , A., & Zografou, L. (2014). *Creative Supervision across Modalities* . London: Jessica Kingsley Publishers .

Corey, G. (2013). *Theory and Practice of Counselling and Psychotherapy*. California: Brooks/Cole Cengage Learning.

Corey, G., Haynes , R. H., Moulton, P., & Muratori, M. (2010). *Clinical Supervision in the Helping Professions*. A Practical guide. (2 ed.). Vancouver: American Counselling Association.

Deaver, S. P., & Shiflett, C. (2011). Art-Based Supervision Techniques. *The Clinical Supervisor*, 30:2, 257-276. doi:10.1080/07325223.2011.619456

Degges-White, S., & Davis, N. L. (2017). *Integrating the Expressive Arts Into Counsellng Practice. THEORY BASED INTERVENTIONS* (2nd ed.). New York: Springer Publishing.

Falender, C. A., & Shafranske, E. P. (2014). Clinical Supervision: The State of the Art. *Journal of clinical Psychology*, 1030-1041. doi:10.10.1002/jclp.22124

Fish, B. (2012). Response Art: The Art of the Art Therapist. *Journal of the American Art Therapy Association*, 29:3, 138-143. doi:10.1080/07421656.2012.701594

Graham, M. A., Scholl, M. B., Smith-Adcock, S., & Wittman, E. (2014). Three Creative Approaches to Counselling Supervision. *Creativity in Mental Health*, 415-426. doi:10.1080/15401383.2014.899482

Green, B. N., Johnson, C. D., & Adams , A. (2006). Writing narrative literature reviews for peer reviewed journals: Secrets of the trade. *Journal of Chiropractic Medicine*, 5, 101-117.

Guiffrida, D. A., Jordan, R., Saiz, S., & Barnes , K. L. (2007). The Use of Metaphor in Clincial Supervision. *Journal of Counselling and Development*, 85, 393-400.

Hawkins, P., & Shohet , R. (2012). *Supervision in the Helping Professions* (4th ed.). Maidenhead: Open University Press.

Koltz, R. (2008). Integrating Creativity Into Supervision Using Bernards' Discrimination Model. *Journal of Creativity in Mental Health*, 3:4, 416-427. doi:10.1080/15401380802530054

Lahad, M. (2000). *Creative Supervision* . London: Jessica Kingsley.

Leibovich, L., & Zilcha-Mano, S. (2016). What Is the Right Time for Supportive Versus Expressive Interventions in Supervision? An Illustration Based on a Clinical Mistake. *Psychotherapy*, 53. no3, 297-301.

Liberati, R., & Agbisit , M. (2016). Using Art Based Strategies in Group -Based Counselor Supervision. *Journal of Creativity in Mental Health*. doi:10.1080/15401383.2016.1189369

Malchiodi, C. A. (2012). *Handbook of Art Therapy* (2nd ed.). NY: Guildford Publications Inc.

Martin , P., Copley, J., & Tyack, Z. (2014). Twelve tips for effective clinical supervision based on a narrative literature review and expert opinion. *Medical Teacher*, 36:3, 201-207.

May , R. (1975). *The courage to create* . New York: W.W Norton & Company.

Milne , D. L. (2009). *Evidence-based clincial supervision: Principles and practice*. Malden Leicester: Blackwell Publishing.

Moreno, Z. T. (2014). Psychodrama Soziom. *Journal of Psychodrama and Sociometry*. doi:10.1007/s11620-014-0245-x

Mullen , J. A., Luke , M., & Drewes , A. A. (2007). Supervison can be playful too: Play therapy techniques that enhance supervision. *International Journal of Play Therapy*, 16(1), 69-85.

Newsome , D. W., Henderson , D. A., & Veach , L. J. (2005). Using Expressive Arts in Group Supervision to Enhance Awareness and Foster Cohesion. *Humanistic Counselling, Education and Development*, 44.

O'Leary , Z. (2014). *THE ESSENTIAL GUIDE TO DOING YOUR OWN RESEARCH PROJECT*. London: Sage.

Peabody, M. A. (2015). Building With Purpose: Using Lego Serious Play in Play Therapy Supervision. *International Journal of Play Therapy*, 24.No1, 30-40.

Perryman , K. L., Anderson, L., Moss , R., & Moss, R. C. (2016). Sandtray Supervision: An Integrated Model for Play Therapy Supervision. *International Journal of Play Therapy*, 25,No.4, 186-196.

Phillips, J. (2010). Poetry as self- supervision for mental health professionals: The use of poetry to process and understand clincial work. *Journal of Poetry Therapy*, 171-182. doi:10.1080/08893675.2010.498212

Purswell, K. E., & Stulmaker, H. L. (2015). Expressive Arts in Supervision: Choosing developmentally appropriate interventions. *International Journal of Play Therapy*, 103-117. doi:10.1037/a0039134

Scholl, M. B., & Smith-Aldcock, S. (2008). Using Psychodrama Techniques to Promote Counselor Identity Development in Group Supervision . *Journal of Creativity in Mental Health*, 13-33.

Schuk, C., & Wood , J. (2011). *Inspiring Creative Supervision*. London: Jessica Kingsley Publishers.

Shiflett, C. L., & Remley , T. P. (2014). Incorporating Case Conceptualization Drawing in Counsellor Group Supervision: A Grounded Theory study. *Journal of Creativity in Mental Health*, 9, 33-52. doi:10.1080/15401383.2013.878680

Stark, M. D., Frels, R. K., & Garza, Y. (2011). The use of sandtray in Solution Focussed Supervision. *The Clinical Supervisor*, 277-290. doi:10.1080/07325223.2011.621869

Stoltenberg, C. D., & McNeill , B. W. (2010). *IDM Supervision*. New York: Routledge.

Williams , A. (1995). *Visual and Active Supervision: Roles, Focus, Technique* (1st ed.). NY: WW Norton and Co.

Williams, A. (2000). Working Visually in Supervision. *Psychotherapy in Australia*, 6:4, 8-11.

# Spotlight on a Counsellor

## *By Tom Parker ACA ILO*

**Spotlight on a Counsellor is a unique glimpse at Registered Counsellors all across the country. Learn more about their successes, struggles and stories in this quarterly edition of Spotlight on a Counsellor.**

Today, we meet David Debono who works for Qantas Airways Ramp Services as their Mental Health & Wellbeing Coordinator at Sydney Airport.

**Tom:** "How did you end up in your current role?"

**David:** "It came by accident, I had just finished my counselling qualification and I was speaking with my manager when we were interrupted by a phone call – it was a critical incident, and a colleague was having a panic attack. The manager didn't know what to do, and my counsellor training kicked in.

I took control with the situation, helped clear the room, and was present with that colleague. As the colleague and I worked through that situation, the manager was watching the whole time.

The manager was so impressed and asked me how I knew what to do. I let them know that I had just finished a counselling qualification. After that interaction, management looked at creating a new role just for me. Now, I split my time between training and counselling, they've even built me a counselling room too!

This role is a permanent role, focused on counselling. Sometimes I even do some presentations about mental health. Having a person on staff, that knows the culture, is important to the team here. Even if I need to refer on, I know where to send my colleagues – whether that be with the EAP, GP or elsewhere. My role has become quite broad, and I've had to roll with it. It is a really great gig."

**T:** "Where did you complete your counselling training?"

**D:** "Australian Institute of Professional Counselling, Diploma of Counselling – finished in 2015, continued with advanced major studies afterwards."

**T:** "What are some of the biggest lessons that you learned in your counselling training?"

**D:** "A few of the biggest lessons and those that I live by every day, "do not judge people" and "listen" – the non-judgemental approach is worthwhile, and working this way is important. If you can't listen, counselling may not be for you. It was the best thing that I have ever done.

As a counsellor, you learn the difference between active listening and hearing. You can hear, and you can listen – they're two different things. We can hear the noise, or we can actively listen at a deeper level with counselling skills. It's like hearing a dog bark, but we can't understand what they are saying. The communications skills have been very worthwhile even at home too!"

**T:** "How did you use your counselling skills and training to be in your current role?"

**D:** "I put into practice the competencies that I had learned as soon as I could. When I first did the course, I was struggling with the homework and the training – the best advice I got from the trainer was this

"We're not after a standard counsellor – we're after a unique counsellor. You need to find where you belong, with your unique style".

As I learned about the different theories and modalities, I was able to find the right style and use my personality to be an effective counsellor. Everyone has their style and "spin" on being a counsellor.

From what I've learned and experienced along the way, I was able to create my identity in counselling. I was able to create me. At the end of the day, I am comfortable counselling anybody and asking the right questions, because this is who I am. My clients appreciate this style because it is relatable and relevant to them; rather than using a strict formula.

If it weren't for my trainer, reminding me to find my unique voice in counselling; I wouldn't have gotten there. After that conversation, it all suddenly made sense; my assignments got better, and grades improved dramatically. Understanding the theories and science behind the counselling was important, and I could add a bit of myself into the equation."

**T:** "How has being a Registered Counsellor impacted your work with your role?"

**D:** "Being registered is what got me to where I am today; there are rules that I need to follow that make sure I look after myself. Management is often checking in with me about my self-care and often ask about my professional development. With ACA standards there is supervision and professional development that I am required to get every year. I also work with a great supervisor that helps me grow. The lessons that I learn in supervision is great for my sessions – I've learned a lot. There are times when I have worked with a client that has been a bit awkward, where I felt not certain about the direction I took and things I had said in the session. Along the way, I had gotten reassurances about my practice and direction about the way that I practice – in the end, we mean the same thing, but sometimes we use different words. The contribution for my role is that it ticks the boxes with my managers and I get a lot of information about the news and updates; ACA membership keeps me in the loop."

**T:** "What advice can you give to others currently looking to advance their careers using counselling qualifications?"

**D:** "I'm passionate about counselling; if you haven't got that passion and that drive, then you probably can't use it as a career path. I feel blessed that I am earning good money and am doing something that I am passionate about; it is a great feeling. You need to have that passion; the work that we do needs to come from inside, and there isn't a "template" or "formula" for everyone. All of our clients are unique with unique stories. When I'm running a session, I am present with a client, not just watching. Please make sure to think about whether you want to work like that or in this field."

**Minor corrections have been made for the sake of clarity.

PEER
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ARTICLE

# Positive disintegration and triumphant transformation

*By Stacey Admiraal*

The impetus for this literature review is the dissonance I experience with traditional trauma research. Empirical studies mainly concentrate on the negative sequelae of adversity in the aftermath of trauma (Joseph, 2011; Tedeschi & Calhoun, 1995, 2004, 2006; Zoellner & Maercker, 2006). For me, this is not a true holistic account of the effects trauma has on survivors, and did not solely fit my own perceived experiences. Enduring childhood sexual abuse and the subsequent adverse effects of complex trauma in adulthood were confronting. Healing took place through a trauma-informed Gestalt psychotherapist, who assisted my awareness of how these experiences not only produced negative consequences, but provided vast experiences of growth and transformation beyond recovery. Like the iconic 'wounded healer' made famous by Carl Jung, I too embarked on a journey that ultimately lead to tertiary studies in the field of counselling, mental health and gestalt therapy. Psychologists, psychiatrists, clinicians and other laypersons seem to adopt such a pessimistic attitude towards the psychological consequences of traumatic events. Trauma literature and research mainly depict one aspect of the traumatic experience, the negative distress outcome. The polarity of this provides the impulse for this review which centralises around the positive outcomes, specifically Posttraumatic Growth (PTG) in the aftermath of trauma (Tedeschi & Calhoun, 1995). Posttraumatic growth moves beyond 'survival' of the individual and into the sphere of 'thriving'. That is, "the experience of personal growth or strengthening that often occurs in persons who have faced traumatic events" (Tedeschi & Calhoun, 1995, p ix).

This literature review surrounding posttraumatic growth concerning adult populations[1] will be presented in three sections. The first section will clarify definitions of what constitutes a traumatic event, and the symptomology associated with negative consequences, in particular posttraumatic stress disorder ([PTSD] – American Psychiatric Association, 2013). The second section identifies posttraumatic growth, and shows how it differs from mere resilience and coping. It also discusses terminology within the positive psychology field that is relevant to growth and critiques appropriate usage. The term 'antifragility' (Taleb, 2012) will be explored and its affiliation to posttraumatic growth.

Finally two models of Posttraumatic Growth theoretical frameworks will be discussed. These frameworks categorised by PTG researchers into three main domains; changes in self-perception, interpersonal relationships and philosophy of life (Tedeschi & Calhoun, 1995, 2004). Consideration and critique of psychometric tools currently used for data collection in research studies are named. This is followed by neuroscientific outcomes highlighting findings that support the subject of this review and its relationship to psychotherapy. The third section of this literature review focuses on Gestalt psychotherapy. Particularly, the Gestalt methodologies of phenomenological enquiry, field theory, relational dialogue within the therapeutic alliance and experiments that support self-actualisation.

Despite Gestalt Therapy not currently adorning the label as an approved evidence-based practice, it encompasses all the attributes necessary. Evidence-based practices currently preference cognitive behavioural approaches, and recent empirical research suggests the benefit of somatic based methodologies, however Gestalt Therapy is inherently aligned with all domains of trauma treatment, and post-traumatic growth, which sets it apart from other holistic therapies. This section considers the effectiveness of Gestalt therapy to support trauma clients according to evidence-based research. Finally, the Paradoxical Theory of Change model (Beisser, 1970), synonymous with Gestalt theory will be discussed and critiqued. Lastly, a summary of the literature draws some conclusions about Gestalt therapy being relevant to the field of Posttraumatic Growth and provides avenues for future research to be conducted.

## Trauma and Posttraumatic Stress Defined

Trauma encompasses a landscape of human experience and overrides all natural ways of being. Traumatic events typically involve threats to one's life or body integrity or a close encounter with violence and death (Levine, 1997,2010; Ogden, Minton,& Pain, 2006; Paivio & Pascual-Leone, 2010), which commonly lead to reactions of "intense fear, helplessness, loss of control, and threat of annihilation" (Herman, 1992, p.33). Trauma refers to a person's enduring emotional, psychological and physical responses to events that are experienced as a threat to their life, their physical integrity or their ability to comprehend and cope with the event or circumstances (Herman, 1992; Levine, 1997, 2010; Ogden et al., 2006). Trauma does not refer to the event or situation that has occurred but the individuals' responses to that particular event (Herman, 1992; Tedeschi & Calhoun, 1995). Threats to one's survival can include not only physical and psychological but also social survival in terms of abandonment, exclusion or humiliation (Herman, 1992; Van der Kolk, 1994; Levine, 2010). Events typically attributed to traumatic responses are: physical/sexual assaults; accidents; natural disasters, witnessing death/ injury; war; torture; extremes of poverty and deprivation; child abuse; neglect or abandonment (Herman, 1992; Paivo et al., 2010; Tedeschi & Calhoun, 2004). These incidents occurring in isolation to an individual are known as "single incident trauma" (Paivio, 2010, p.15). When a person has experienced several single traumatic incidents, whereby the impact of

1 The scope of this literature review will be solely focused on adult populations, although children and adolescent populations do feature in current PTG research (Taku, Calhoun, Tedeschi, Gil-Rivas, Kilmer, & Cann, 2007), it is beyond the scope of this review.


these collective occurrences have ongoing, and multidimensional consequences they are known to be 'complex' (Herman, 1992; Paivio et al., 2010; Van der Kolk, McFarlane, & Weisaeth, 1996). Complex trauma identifies the severe, repeated impacts of the events that generally occurred during childhood, and involving ongoing relationship with the perpetrator of the abuse (Briere & Scott, 2006; Herman, 1992; Levine, 2010). Interpersonal trauma typically involves the use and abuse of power or betrayal by one person (or group) over another person (or group) (Briere et al., 2006; Taylor, 2014). The core tenet of interpersonal trauma is the betrayal of trust (Taylor, 2014; Van der Kolk et al., 1996). The loss of trust has the potential to compromise how the individual forms and understands all other relationships throughout their life (Joseph, 2011; Kepner, 1995; Taylor, 2014). Given that protective factors and healing can be found in relationships, this leaves the person susceptible to experiencing negative symptomology in isolation, often unable to seek appropriate supports directly due to compromised contacting functions (Taylor, 2014) and diminished sense of self (Kepner, 1995).

Mental health consequences attributed to the persistent negative symptoms experienced by trauma survivors have been classified as Posttraumatic Stress Disorder ([PTSD] - American Psychiatric Association [APA], 2000) or Complex Posttraumatic Stress Disorder ([CPTSD] - American Psychiatric Association [APA], 2013). Posttraumatic Stress Disorder is characterised by patterns of responses that persist over time, at least one month and cause significant impairment to the persons' functioning (Spiegel, 1997). Symptoms of intense fear, helplessness, or horror; persistent re-experiencing of the trauma; repeated avoidance of trauma related stimuli; and increased arousal (APA, 2013). PTSD occurs as a result of the individual's inability to adequately process trauma-related information (Herman, 1992; Spiegel, 1997). For instance fragmented and disorganised memory functions (Levine, 2010; Spiegel, 1997); intrusive thoughts and flashbacks often causing disorientation in time and context; hyperarousal resulting in self-regulation difficulties (Gwynn, 2008; Taylor, 2014), disturbed sleep functions, hyper-vigilance and concentration challenges (Gwynn, 2008; Rothschild, 2002; Tedeschi & Calhoun, 1995). "Exposure to traumatic events puts a person at increased risk of developing psychiatric disorders. Most likely PTSD, anxiety, depression" (Garbarino, Kostelny, & Durow, cited in R.Tedeschi & L.Calhoun, 1995, p.25). As the symptoms above depict, PTSD affects the whole of the organism.

Exposure to traumatic events does moderately increase the likelihood that physical disease will occur (Herbert & Cohen 1993; Levine, 2010; Rothschild, 2002). Common somatic ailments associated with PTSD diagnosed individuals include fatigue, gastrointestinal difficulties, headaches, loss of appetite, respiratory difficulties, urinary problems, immune functioning compromised, adrenal glands and thyroid issues in addition to general aches and

2 Holistic persona of the individual refers to their whole being; all facets viewed in context of their unique situation, personality and experiences.

pains (Levine, 2010, Ogden et al., 2006; Tedeschi &Calhoun,1995). Individuals who are experiencing these symptoms also undergo behavioural modifications like increased aggression, irritability, isolation and withdrawal from others, and may experience sexual dysfunctions or difficulties (APA, 2013; Rothschild, 2002; Tedeschi & Calhoun, 1995). Engaging in creative coping mechanisms such as drug and alcohol abuse is often a way of numbing symptoms whilst believing they are beyond help or worthy of support (Herman, 1992; Joseph, 2011; Tedeschi & Calhoun, 1995). Avoidance employed as a psychological defence to keep awareness at bay and, repress emotions keep the individual in a fixed stagnant position and repeat past experiences and emulating pathologies (Herman, 1992; Lew, 1996; Morwood, 2002). There is a multitude of academic research and discussion amongst the mental health sector around trauma and PTSD which predominately concentrates on these negative attributes following a traumatic event (Amir, Stafford, Freshman, & Foe, 1998; Hackman, Ehlers, Speckens, & Clark, 2004; Halligan, Michael, Clark, & Ehlers, 2003). The reason is these distressed individuals are seeking treatment and the purpose and goal of health professionals is to relieve suffering and return functioning (See Figure 1.). Therefore what becomes figural are pathologies and diagnosis rather than encompassing the holistic persona[2] of the individual thus dismissing any opportunity for positive post trauma occurrences to be observed (Heller & LaPierre, 2012; Joseph, 2011; Joseph & Linley, 2005).

## Post Traumatic Growth

A recent focus in trauma literature is the acknowledgement of positive psychological changes in the aftermath of adversity and suffering. Posttraumatic growth (PTG) emphasizes the transformative qualities attributed to an individual that reconfigures their pre-trauma schema (Gwynn, 2008; Joseph, 2011; Tedeschi & Calhoun, 2004). Various terminology related to positive psychology (Seligman, 1999) over the past decades, encompass characteristics synonymous with transformation and change within individuals who have endured traumatic experiences; for example, positive changes in outlook (Joseph, Williams, & Yule, 1993), stress-related growth (Park, Cohen, & Murch, 1996), thriving (Abraido-Lanza, Guier, & Colon, 1998) and perceived benefits (McMillen & Fisher, 1998), as a result of trauma. Positive psychology makes figural the positive qualities and nourishing what is best within the person, rather than focusing exclusively on healing pathology (Seligman & Csikszentmihalyi, 2000). Researchers have gravitated towards the term Posttraumatic Growth (Keidar, 2013; Tedeschi & Calhoun, 2004; Woodward & Joseph, 2003) to describe a new perspective on psychotraumatology (Everly, 1993; Tedeschi & Calhoun, 2004). PTG more accurately demonstrates the breadth of the human experience and subsequent changes in the aftermath of trauma. Changes invoked include how a person perceives themselves, others and a global worldview, and how they relate to these paradigms in the here and now (Joseph, 2011; Taylor, 2014). Historically, the tradition of viewing human suffering as offering the origin of personal positive change was the theme of much philosophical inquiry. The most recited example is" That which does not kill me, makes me stronger" (Nietzsche, 1889 cited in Joseph, 2011, p.xii). This laid the foundation for future theorists and clinicians to explore the meaning of human travail (Caplan, 1964; Frankl, 1963; Maslow, 1970; Yalom and Lieberman, 1991) through humanistic lenses and consequently the elements for transformation change.

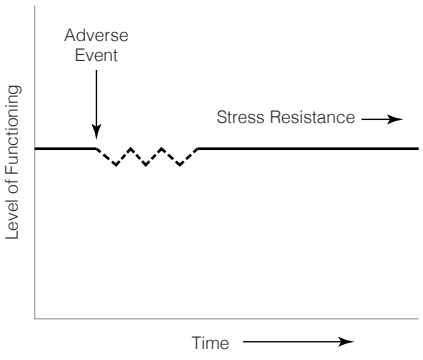
Posttraumatic Growth (PTG) is defined by the positive changes experienced and higher level of functioning which is exhibited (See Figure 2.), in the aftermath of trauma which was not previously attained (Tedeschi & Calhoun, 2004; Joseph & Butler, 2010; Lowe, Manove, & Rhodes, 2013). "The opportunity for psychological growth that would not be possible without the challenge of the traumatic event" (Tedeschi & Calhoun, 1995, p. 28).

PTG researchers emphasise that it is not the actual event but rather the struggle in the repercussion of trauma that is believed to lead to PTG (Joseph & Linley, 2005; Kilmer, 2006; Woodward & Joseph, 2003). These traumatic events propel an individual to reconfigure their assumptive beliefs about themselves, others, their relationships and the world at large after previously held philosophies have been shattered (Tedeschi & Calhoun, 2004). For this reconfiguration and growth to occur a certain amount of distress is imperative (Taleb, 2012).

In addition to automatic intrusive cognitive rumination (Kilmer & Gil-Rivas, 2010), that sustains distress therefore in sighting coping efforts including volitional rumination (Kilmer & Gil-Rivas, 2010). The narrative development associated assists the individual to reconcile the traumatic event and make meaning of their experiences (Joseph, 2011; Taylor, 2014; Tedeschi & Calhoun, 2006). It is from this platform that growth may occur over time due to the assimilation of their newly constructed reality, acceptance of current phenomenology (Beisser, 1970), in conjunction with psychosocial supports and philosophy of life change (Joseph, 2011; Meyerson, Grant, Carter, & Kilmer, 2011). The perceived positive changes reflected in the PTG literature over the past two decades such as Organismic Valuing Theory[3] (Joseph & Linley, 2005), and Posttraumatic Growth Theory (Tedeschi & Calhoun, 1995) are organised into several main domains. These include:

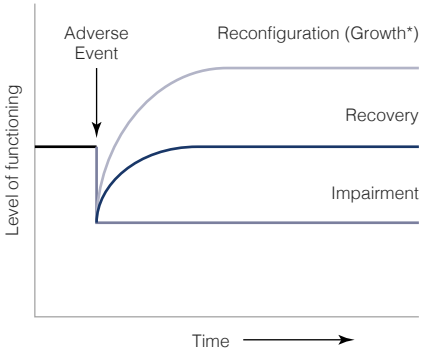
- Changes in self-perceptions which includes resilience and coping levels in

**Figure 1. Resistance to trauma**




Source: Butler (2010)

**Figure 2. Three trajectories of adjustment to adversity**




* Posttraumatic growth means going beyond previous levels of functioning.

Source: Adapted from O'Leary and Ickovics (1995)

3 Organismic Valuing Theory encompasses four theoretical principles. These centralise humans as being naturally growth-orientated active individuals, whom are inclined to completion tendency. Individuals know their own best direction for the pursuit of wellness, which include incorporating experiences for unification and to integrate into social contexts. This leads to new meanings and ways of relational connection, self-acceptance, and a deeper level of spirituality (Gwynn, 2008; Joseph & Linley, 2005)

order to survive;
- A greater sense of one's personal strength and capacity to endure;
- Changes in interpersonal relationships as seen by increased awareness of others plight and a greater sense of compassion:
- An increased ability to determine risk and trust polarities;
- An increased contact functions and better judgement in whom can be depended upon for support;
- A changed outlook on life, with modified priorities and values;
- A greater appreciation for life and their place in the universe; and,
- A spiritual awareness and deepening to existential life. (Joseph, 2011; Sheikh, 2008; Tedeschi & Calhoun, 2006).

These areas or domains where growth can be psychometrically measured, allowed for the inception of The Post-traumatic Growth Inventory (PTGI) in adult populations, to gather evidence for the existence of PTG to quantify growth changes in the aftermath of trauma (Tedeschi & Calhoun, 1995).

The term growth is often used explicitly to invoke the biological metaphor associated with the humanistic psychology frameworks. Growth arises through resolution of an adversarial tension between pre-existing assumptive worlds and the new trauma related information. Other interrelated terms such as benefit-finding (Helgeson, Reynolds, & Tomich, 2006), stress-related growth (Park, Cohen, & Murch, 1996), perceived benefits (McMillen & Fisher, 1998) and positive change (Joseph, Williams, & Yule, 1993) are often interchangeably used when discussing adjustments to an individual's state of being that demonstrates increased positive attributes (Tillier, 2012; O'Leary & Ickovics, 1995). However literature in the field of positive growth and in particular the area of posttraumatic growth studies, argues that different epistemological positions are represented by each term (Taylor, 2014; Tedeschi & Calhoun, 2006; Tillier, 2012). This means risking dilution of the transformational growth experienced by survivors of trauma into the realm of common strength based concepts and developmental growth that most individuals experience to a degree (Armeli, Gunthert & Cohen, 2001; Park & Folkman, 1997). This minimisation can conversely affect a person's ability to recognise the magnitude of their self-actualization, whilst diminishing the capacity for rejecting societal norms and accepting introjected globalised beliefs (Siegel & Schrimshaw, 2000; Taylor, 2014). "Self-functions, the means by which we manage our experience and interactions, are learned in relation to the developmental context in which we are growing" (Kepner, 1995, p.4).

Posttraumatic growth is related to and distinct from resilience. PTG emphasises the process of transformation, whilst resilience can be defined as a "dynamic developmental process reflecting evidence of positive adaptation despite significant life adversity" (Cicchetti, 2003, p.xx). The absence and/or reduction of psychopathology or else the progression in meeting developmental markers, signify the quality of resilience in relation to positive adaptation (Bonanno, 2004; Tedeschi & Calhoun, 2004; Westpha & Bonanno, 2007). Although resilience correlates to effective coping, its beginning point is the biopsychospiritual balance or homeostasis of one adapting body, mind and spirit to current life circumstances (Connor & Davidson, 2003). It is proposed that resilience is also determined by the influence of both successful and unsuccessful adaptations to previous disruptions of functioning (Bensimon,

2012). Furthermore, the time span to this disruption is a regenerative process that generally delivers outcomes situated in one of the following four arenas: Firstly, the disruption represents an opportunity for growth and increased resilience, whereby adaptation to the disruption leads to new, higher level of homeostasis; Secondly, a return to baseline homeostasis, in an effort to just get past or move beyond the disruption; Thirdly, recovery with loss, establishing a lower level of homeostasis; or fourthly, a dysfunctional state in which maladaptive strategies or creative adjustments are used to cope with stressors (Connor & Davidson, 2003). "Resilience hence is the measure of successful stress-coping ability" (Connor & Davidson, 2003, p.76).

Posttraumatic Growth can co-exist alongside negative or maladaptive experiences. However, PTG is viewed as "movement beyond pretrauma adaptation across various domains" within the human experience (Cryder, 2006, p.65-66). Posttraumatic growth also isn't indicative of positive adjustment, in the sense that distress, symptomology and general less emotional wellbeing simultaneously occurs within individuals reporting posttraumatic growth, than those exhibiting resilience (Calhoun & Tedeschi, 2006).

> If they are able to cope successfully with such rough times, they can cope with anything; that is their self-reliance is substantially elevated beyond what it was before the trauma, as a result of meeting the most difficult challenge they have faced. Everything after trauma is perceived as less difficult as a feeling of confidence and strength is often evoked (Tedeschi & Calhoun, 1995, p.31-32).

Posttraumatic growth dictates that some "individuals benefit from shocks; they thrive and grow when exposed to adversity, volatility, randomness, disorder, risk and uncertainty. Yet, in spite of the ubiquity of the phenomenon, there is no word for the exact opposite of fragile" (Taleb, 2012, p.1). The phrase antifragile (Taleb, 2012) and antifragility has been coined. "Antifragility is beyond resilience or robustness. The resilient resists shocks and stays the same; the antifragile gets better" (Taleb, 2012, p.3). Much like recovery meaning to come back to normal functioning after a traumatic event, thriving and antifragile determines growth beyond previous normal functioning (Hartman & Zimberoff, 2007; Hefferon, 2012; Taleb, 2012). The term antifragile and its associated meaning parallels much of the posttraumatic growth tenets by citing that complex systems inclusive of human beings are debilitated, even killed when deprived of stressors (Taleb, 2012). Our evolution as a species relies on organic volatility and stressors to evoke changes in accordance with our environment (Darwin, 2003, original text 1859). Antifragile distinguishes the boundary between what is inanimate and what is living (Taleb, 2012). It enables growth from randomness, uncertainty and chaos, by allowing the unknown to not inhibit our capacity "to do things without first understanding them and do them well" (Taleb, 2012, p.4). Similarly, like Posttraumatic Growth as a result of experiencing trauma which wasn't predestined or determined, an individual can still operate at a higher level without necessarily having drawn conclusions as to their entire experience (Cohen & Collens, 2013; Frankl, 1963; Hall, Thomas, Travis, Powell & Tennison, 2009). Fragility and antifragility are polarities on a spectrum (Taleb, 2012), much akin to disease and health, PTSD and PTG, whereby the negative attributes allow for greater understanding of the positive. Fragility and antifragility is measurable and detectable by utilizing an easy asymmetrical test: "Anything that has more upside than downside from random events or shocks is antifragile; the reverse is fragile" (Taleb, 2012, p. 5). The process of discovery often eventuates from a bottom-up rather than a top-down ethos, much like a plant growing up through the earth to reach the sun; 'under' the right amount of stress and disorder thriving can occur, if not blocked or 'fragilized' from a top-down approach

4 This relates to fear of uncertainty, risk mitigating tools designed to calculate hypothesis to promote safety and survival thus reducing chaos and anxiety. Taleb (2012) also describes this in detail calling it the 'Black Swan' problem. Commenting on anthropology to qualify human behaviour, current notions relating to quantum physics, chaos theory, and field theory are also incorporated.

5 Translation of the PTGI used in research studies include German (Maercker & Langner, 2001), Bosnian (Powell, Rosner, Butollo, Tedeschi & Calhoun, 2003), Hebrew (Lev-Wiesel & Amir, 2003), Chinese (Ho, Chan & Ho, 2004), Spanish (Weiss & Berger, 2006) and Japanese (PTGI-J, Taku, Calhoun, Tedeschi, Gil-Rivas, Kilmer & Cann, 2007).

(Taleb, 2012). An example of this would be an overprotective neurotic parent, or the expert clinician; those trying to help are often the individuals causing most harm.

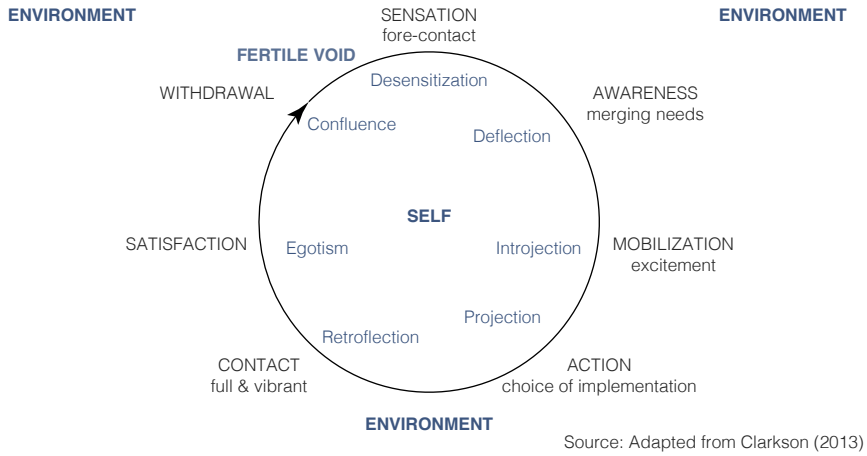
Unconsciously, "antifragility has been exploited in practical life, and consciously rejecting it – particularly in intellectual life"[4] (Taleb, 2012, p.9) . If "fragility is measurable, risk not so at all, particularly risk associated with rare events" (Taleb, 2012, p.8) then it seems experts in the field of trauma, concentrating on empirical studies and data analysis to determine an individual's growth trajectory (Joseph, 2011; Norton, 2007), would be bias towards certain therapeutic models if they cannot calculate risk and outcome measures (Beaumont, 2012; Woodward & Joseph, 2003), whereby missing opportunities to delve into unknown terrains within a therapeutic alliance (Joseph, 2011; Rossouw, 2012; Stratford, Lai & Meara, 2009).

The use of psychometric questionnaires to determine positive changes and growth following a traumatic event, has become imperative for scientific research and clinical studies in the growing positive psychology field, specifically trauma therapy (Tillier, 2012). The Post-traumatic Growth Inventory (PTGI- see Appendix 1 ) is a self-assessed 21 item inventory for adults surrounding the five domains of PTG; (1) Relating to others, (2) New Possibilities, (3) Personal Strength, (4) Spiritual Change and (5) Appreciation for Life (Tedeschi & Calhoun, 1995). Subsequently, a short form version of this assessment (SF-PTGI) with only 10 questions which comprise of two questions from each of the five domains, five in original form taken directly from PTGI, and five moderated (Cann, Calhoun, Tedeschi, Taku, Vishnevsky, Triplett & Danhauer, 2010). Additionally, few studies regarding PTG in children and adolescents have been conducted (Kilmer, 2006; Laufer, Hamama-Raz, Levine & Solomon, 2009; Yaskowich, 2003) using a modified version of the original PTGI known as PTGI-C-R (see Appendix 2 - Kilmer, Gil-Rivas, Tedeschi, Cann, Calhoun, & Buchanan, 2009).

Cross-cultural studies of PTG have been executed using translations of the PTGI[5]. Themes emerged surrounding perceived spiritual changes and appreciation of life, showed variance from one country or cultural group to another (Sheikh & Marotta, 2005), whereby considerations regarding education, socio-economic impacts, stages of life and type of traumatic event are factors (Taku et al., 2007). These studies demonstrate that PTG tenets are universal, as opposed to being a predominately western notion (McMillen, 2004). Research data in respect to PTG with adults have been mixed regarding gender and age differentials (Laufer & Solomon, 2006; Prati & Pietrantoni, 2009; Taku et al., 2007), however evidence citing that females exhibit higher degrees of PTG than males (Vishnevsky, Cann, Calhoun, Tedeschi & Demakis, 2010), and PTG scores rose as aged increased amongst the female population (Taku et al., 2007). Prior stress exposure and environmental influences also emerged showing that 'natural' causes such as birth, death, and physical health were associated with higher degrees of PTG, as opposed to events relating human intervention, such as relationship issues, sexual abuse or harassment, violence and maltreatment (Ickovics, Meade, Kershaw, Milan, Lewis & Ethier, 2006; Shakespeare-Finch & Armstrong, 2010). Questionnaire methods have been critiqued for failing to consider timing and severity of stressors relating to exposure of the event (Frazier, Gavian, Tomich & Tashiro, 2009; Grant & McMahon, 2008). Other self-reported psychometric tools (see Appendix 3-7) utilized for PTG research include:

- Changes in Outlook Questionnaire (CiOQ: Joseph, Williams, & Yule, 1993)
- Stress-Related Growth Scale (SRGS: Park, Cohen, & Murch, 1996)
- Perceived Benefit Scale (PBS: McMillen & Fisher, 1998)
- Thriving Scale (TS: Abraido-Lanza, Guier, & Colon, 1998)
- Psychological Well-being Post-Traumatic Changes Questionnaire (PWB-PTCQ: Joseph, Maltby, Wood, Stockton, Hunt, & Regel, 2012)
- Posttraumatic Growth is based on subjective or objective data (Keidar, 2013; Wortman, 2004).

Figure 3. Cycle of experience




Source: Adapted from Clarkson (2013)

Current literature surrounding the validity of PTG and its assessment methods are scrutinized, due to being heavily reliant upon the individuals' ability to determine how much change is attributed to the traumatic event itself (Boals & Schuettler, 2011; Coyne & Tennen, 2010; Wortman, 2004) and personal changes. The literature also suggests that people tend to "deprecate their past selves to enhance themselves in the present" (Tillier, 2012, p.15) and through illusory association either overestimate the magnitude of the relation or insinuate a relation when none exists (Coyne & Tennen, 2010; McMillen, Smith, & Fisher, 1997; Wortman, 2004). The meta-analysis of statistics obtained from administering PTG psychometric tools, showed emphasis of growth in relational interactions and attitudes (Kilmer, 2006; Joseph, 2011; Tedeschi & Calhoun, 2007), which have been correlated with biofeedback results in neuroscience (Cozolino, 2006; Rossouw, 2010).

Neuroscientific discoveries such as Polyvagal Theory (Porges, 1997), depicts a connection between cranial nerves and all our regulatory organs (Stauffer, 2010). The vagus nerve is the "only nerve to derive from this deep emotional brain" (Stauffer, 2010, p.51), an integral part in a person's contact functions (Taylor, 2014). The therapeutic alliance is a horizontal collaborative process whereby each is changed by the other as a result of the meeting (Jacobs & Hycner, 2009). Recent neuroscience confirms that during moments of successful high alliance (Cozolino, 2006), mirror neuron activity fires in more beneficial ways. This happens via feeling

states, opposed to thinking states (Rizzolatti & Sinigaglia, 2008; Rossouw, 2010), thus both client and therapists brains are altered (Linford & Arden, 2009). "Each of us secretly and desperately yearns to be met – to be recognised in our uniqueness, our fullness and our vulnerability" (Hycner & Jacobs, 1995, p.9).

Vulnerabilities within the confines of the therapy situation are present, and therapists need to adhere to ethical considerations when supporting people who have experienced traumatic events. Although individuals may be exhibiting growth in certain domains, often negative symptoms still co-exist and therapists need to acknowledge the impact of the trauma that is residing (Joseph, 2011; Keidar, 2013; Tedeschi & Calhoun, 2008). Therapists and researchers alike need to be mindful of clients inhibiting distress, in favour of positive experiences thus corrupting inherent needs and compromising their possibility for assimilation and healing (Lechner, Stoelb, & Antoni, 2008). Therapeutic inventions that support posttraumatic growth need to be morally and ethically appropriate in accordance to the recovery journey of the individual, in order to not create an atmosphere where all trauma survivors' are assumed to display Posttraumatic Growth attributes (Calhoun & Tedeschi, 2004; Gwynn, 2008; Joseph & Linley, 2005). "Rather than pushing the idea of growth, therapists must allow clients to notice it in their own time" (Joseph, 2011, p.149). This honours where the client presently is, for who they are. The transformation of relationships through emphasis on awareness and philosophy of life domains noted in PTG, paves way for humanistic therapeutic interventions such as Relational Gestalt Psychotherapy, to provide effective trauma therapy supported by neuroscience. The integration neurologically which occurs as a "result of bringing to conscious awareness the automatic, non-verbal and unconscious processes organised in the right hemisphere and subcortical neural networks, maximising awareness of all aspects of self that supports the process of integration" following trauma (Cozolino, 2002 cited in Taylor, 2014, p.12). Gestalt allows the full range of human experience following trauma including Posttraumatic Growth.

## Gestalt Therapy

Gestalt psychotherapy is well positioned to provide appropriate therapeutic support relating to Posttraumatic Growth. "Gestalt therapy values human potential; change and growth" (Taylor, 2014, p.23). Surviving traumatic events leads to figural changes and new gestalt formations (Bauer & Toman, 2003). Narrating of the original trauma through a phenomenological lens, aids clients in reorganising their pretrauma schemas (Taylor, 2014; Vidakovic, 2013). This allows new, realistic and consistent perspectives of self in process (Phillipson, 2012; Taylor, 2014) which supports posttraumatic growth.

Gestalt theory and methodology is situated within a humanistic existential paradigm (Brownell, 2010; Taylor, 2014; Yontef, 1993). Holistic in essence, as Gestalt literally means 'the whole is greater than the sum of its parts' (Perls, Hefferline, & Goodman, 1951). Gestalt is a model of growth, in that the organism is constantly moving toward integrated wholeness, whilst adapting to the environment in which it is inseparable (Bowman, 2005; Kirchner, 2000; Wollants, 2012). Gestalt theory focuses on the unique human being as part of a wider relational field (Lewin, 1952; Parlett, 2005; Wheeler & Axelsson, 2015). Orientated in present time and space (MacKewn, 2010), experiencing life through not only cognitive functioning, but also somatically and spirituality (Beaumont, 2012; Brownell, 2010; Haarburger, 2014). Gestalt therapy is set apart from other modalities, with a focus on how we as humans make meaning from our experiences, by noticing how things surface to awareness [phenomenology] and consequently the patterns we create from that information [relational themes] (Jacobs & Hycner, 2009). Gestalt therapy's core tenets are based upon an application of a number of theories including: Husserl's phenomenological method of enquiry (Bloom, 2009; Crocker, 2009; Spinelli, 2005); Lewin's field theory (Lewin, 1951; Parlett, 2005; Schultz, 2013); Buber's dialogical relationship (Buber, 1958; Hycner & Jacobs, 2009; Joyce & Sills, 2014); and experiential experiencing synonymous with Zinker (Brownell, 2010; O'Leary, 2013a; Zinker,1978). These tenets are derived from a combination of early psychology doctrines, philosophical teachings, eastern practices and universal field theories (Brownell, 2010; Levin & Levine, 2012; Yontef, 2002). "Specific to our theory is the notion that the self is midway between the organism and the environment and thus in a uniquely relational position" (Spagnuolo Lobb, 2005a, p.26).

Relational Gestalt therapy, emphasise

6 Four common curative factors in effectiveness of therapy are: expectancy (15%); common factors (30%); techniques (15%) and extra-therapeutic change (40%). Relationship factors include a combination of interpersonal style of the therapist, empathy, warmth, positive regard and the client alliance itself.

7 The figure is what stands out in awareness from the background. Ground refers to background, the whole context of the figure (Yontef, 2005).

8 The term unfinished business, is also known as the Zeigarnik effect in some early Gestalt literature (Mann, 2011). This is derived from early psychologist Bluma Zeigarnik [1901-1988] discussing intrusive thoughts that were once pursued and left incomplete, and the 'need' to complete in order to not feel dissonance.

9 The Gestalt cycle of experience is a model widely used to demonstrate styles of making contact between organism and environment. It divides the process into sub-processes of fore-contact, contact, final contact and post-contact (Mann, 2011). It is also called the awareness cycle, contact cycle, or Gestalt formation and deformation cycle (Wollants, 2012).

the therapeutic dyad as a crucible for effective trauma therapy (Cohen, 2003; Taylor, 2014; Wheeler & Axelsson, 2015). The mutuality and co-created nature of relational therapy invokes a dialogic attitude; the stance the therapist takes in support of presence, acceptance, confirmation and commitment to the process of relating (Jacobs, 1995; Mann, 2011). Evidence-based research on the effectiveness of psychotherapy, demonstrates that relationship factors account for 30% of the positive outcomes derived from four common curative factors[6] (Lambert & Barley, 2002). Therefore Gestalt methodologies focussing on dialogical relating, allows new figures to emerge for processing in relation to trauma, whilst simultaneously exploring the client-therapist relationship (Taylor, 2014). Literature depicts Gestalt therapy as being equal or more effective at reducing symptoms of psychopathology than other modalities (Gold & Zahm, 2008; Strumpfel, 2004). By exploring emotional awareness, expression and somatic experiencing, it's been shown more effective for clients, than other modalities without this component (Strumpfel, 2004).

Awareness raising in Gestalt therapy is via the method of phenomenological enquiry (Joyce & Sills, 2014). This psychological approach moves toward pure awareness, as opposed to mere concepts (Yontef, 2005). Awareness consists of sensory, affective and cognitive elements which include observing self and others (Yontef, 2005). Phenomenological awareness involves contacting, sensing, excitement, and Gestalt formation (Perls et al.,1951). Gestalt formation relates to figure/ground[7] process which is the "relational bridge" to what is meaningful for the client (Yontef, 2005, p.88). Through awareness of figure/ground, "people learn and improve, grow and integrate, broaden and deepen wisdom. With this wisdom, people can maximize their growth" (Yontef, 2005, p.90).

The therapeutic alliance acts as a vessel for growth (Sapriel, 2012; Taylor, 2014) and opportunity for completing unfinished business[8] (Mann, 2011) of past trauma(s) within the present, here-and-now of the therapy situation. An example of unfinished business in relation to Gestalt trauma therapy, asserts negative symptoms exhibited in PTSD would be "a special case of unfinished business" (Cohen, 2003, p.42-55). It is the repeated unsuccessful attempts at completion of the cycle of experience[9] (see Figure 3) process (Cohen, 2003; Taylor, 2014), which can enable fixed behaviours (fixed gestalts) to become intrinsic.

Criticisms in Gestalt literature of the cycle suggest idealise mechanical contact processes/disturbances, without adequately incorporating organism/environment dynamics in which field theory is based. Also without acknowledging therapeutic situational contact processes (Wheeler, 2015; Wollants, 2012) which show "growth as the aftermath of contact" (Perls, Hefferline & Goodman, 1951, p.421).

Field theoretical principles demonstrate the interrelatedness of all relevant experiences (Mann, 2011). The field refers to everything we are in contact with, the environment which it takes place and associated interactions with each other (Parlett, 2005). "No relevant dimension is excluded in basic theory" (Yontef, 1969, p. 33-34). The field is constantly being reconfigured according to the organisms' need, providing a context in which behaviour, patterns, styles of self-organisation, and relating can be explored (MacKewn, 2010; Wollants, 2012). "Everything in our phenomenal field becomes part of the matrix from which we co-create fields with others" (Parlett, 1991, p.78). Change and growth after trauma is therefore considered a dynamic of healthy reorganisation of self in response to different field conditions (Taylor, 2014).

The Paradoxical Theory of Change (Beisser, 1970), is a model which proposes that change occurs when a person acknowledges fully who they are, and what they experience in the present moment (Beisser, 1970). Thus providing conditions where wholeness and growth are generated (Yontef, 2005). This theory however is scrutinised due to lack of embodiment process in the client's experience (Kepner, 1995; Taylor, 2014; Yontef, 2005). Proposing preliminary change models[10]; Integrated Model of Change (Taylor, 2014) which incorporates stages of embodiment, and/or Healing Tasks Model (Kepner, 1995) be employed as a precursor to seminal Paradoxical Theory of Change theory within Gestalt therapy (Taylor, 2014). Experiments to raise phenomenological awareness of embodied states, aims to support and enhance the client's experience of self (Kepner, 2003).

Trauma clients readily hold unexpressed or incomplete experiences within the body (Ginger, 2007; Taylor, 2014). Experiments can be utilised to repeat, develop, exaggerate, enact or give words to gestures and body felt experiences (Zinker, 1978) which engages the client to explore them. The deconstruction of fixed beliefs, and exploration of polarities are bought into awareness inciting a platform for growth and development to occur (Kepner, 2003; O'Leary, 2013a). The therapist in designing experiments individualised for the client, needs balance between support and risk (Taylor, 2014; Zinker, 1978). "Sensitivity and careful attention on the therapist's part is essential so that the client are neither blasted into experience that are too threatening nor allowed to stay in safe but infertile territory" (Polster & Polster 1990, p. 104). Experiments provide fresh emotional experiencing, bringing possibilities for action into direct experience within the safety of the therapy session for creation of new meanings (Taylor, 2014; Zinker, 1978).

## Conclusion

The literature review encapsulates a balanced perspective of individuals experience following traumatic events. There is a plethora of literature pathologizing post trauma experiences, emphasising negative distress outcomes and mental health diagnoses. Positive transformational experiences do exist. Posttraumatic Growth studies commenced demonstrate the spectrum individuals embody, that are not exclusive to pathology, long term suffering and diminished self-actualization. Current medical model frameworks for therapeutic interventions surrounding trauma , shows distinct lack of awareness for possibilities of growth and transformation. The absence of guidelines depicting how a therapist can support growth is also non-existent. Traditional cognitive medical models for example do not appear to view people as unique whole human beings, with differing needs. Clearly, there is a need for another paradigm shift within the psychology realm, that more accurately reflects people's experiences and trained therapists who can support those experiences. The way Gestalt psychotherapists work seems inherent to PTG models, by fully encompassing all aspects of the human experience, within the here-and-now. Currently there is a dearth of literature specific to Gestalt trauma therapy, and notably the absence of literature regarding Posttraumatic Growth. Further research is warranted to demonstrate Gestalt methodologies effectiveness, in both individual and group therapeutic arenas, for working with trauma related disturbances, as well as supporting posttraumatic growth and transformation.

## REFERENCES


Abraido-Lanza, A.F., Guier, C., & Colon, R.M. (1998). Psychological thriving among Latinas with chronic illness. *Journal of Social Issues*, (54), 405-424.

American Psychiatric Association (2000). *Diagnostic and Statistical Manual of Mental Disorders*, (4th ed.) DSM-IV-TR®. Washington, DC: American Psychiatric Publishing.

American Psychiatric Association (2013). *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition: DSM-V-TR®. Washington, DC: American Psychiatric Publishing.

Amir, N., Stafford, J., Freshman, M.S., & Foe, E.B. (1998). Relationship between trauma narratives and trauma pathology. *Journal of Traumatic Stress*, (11), 385-392.

Armeli, S., Gunthert, K.C., & Cohen, L.H. (2001). Stressor appraisals, coping, and post-event outcomes: The dimensionality and antecedents of stress-related growth. *Journal of Social and Clinical Psychology*, 20(3), 366-395. doi: 10.1521/jscp.20.3.366.22304.

Bauer, A.L., & Toman, S. (2003). A gestalt perspective of crisis debriefing. *Gestalt Review*, 7(1), 56-71.

Beaumont, H. (2012). Toward a spiritual psychotherapy: Soul as a dimension of experience. Berkeley, CA: North Atlantic.

Beisser, A. (1970). The Paradoxical Theory of Change. In J. Fagan and I. L. Shepherd (Eds.), *Gestalt Therapy Now*, (pp.77-80). New York: Harper & Row.

Bensimon, M. (2012). Elaboration on the association between trauma, PTSD and posttraumatic growth: The role of trait resilience. *Journal of Personality and Individual Differences*, (52), 782-787.

Benstead, U. (2001). 'The Shark Cage': The use of metaphor with women who have experienced abuse'. *Psychotherapy in Australia*, 17(20), 70-76.

Bloom, D. (2009). The phenomenological method of gestalt therapy: Revisiting Husserl to discover the "essence" of gestalt therapy. *Gestalt Review*, 13(3), 277-295.

Boals, A., & Schuettler, D. (2010). A double edged sword: Event centrality, PTSD and posttraumatic growth. *Applied Cognitive Psychology*, 25(5), 817-822.

Bonanno, G. (2004). Loss, Trauma, and Human Resilience: Have we underestimated the human capacity to thrive after aversive events? *American Psychologist*, 59(1), 20-28.

Bowman, C.E. (2005). The history and development of gestalt therapy. In A.L. Woldt and S. Toman (Eds.), *Gestalt therapy: History, theory, and practice* (pp.3-21). Thousand Oaks, CA: Sage.

Briere, J., & Scott, C. (2006). Principles of trauma therapy: A guide to symptoms, evaluation and treatment. Los Angeles, CA: Sage.

Brownell, P. (2010). Gestalt therapy: A guide to contemporary practice. New York: Springer.

Buber, M. (1958). I and thou. New York: Charles Scribner's Sons.

Cann, A., Calhoun, L., Tedeschi, R., Kilmer, R., Gil-Rivas, V., Vishnevsky, T., & Danhauer, S. (2009). 'The core beliefs Inventory: A brief measure of disruption in the assumptive world.' *Anxiety, Stress & Coping*, 23(1), 19-34.

Caplan, G. (1964). Principles of preventative psychiatry. New York: Basic Books.

Cicchetti, D. (2003). Foreword. In S. Luthar (Ed.), Resilience and vulnerability: Adaptation in the context of childhood adversities (pp. xix-xxvii). New York: Cambridge University Press.

Clarkson, P., & Cavicchia, S. (2013). Gestalt counselling in action. London: Sage.

Cohen, A. (2003). Gestalt therapy and post-traumatic stress disorder: The irony and the challenge. *Gestalt Review*, 7(1), 42-55.

Cohen, K. & Collens, P. (2013). 'The impact of trauma work on trauma workers: A metasynthesis on vicarious trauma and vicarious posttraumatic growth.' Article in Psychological Trauma: Theory, *Research, Practice, and Policy*, 5(6), 570-580. American Psychological Association.

Coyne, J.C., & Tennen, H. (2010). Positive psychology in cancer care: Bad science, exaggerated claims, and unproven medicine. *Annals of Behavioral Medicine*, (39), 16-26. doi: 10.1007/s12160-009-9154-z.

Cozolino, L. (2002). The neuroscience of psychotherapy: Building and rebuilding the human brain. New York: Norton.

Cozolino, L. (2006). The neuroscience of human relationships: Attachment and the developing social brain. New York: Norton.

Crocker, S. (2009). Phenomenology in Husserl and gestalt therapy. *British Gestalt Journal*, 14(1), 56-59.

Cryder, C.H., Kilmer, R.P., Tedeschi, R.G., & Calhoun, L.G. (2006). An exploratory study of posttraumatic growth in children following natural disaster. *The American Journal of Orthopsychiatry*, (76), 65-69.

Darwin, C. (2003). Origin of species [original, 1859]. London, UK: Signet.

Erlanger, H. & Fothergill, N. (1998). 'From just coping to better living', in *Psychotherapy in Australia*, 4(2), 17-23.

Everly, G.S. (1993). Psychotraumatology: A two-factor formulation of posttraumatic stress. *Integrative Physiological and Behavioural Science*, 28(3), 270-278.

Frankl, V.E. (1963). Man's search for meaning: An introduction to logotherapy. New York: Pocket Books.

Frazier, P.T., Gavian, H., Tomich, C., & Tashiro, P.T. (2009). Does self-reported posttraumatic growth reflect genuine positive change? *Psychological Science*, 20(7), 912-919.

Garbarino, J., Kostelny, K., & Durow, N. (1991). What children can tell us about living in danger. *American Psychologist*, (46), 376-383.

Ginger, S. (2007). Gestalt therapy: The art of contact. London: Karnac.

Gold, E.K., & Zahm, S.G. (2008). The need for Gestalt therapy research. In P. Brownell (Ed.), *Handbook for theory, research and practice in Gestalt therapy*, (pp. 27-36). Newcastle, UK: Cambridge Scholars Publishing.

Grogan, M. (unknown). 'New Beginnings'. Article published in *Mindfood* magazine,16-18.

Gwynn, S.R. (2008). Adult attachment and posttraumatic growth in sexual assault survivors. Ann Arbor, MI: Proquest UMI Publishing.

Haarburger, N. (2014). In dialogue with Gabe Phillips on psychology and spirituality. *Gestalt Journal of Australia and New Zealand*, 11(1), 41-51.

Hackmann, A., Ehlers, A., Speckens, A., & Clark, D.M. (2004). Characteristics and content of intrusive memories in PTSD and their changes with treatment. *Journal of Traumatic Stress*, (17), 231-240.

Hagon, Z. (1998). 'Spirituality and trauma therapy' in *Psychotherapy in Australia*, 4(3), 26-30.

Hall, J., Roman, M., Thomas, S., Travis, C., Powell, J., & Tennison, C, et al,.(2009). 'Thriving as becoming resolute in narratives of women surviving childhood maltreatment.' Article in *American Journal of Orthopsychiatry*, 79(3), 375-386.

Halligan, S.L., Michael, T., Clark, D.M., Ehlers, A. (2003). Posttraumatic stress disorder following assault: The role of cognitive processing, trauma memory, and appraisals. *Journal of Consulting and Clinical Psychology*, (71), 419-431.

Hartman, D., & Zimberoff, D. (2007). Posttraumatic growth and thriving with heart-centered therapies. *Journal of Heart-Centered Therapies*, 10(1), 65-85.

Hefferon, K. (2012). Bringing back the body into positive psychology: The theory of corporeal posttraumatic growth in breast cancer survivorship. *Psychology*, 3(12A), 1238-1242.

Helgeson, V.S., Reynolds, K.A. & Tomich, P.L. (2006). A meta-analytic review of benefit finding and growth. *Journal of Consulting and Clinical Psychology*, (74), 797-816.

Heller,L.& LaPierre, A. (2012). Healing Developmental Trauma: How early trauma affects self-regulation, self-image, and the capacity for relationship. Berkeley, CA: North Atlantic Books.

Herbert, T.C., & Cohen, S. (1993). Stress and immunity in humans: A meta-analytic review. *Psychosomatic Medicine*, (55), 364-379.

Herman, J. (1992). *Trauma and recovery*. New York: Basic Books.

Ho, S.M.Y., Chan, C.L.W, & Ho, R.T.H. (2004). Posttraumatic growth in Chinese cancer survivors. *Psycho-oncology*, (13), 377-389.

Hycner, R., & Jacobs, L. (1995). The healing relationship in gestalt therapy: A dialogic/self psychology approach. Highland, NY: Gestalt Journal Press.

Hycner, R., & Jacobs, L. (2009). Relational approaches in gestalt therapy. Santa Cruz, CA: Gestalt Press.

Ickovics, J.R., Meade, C.S., Kershaw, T.S., Milan, S., Lewis, J.B., & Ethier, K.A. (2006). Urban teens: Trauma, posttraumatic growth, and

emotional distress among female adolescents. *Journal of Consulting and Clinical Psychology*, (74), 841-850.

Jacobs, L. (1995). Dialogue in gestalt theory and therapy. In R. Hycner and L. Jacobs (Eds.), *The healing relationship in gestalt therapy: A dialogic/self psychology approach*, (pp.51-84). Highland, NY: The Gestalt Journal Press.

Jacobs, L., & Hycner, R. (2009). Relational approaches in Gestalt therapy. Santa Cruz, CA: Gestalt Press.

Joseph, S. & Linley, P.A. (2005). Growth following adversity: Theoretical perspectives and implications for clinical practice. *Clinical Psychology Review*, (26), 1041-1053.

Joseph, S, & Butler, L.D. (2010). Positive changes following adversity. *PTSD Research Quarterly*, 21(3), 1-3.

Joseph, S., Maltby, J., Wood, A.M., Stockton, H., & Hunt, N. (2011). The psychological well-being posttraumatic changes questionnaire (pwb-ptcq): *Reliability and validity. Psychological Trauma: Theory, Research, Practice, and Policy*, 4(4), 420-428. doi: 10.1037/a0024740.

Joseph, S. (2011). What doesn't kill us: The new psychology of post traumatic growth. New York, NY: Basic Books.

Joseph, S., Williams, R., & Yule, W. (1995). Psychosocial perspectives on post-traumatic stress. *Clinical Review*, 15(6), 515-544.

Joseph, S., Williams, R., & Yule, W. (1993). Changes in outlook following disaster: The preliminary development of a measure to assess positive and negative responses. *Journal of Traumatic Stress*, (6), 271-279.

Joyce, P., & Sills, C. (2014). Skills in gestalt counselling and psychotherapy. London: Sage.

Kashdan, T. & Kane, J. (2011). 'Post-traumatic distress and the presence of post-traumatic growth and meaning in life: Experiential avoidance as a moderator.' Published in *Journal of Personality and Individual Differences*, (50), 84-89. George Mason University, Fairfax, VA. Elsevier.

Keidar, M. (2013). Conceptualization of posttraumatic growth in the work of expert trauma therapists. A thesis. Unpublished manuscript. University of Washington.

Kepner, J. (1995). Healing Tasks: Psychotherapy with adult survivors of childhood abuse. San Franciso, CA: Jossey-Bass.

Kepner, J. (2003). The Embodied Field. *British Gestalt Journal*, 12(1), 6-14.

Kilmer, R. (2006). Resilience and posttraumatic growth in children. In L.G. Calhoun, & R.G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 264-288). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Kilmer, R., & Gil-Rivas, V. (2010). Exploring posttraumatic growth in children impacted by hurricane Katrina: Correlates of the phenomenon and developmental considerations. *Child Development*, (81), 1211-1227.

Kirchner, M. (2000). Gestalt therapy theory: An overview. *Gestalt!* 4(3). Retrieved 17th March, 2015 from http://www.g-gej.org/4-3/theoryoverview.html

Lambert, M.J., & Barley, D.E. (2002). Research summary on the therapeutic relationship and psychotherapy outcome. In J.C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*, (pp.16-32). New York: Oxford University Press.

Larner, B., & Blow, A. (2011). 'A model of meaning-making coping and growth in combat veterans'. Article in *Review of General Psychology*, 15(3), 187-197.

Laufer, A., & Solomon, Z. (2006). Posttraumatic symptoms and posttraumatic growth among Israeli youth exposed to terror incidents. *Journal of Social and Clinical Psychology*, (25), 429-447.

Levin, J., & Bar-Yoseph Levine, T. (2012). Gestalt in the new age. In T. Bar-Yoseph Levine (Ed.), *Gestalt therapy: Advances in theory and practice*, (pp.1-12). London: Routledge.

Levine, P.A. (1997). Waking the Tiger: Healing Trauma. Berkeley, CA: North Atlantic Books.

Levine, P.A. (2010). In an Unspoken Voice: How the body releases trauma and restores goodness. Berkeley, CA: North Atlantic Books.

Lev-Wiesel, R., & Amir, M. (2003). Posttraumatic growth among holocaust child survivors. *Journal of Loss and Trauma*, (8), 229-237.

Lew, M. (1996). 'Men in recovery from sexual child abuse: Obstacles and triumphs' in *Psychotherapy in Australia*, 2(2), 39-44.

Lewin, K. (1951). Field theory in social science: Selected theoretical papers. New York: Harper.

Lowe, S.R., Manove, E.E., & Rhodes, J.E. (2013). Posttraumatic stress and posttraumatic growth among low-income mothers who survived hurricane Katrina. *Journal of Consulting and Clinical Psychology*, 81(5), 872-889.

MacKewn, J. (1997). Developing gestalt counselling. London: Sage Publications Ltd.

Maercker, A., & Langner, R. (2001). Posttraumatic personal growth: Validation of German versions of two questionnaires [written in German with English abstract]. Diagnostica, (47), 153-162.

Mann, D. (2011). *Gestalt Therapy: 100 Key points and techniques*. (2nd Ed.). London: Routledge.

Maslow, A. (1970). Motivation and personality (Rev. ed.). New York: Harper & Row.

McIndoe, R. (2006). 'Mindful psychotherapy for pain and trauma: Learning to stay with experience' in *Psychotherapy in Australia*, 13(1), 38-44.

McMillen, J.C., Smith, E.M., & Fisher, R.H. (1997). Perceived benefit and mental health after three types of disaster. *Journal of Consulting and Clinical Psychology*, 65(5), 733-739. doi: 10.1037/0022-006X.65.5.733.

McMillen, J.C., & Fisher, R.H. (1998). The perceived benefit scales: Measuring perceived positive life changes after negative events. *Social Work Research*, (22), 173-187.

McMillen, J.C. (2004). Posttraumatic Growth: What's it all about? *Psychological Inquiry*, (15), 48-52.

Mental Health Coordinating Council. (2007). Trauma recovery and empowerment model. Retrieved on 20th June, 2015 from www.mhcc.org.au/sector-development/recovery-and-practice-appoaches/ticp-articles-and-papers.aspx.

Meyerson, D., Grant, K., Carter,J., & Kilmer, R. (2011). 'Posttraumatic growth among children and adolescents: A systemic review'. Article in Clinical *Psychological Review*, 31(1), 949-964.

Moore, M. (2012). 'Posttraumatic Growth: Positive changes in the aftermath of crisis.' Article retrieved on 26th November 2013, http://www.posttraumaticgrowth.com/what-is-ptg/

Morwood, S. (2002). 'Sneaking up on traumatic memory: The use of creative metaphors with child sexual assault'. *Article in Psychotherapy in Australia*, 8(4), 40-44.

Nietzsche, F. (1889). Twlight of the idols. In S. Joseph, What doesn't kill us: *The new psychology of post traumatic growth*, (pp.ix) New York, NY: Basic Books.

Norton, J. (2007). Putting the brakes on the influence of neuroscience on psychotherapy. *Psychotherapy in Australia*, 13(3), 60-65.

Nuttman-Shwartz, O., Dekel, R., & Tuval-Mashiach. (2011). 'Post-traumatic stress and growth following forced relocation.' Article in *British Journal of Social Work*, (41), 489-501. Oxford University Press.

Ogden, P., Minton, K., & Pain, C. (2006). Trauma and the Body: A Sensorimotor Approach to Psychotherapy. New York: Norton.

O'Leary, E. (2013a). Ley concepts of gestalt therapy and processing. In E. O'Leary (Ed.), *Gestalt therapy around the world*, (pp. 15-36). Oxford: Wiley & Sons.

O'Leary, V.E., & Ickovics, J.R. (1995). Resilience and thriving in response to challenge: An opportunity for a paradigm shift in women's health. *Women's Health: Research on Gender, Behaviour, and Policy*, (1), 121-142.

Paivio, S.,& Pascual-Leone, A. (2010). *Emotion-Focused Therapy for Complex Trauma: An integrative approach.* Washington, DC : American Psychological Association.

Park, C. L., Cohen, L. H., & Murch, R. (1996). Assessment and prediction of stress related growth. *Journal of Personality*, 64(1), 71-105.

Park, C.L., & Folkman, S. (1997). Meaning in the context of stress and coping. *Review of General Psychology*, (1), 115-144.

Parlett, M. (1991). Reflections on field theory. *British Gestalt Journal*, 1(2), 69-81.

Parlett, M. (2005). Contemporary gestalt therapy: Field theory. In A. Woldt and S. Toman (Eds.), *Gestalt therapy: History, theory and practice* (pp. 41-64). Thousand Oaks: CA: Sage.

Perls, F., Hefferline, R.F., & Goodman, P. (1951). *Gestalt therapy: Excitement and growth in the human personality.* London: Souvenir Press.

Philipson, P. (2012). Mind and matter: The implications of neuroscience research for gestalt psychotherapy. In T. Bar-Yoseph Levine (Ed.), *Gestalt therapy advances in theory and practice* (pp. 84-92). East Sussex: Routledge.

Polster, M., & Polster, E. (1990). Gestalt therapy. In J.K. Zeig, & W.M. Munion (Eds.), *What is psychotherapy? Contemporary perspectives* (pp.103-107). San Francisco: Jossey-Bass.

Porges, S. (1997). Emotion: An evolutionary by-product of the neural regulation of the automatic nervous system. *Annals of the New York Academy of Sciences*, 807: 62-77. doi:10.1111/j.1749-6632.1997.tb51913.x.

Powell, S., Rosner, R., Butollo, W., Tedeschi, R., & Calhoun, L. (2003). 'Posttraumatic growth after war: A study with former refugees and displaced people in Sarajevo'. Article in *Journal of Clinical Psychology*, 59(1), 71-83.

Prati, G., & Pietrantoni, L. (2009). Optimism, social support and coping strategies as factors contributing to posttraumatic growth: A meta-analysis. *Journal of Loss and Trauma*, (14), 364-388.

Rizzolatti,G., & Sinigaglia, C. (2008). Mirrors in the brain: How our minds share actions and emotions. England: Oxford University Press.

Rothschild, B. (2002). The Body Remembers: The psychophysiology of trauma and trauma treatment. New York: Wiley.

Rossouw, P. (2010). The world as one: The neuroscience of interconnectedness. Retrieved 17 March, 2013 from The Neuropsychotherapist Website : www.neuropsychotherapist.com/wp-content/uploads/2013/01/World-As-One.pdf

Rossouw, P. (2012). Engaging in therapy and history taking: Right brain to right brain communication. Retrieved 17 March, 2013 from The Neuropsychotherapist Website : www.neuropsychotherapist.com/wp-content/uploads/2012/11/ANPT_17.pdf

Sapriel, L. (2012). Creating an embodied, authentic self: Integrating mindfulness with psychotherapy when working with trauma. In T. Bar-Yoseph Levine (Ed.), *Gestalt therapy: Advances in theory and practice*, (pp. 107-122). New York: Routledge.

Schaefer, F., Blazer, D., & Koenig, H. (2008). 'Religious and spiritual factors and the consequences of trauma: A review and model of the interrelationship.' Article in *International Journal of Psychiatry in Medicine*, 38(4), 507-524.

Schultz, F. (2013). In dialogue with roots and shoots of gestalt therapy field theory: Historical and theoretical developments. *Gestalt Journal of Australia and New Zealand*, 10(1), 24-47.

Seligman, M.E. (1999). The president's address. *American Psychologist*, (54), 559-562.

Seligman, M.E., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist*, (55)1, 5-14.

Shakespeare-Finch, J., & Armstrong, D. (2010). Trauma type and posttrauma outcomes: Differences between survivors of motor vehicle accidents, sexual assault, and bereavement. *Journal of Loss and Trauma*, (15), 69-82.

Sheikh, A.I. (2008). Theory and practice: Posttraumatic growth in survivors. *Counselling Psychology Quarterly*, 21(1), 85-97. doi:10.1080/09515070801896186.

Sheikh, A.I., & Marotta, S.A. (2005). A cross-validation study of the Posttraumatic growth inventory. *Measurement and Evaluation in Counselling and Development*, (38), 66-77.

Siegel, K., & Schrimshaw, E.W. (2000). Perceiving benefits in adversity: Stress related growth in women living with HIV/AIDS. *Social Science and Medicine*, 51(10), 1543-1554.

Smidt, S. (2013). 'How does a woman's attachment style influence posttraumatic growth following betrayal? A literature review.' Unpublished manuscript. Adler Graduate School.

Spagnuolo Lobb, M. (2005a). Classical gestalt theory. In A.L. Woldt & S. Toman (Eds.), *Gestalt therapy: History, theory and practice*, (pp.21-39). Thousand Oaks, CA: Sage.

Spiegel, D. (1997). Trauma, dissociation and memory. *Annals of New York Academy of Sciences*, (821), 225-237.

Spinelli, E. (2005). The interpreted world: An introduction to phenomenological psychology. London: Sage.

Stauffer, K.A.(2010). Anatomy and physiology for psychotherapists: *Connecting body and soul*. New York: Norton.

Stratford,T., Lai, S., & Meara, A. (2009). Neurophysiology of the therapeutic alliance. *Gestalt Journal of Australia and New Zealand*, 5(2), 19-47.

Strumpfel, U. (2004). Research on Gestalt therapy. *International Gestalt Journal*, 27(1), 9-54.

Taku, K., Calhoun, L., Tedeschi, R., Gil-Rivas, V., Kilmer, P., & Cann, A. (2007). Examining posttraumatic growth among Japanese university students. *Anxiety,Stress & Coping*, 20(4), 353-367.

Taleb, N.N. (2012). Antifragile: Things that gain from disorder. New York. NY: Penguin.

Taylor, M. (2014). Trauma therapy and clinical practice: neuroscience, gestalt and the body. Berkshire. England: Open University Press.

Tedeschi, R.G., & Calhoun, L.G. (1995). Trauma & transformation: growing in the aftermath of suffering. California: Sage Publications.

Tedeschi, R.G., & Calhoun, L.G. (2004a). A clinical approach to posttraumatic growth. In P.A. Linley & S. Joseph (Eds.), *Positive psychology in practice* (pp.405-419). Hoboken, NJ: Wiley.

Tedeschi, R.G., & Calhoun, L.G. (2004b). Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry*, 15(1), 1-18.

Tedeschi, R.G., & Calhoun, L.G. (2004c). Posttraumatic growth: A new perspective on psychotraumatology. *Psychiatric Time*, 21(4), 1-4.

Tedeschi, R.G., & Calhoun, L.G. (2006). The posttraumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, 9(3), 455-471. doi: 101002/jts.2490090305.

Tedeschi, R.G., & Calhoun, L.G. (2007). Evaluating resource gain: Understanding and misunderstanding posttraumatic growth. *Applied Psychology*, 56(3), 396-406.

Tedeschi, R., & Calhoun, L. (2008). Beyond the concept of recovery: Growth and the experience of loss. Death Studies, (32), 27-39.

Tillier, W.D. (2012). Posttraumatic growth bibliography. Article Retrieved on 26th November, 2013, www.positivedisintegration.com/ptg

Todd, B. (2007). Assisting the traumatised: Vicarious traumatisation and the preservation of meaning. *Psychotherapy in Australia*,13(3), 44-49.

Van der Kolk, B.A (1994). The body keeps the score. *Harvard Review of Psychiatry,* (1), 253-265.

Van der Kolk, B., McFarlane, A.C., & Weisaeth, L. (1996). Traumatic stress: The effects of overwhelming experience on mind, body and society. New York: Guilford.

Vidakovic, I. (2013). 'The power of "moving on": A Gestalt therapy approach to trauma treatment. In G. Francesetti, M. Gecele and J. Roubal (Eds.), Gestalt Therapy in Clinical Practice: From psychopathology to the aesthetics of contact (pp.317-329). Milano, Italy: FrancoAngeli.

Vishnevsky, T., Cann, A., Calhoun, L.G., Tedeschi, R.G., & Demakis, G.J. (2010). Gender differences in self-reported posttraumatic growth: A meta-analysis. *Psychology of Women Quarterly*, (34), 110-120.

Wadey, R., Clark, S., Podlog, L., & McCullough, D. (2013). Coaches' perceptions of athletes' stress-related growth following sport injury. *Psychology of Sport and Exercise*, (14), 125-135.

Weiss, T., & Berger, R. (2006). Reliability and validity of a Spanish version of the Posttraumatic growth inventory. *Research on Social Work Practice*, (16), 191-199.

Westphal, M., & Bonanno, G.A. (2007). Posttraumatic growth and resilience to trauma: Different sides of the same coin or different coins? *Applied Psychology*, 56(3), 417-427. doi:10.1111/j.1464-0597.2007.00298.x

Wheeler, G., & Axelsson, L. (2015). Gestalt therapy. Washington, DC: American Psychological Association.

Wollants, G. (2012). Gestalt therapy: Therapy of the situation. Thousand Oaks, CA: Sage.

Woodward, C., & Joseph, S. (2003). Positive change processes and posttraumatic growth in people who have experienced childhood abuse: Understanding vehicles of change. *Psychology and Psychotherapy: Theory, Research and Practice*, (76), 267-283.

Wortman, C.B. (2004). Posttraumatic growth: Progress and problems. Psychological Inquiry, 15(1), 81-90.

Yalom, I.D., & Lieberman, M.A. (1991). Bereavement and heightened existential awareness. *Psychiatry*, 54(4), 334-345.

Yontef, G.M. (1993). Awareness, dialogue and process: Essays on gestalt therapy. Highland, NY: Gestalt Journal Press.

Yontef, G.M. (2002). The relational attitude in gestalt theory and practice. *International Gestalt Journal*, 25(1), 15-34.

Yontef, G. (2005). Gestalt therapy theory of change. In A.L. Woldt & S. Toman (Eds.), *Gestalt therapy: History, theory and practice*, (pp.81-100). London: Sage.

Zinker, J. (1978). Creative process in gestalt therapy. New York: Vintage Books.

Zoellner, T. & Maercker, A. (2006). 'Post-traumatic growth in clinical psychology: A critical review and introduction of a two component model.' Article in *Clinical Psychology Review*, (26), 626-653. Elsevier.

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# The Impact of Female Child Sexual Abuse on Adult Sexual Intimate Relationships

*By Helena Green*

It is generally well accepted that a history of child sexual abuse/assault (CSA), is damaging to a fulfilling adult relationship. However, it wasn't until the 1960's that CSA of girls by males or females was openly discussed (Hartlein, Weeks, Gambescia, 2009), at which time the issue of male CSA came more to light.

The purpose of this paper is to look at the potential consequences of female childhood sexual abuse on adult sexual intimacy and sexual function. The paper will not specifically examine different types of CSA per se; instead, it will highlight from research, the current views, some statistical information and understandings of what CSA is, and the potential long term sequelae of CSA on adult female sexuality. The paper will then outline two psychotherapeutic models of intervention to assist clients who present with sexuality and intimacy issues as a consequence of CSA.

## Definition

Child sexual assault by definition, is the sexual assault of a child; in our society a child is legally defined as anyone under the age of 16 years. Brick (2005) highlights that CSA has been defined in a variety of ways, incorporating 'overt' abuse, the direct physical abuse, or sexual contact, and 'covert' abuse, referring to non-physical non- contact abuse, such as sexual comments to a child.

Another method of defining CSA is with the use of an Offence-Based Definition: In general terms this is a physical act of a sexual nature towards another person without their consent, and may range from unwanted touching to sexual penetration without consent, including attempts (adapted from Australian Bureau of Statistics, Sexual Assault in Australia: A Statistical Overview, 2004). While general sexual assault occurs when the victim does not provide consent, it should be noted that from a legal perspective, any person under the age of 16 cannot give consent to sexual contact with a person over the age of 16. It is determined by law that the child in this case cannot provide 'informed consent' to sexual contact. While not the place of this paper to examine the issue further, it is also noted that CSA can occur when both the offender and the victim are under the age of 16.

## Prevalence

According to Briere and Scott, (2006), up to 70% of females in treatment for mental health issues, if asked, self-disclose a history of CSA. Determining the specific prevalence of CSA in our community is difficult, with the numbers reported thought to be an underestimate because of a number of factors. However, according to Bravehearts, Child Sexual Assault: Facts and Statistics (2012, p.5): "research over the past decade has provided us with an indication of the prevalence and effect of CSA", with such occurrence being one in three females, (and one in six males), before the age of 18 years in Australia.

## General Impact of CSA

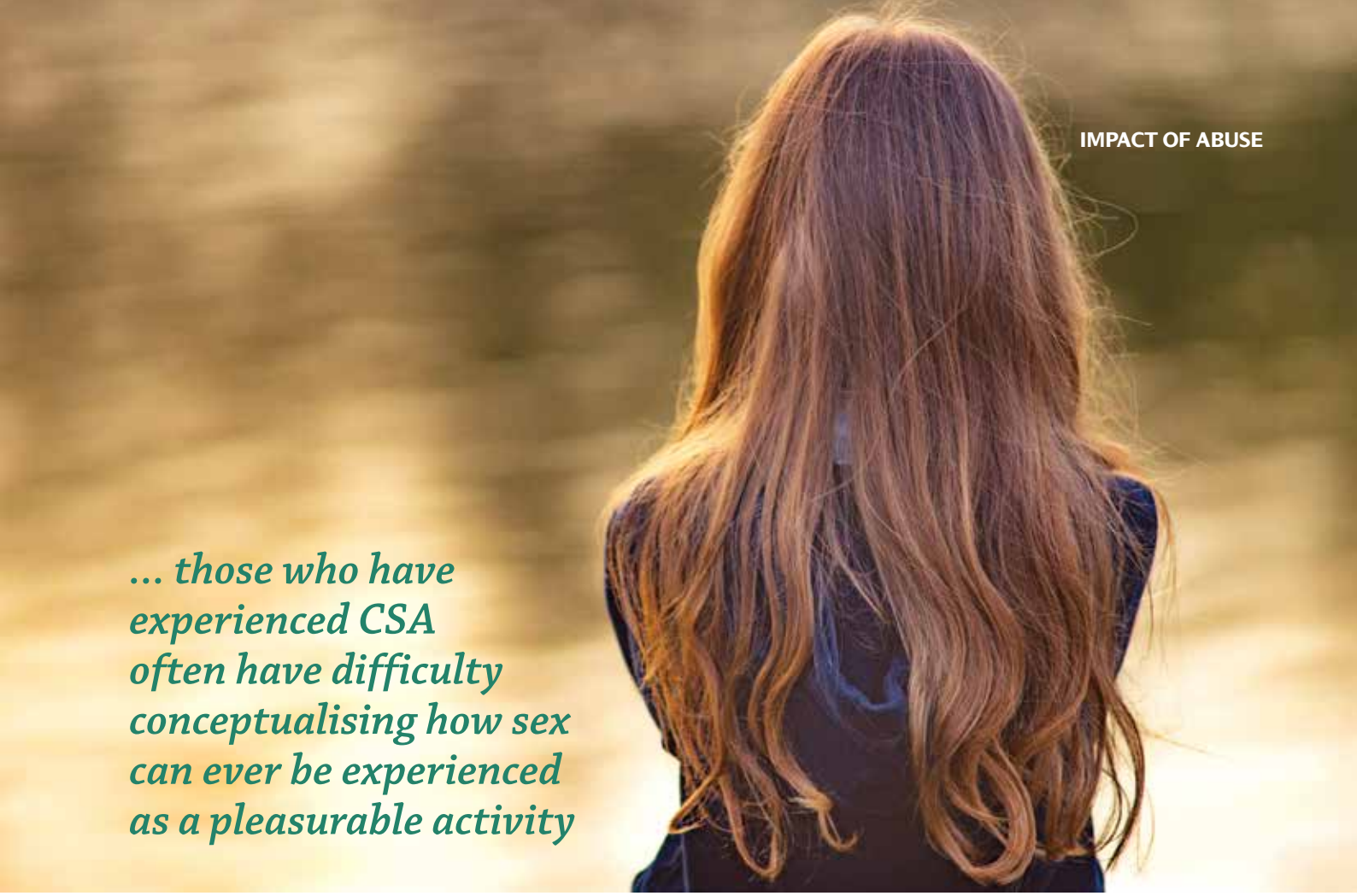
Research commencing in the 1980's, reveals the potential serious long-term impact of childhood sexual abuse. However, even given the increase in community awareness, there still remains a general lack of open discussion of CSA and of the potential consequences of such abuse (Leonard, Iverson & Follette, 2008; Najman, Dunne, Purdie, Boyle & Coxeter, 2005; Noll, Trickett & Putnam, 2003; Zollman, Rellini & Desrocher, 2013). Perhaps a part of this difficulty might be traced to our current culture in which there is an inclination to glamorise sexuality via the internet, 'reality' television series and movies. It is suggested that this trivialising of sex and sexual behaviour does little to model a 'healthy sexual relationship', especially for those who have experienced early sexual trauma (Keinplatz, 2012).

There is growing evidence in the literature that suggests that adults with a history of CSA are at potential risk of developing an insecure attachment style, depression and difficulty with conflict resolution (Brick, 2005; Dominguez, Nelke & Perry 2006; Bloom, 2013; Hughes, Johnson, Wilsnack & Szalacha, 2007; Littleton, Breitkopf & Berenson, 2007). Women who experienced incest (intrafamilial sexual abuse), later as adults, experienced psychological problems, as well as difficulty enduring healthy relationships with their family members, partner, children and friends (Brick, 2005; Bloom, 2013; Littleton, Breitkopf & Berenson, 2007; Zala, 2012; Senn, Carey & Coury- Doniger, 2011).

It has also been found that there is a significant detrimental effect on general self- esteem, with individuals displaying considerable self-doubt and lack of self-worth in making discriminating positive choices to care for oneself (Brick 2005; Bloom, 2013). One of the psychosomatic consequences of CSA is that over 50% of children met at least partially, the criteria for Post-traumatic Stress Disorder (PTSD) (Dominguez, Nelke & Perry 2001). This is a psychological disorder that occurs when the individual has experienced a near death event or, more relevant here, one or more events in which they have felt extreme powerlessness (Dominguez, Nelke & Perry 2001). Dominguez, Nelke & Perry (2001) even suggest that females were twice as likely to commit suicide as non-abused controls.

## Impact of CSA on Sexual Intimacy

Women with a history of CSA frequently have problems with sexual desire, sexual functioning, romantic attachment and overall sexual and intimacy satisfaction, with higher levels of psychological and physical distress related to sexual function and intimacy, (Stephenson, Hughan, &



*... those who have experienced CSA often have difficulty conceptualising how sex can ever be experienced as a pleasurable activity*

Meston, 2012). Although there is a paucity of research in the area of CSA specifically on sexual arousal, empirical studies on mood and anxiety disorders have found strong evidence that self-schemas play a vital role in developing and maintaining sexual dysfunction and discontent (Rellini & Meston, 2010). It is noted that women who have been sexually abused as children are likely to have strong such negative self-beliefs, and this will often cause difficulty experiencing and or recognizing sexual desire or cues as adults (Brotto, Seal & Rellini, 2012).

In addition, those who have experienced CSA often have difficulty conceptualising how sex can ever be experienced as a pleasurable activity (Noll, Trickett & Putnam, 2003; Maltz, 2012) suggest that the following are just a few of the common sexual issues/concerns to these individual:

- Avoidance and anxiety about sex
- Adverse emotional reactions when being touched (fear, guilt, revulsion or physical symptoms such as nausea)
- Post-traumatic Stress Disorder (PTSD)
- Compulsive or inappropriate sexual behaviours (over sexualisation)
- Difficulty establishing sustain intimate health relationship/s
- Specific sexual functioning difficulties, including lack of orgasm, genital and pelvic pain-dyspareunia, vaginismus (adapted from Wendy Maltz 'Healing the Sexual Repercussions of Sexual Abuse', 2012).

Researchers concur that these women will experience less sexual satisfaction. Among women examined in the United States, the most common sexual functioning complications include low desire for sex (64%), difficulties with orgasm (35%) and arousal (31%) and sexual pain-pelvic pain (26%) (Stephenson, Hughan, & Meston 2012; Najman, Dunne, Purdie, Boyle & Coxeter, 2005). This research strongly supports the studies by Bageley and Ramsay (1986) and Briere and Runtz (2012), of a direct relationship between CSA and adult female sexual problems. This has also been found to include psychological distress and difficulty maintaining intimacy and trust, even if there is not physical distress with their sexual functioning (Marendaz & Wood, 1999; Stephenson, Hughan, & Meston 2012).

It should be noted that an experience of CSA does not automatically lead to adverse psychosexual sequelae. The short-term and long-term impact of CSA is variable and at times unpredictable. For example, research suggests that even though 80% of women report a range of negative outcomes in their life, less than half of them accredited these to their history of sexual abuse (Najman, Dunne, Purdie, Boyle & Coxeter, 2005; Walsh, Fortier & DiLillo, 2009; Noll, Trickett & Putnam, 2003).

There have been several models created to help conceptualise and explain the negative sequelae of CSA. One of the most known in the area of child sexual abuse, is the Traumagenic Dynamics (TD) model of Child sexual abuse by Finkelhor & Browne (1985) (South Eastern CASA; Collin-Vezina, Daigeault & Hebert, 2013; Walsh, Fortier & DiLillo, 2010). Even though the well-established Post-traumatic Stress Disorder (PTSD) approach has been vital in advancing understanding of the psychopathology of CSA, (www.secasa.com.au; Collin-Vezina, Daigeault, & Hebert, 2013), the TD model appears to be more inclusive of symptoms and effects of the potential abuse and fluid when assessing the impact of CSA. This conceptual model of CSA suggests that the impact of CSA results in ones worldview being turned 'upside down', thus resulting in: "An experience that alters a child's cognitive or emotional orientation to the world and causes trauma by distorting the child's self-concept, worldview, or affective capacities" (Walsh, Fortier & DiLillo, 2010, p3). The model suggests that these distortions give rise to four unhelpful thinking paradigms that can play throughout their lives:

Traumatic sexualisation: This paradigm

involves the use of secondary gains and rewards by the abuser for improper sexual behaviour. As a result of the rewards the child may adopt sexual behaviour in order to manipulate others as a means to an end.

Stigmatisation: Focussing on the received negative messages operating in the abuse experience, such as iniquity, worthlessness, shamefulness and guilt, which are overtly or covertly communicated during the abuse by the abuser as a way of blaming or attributing negative labels to the child. If there is disclosure, then moral judgments about the deviancy of their experiences may be communicated by family members, relatives or professionals.

Betrayal: This breach of trust depends on how much the child feels betrayed, not just as a result of the closeness of the relationship. Betrayal is likely to be greater when the relationship was initially loving and nurturing, than if there was mistrust from the beginning.

Powerlessness: Consisting of (i) Continued overruling and frustration of desires and wishes, along with a reduced sense of productivity, and (ii) The threat of injury and total destruction leading to disempowerment. Central core to this theme is the invasion of one's body through threat and deceit, (adapted from Finkelhor & Browne, 1985).

The TD model is useful for clinicians working with individuals with a history of CSA as it captures CSA as a process (multilayered) not just as an event as the PTSD formulation might do. As such, the implication for counselling intervention is that it can allow for targeting specific interventions to meet the individual needs; for example, the needs of someone presenting with promiscuity-like behaviour could be addressed by referring to the paradigm of traumatic sexualisation (www.secasa.com.au; Collin- Vezina, Daigeault & Hebert, 2013; Walsh, Fortier & DiLillo, 2009).

## Psychological Impact on Sexual Intimacy

The psychological impact of CSA includes emotional, cognitive and behavioural problems related to sex; for example, sexual guilt and anxiety, acting out in promiscuity, confusion about sexual orientation, symptoms of Post-traumatic Stress Disorder and lowered sexual-esteem (Najman, Dunne, Purdie, Boyle & Coxeter, 2005; Collin-Vezina, Daigneault & Hebert, 2013; Noll, Trickett & Putnam, 2003; Stephenson, Hughan, & Meston 2012; Marendaz & Wood, 1999; Brick, 2005; Dominguez, Nelke & Perry 2001; Bloom, 2013; Hughes, Johnson, Wilsnack & Szalacha, 2007; Littleton, Breitkopf & Berenson, 2007). These can be divided into three broad categories: Cognitive, behavioural and emotional sequelae.

Cognitive Sequelae: A preoccupation with sexual thoughts associated with depression, anxiety, dissociation and unpleasant memories or flashbacks (Noll, Trickett & Putnam, 2003). Women with a history of CSA will tend to filter their sexual experiences through a negative sexual self-schema, thus more likely to experience guilt, regret and disgust during sex, (Stephenson, Hughan & Meston, 2012). Barlow, in 1986, reported by Rellini & Meston (2010), found that women with a negative sexual self-schema from their CSA trauma, displayed anticipatory anxiety with subsequent sexual discontent and related psychopathologies (Zollman, Rellini & Desrocher, 2013).

Behavioural Sequelae: Women have a high risk of re-victimisation in adulthood, being more likely to experience sexual or other abuse, an increase in sexualised behaviours and more sexual partners in their life time compared to women with no history of CSA (Najman, Dunne, Purdie, Boyle & Coxeter, 2005).

Emotional Sequelae: Women who were abused as children may view sex as 'instrumental rather than intimate' to their relationship, suggesting that they had much difficulty connecting emotionally during sexual contact when compared to women without an abuse history (Stephenson, Hughan, & Meston 2012). Further consequences of such abuse include, difficulty maintaining friendships and relationships, and issues within intimate connections, particularly achieving and maintaining intimacy (Stephenson, Hughan & Meston, 2012).

## Models of Psychotherapeutic interventions

The goal of counselling is to provide the opportunity to facilitate restorative healing opportunities. The counselling of women with a history of CSA tends to be individually focused as a therapy (Marendaz & Wood, 1999). However, the provision of couple therapy can greatly assist those who present with issues of intimacy and sexual difficulties in relationships. Individual and couple therapy can assist each person to see the connections between current and past problems of abuse, with the intention of bringing to awareness the negative thinking pattern, in a safe and accepting environment, and assist the client to experience satisfying and sustaining intimate relationships (Maltz, 2012; Zala, 2012).

There are several models of therapeutic interventions used in this area, including client-centred (Maltz, 2012), Solution Focused Therapy, (Langer, nd), Mindfulness Based Therapy (Brotto, Seal & Rellini, 2012) and Gelstalt (Lapides, 2011; Maltz, 2012). A brief outline of the following two models in the current context with a client centred approach, is provided:

- Narrative Therapy
- Cognitive Behavioural Therapy

## Narrative therapy (NT)

This therapy attempts to separate the problem from the person (White,1998), with one of the core premises being that

a person's identity is formed by their experiences. NT's use of externalisation of sensitive issues such as difficulties with sexual intimacy, sets the therapeutic scene for creating an environment of positive interaction. It also allows for the potential to transform negative communication, encouraging clients to be responsive to accepting more positive and non-judgemental processes (Dulwichcentre, nd).

Utilizing externalising conversations and questioning provides a therapeutic process of deconstructing client stories. Michael White (1991) refers to this as the 'deconstructive method', giving expression to a notion, feeling or ideal in a form that can be experienced outside of 'self' or by others. This allows the counsellor to respectfully question the stories people have chosen for their lives, which have been co-created with other people as well as by one's cultural, social community and history (Goldenberg & Goldenberg, 2004; Gurman, 2008; Percy, 2007; White, 1991). It is from this perspective, what is described in the literature by Morgan, 2000 & 2002; White, 1991; Payne, 2006; Percy, 2007) as the awakening of how the problem may be shaping their existence, which is taken for granted. As a therapist we give respectful and attentive listening to our clients to tell us their 'problem-saturated description', or the person's present 'dominant story'. Using externalising language or conversation (Payne p. 11-12), we aim to help the person separate their identity from the problem: for example, in the case of CSA, the client is likely to have a story such as 'I am the problem, I have no desire for sex'. Narrative counselling would support the person to see how the past sexual abuse may be causing issues in their current relationships (such as low desire or sexual pain), with the purpose being for the person to reduce identifying 'as' the problem and reclaim a sense of control over their lives.

Using the deconstructive method to trace the history and identify and separate the problem or the dominant story from the 'self', is a powerful method of finding an alternative story. This alternative option can then be chosen to live by and provide a way forward to the reconstruction of preferred storylines (Gershoni, Cramer & Gogol- Ostrowsky, 2008; White, 1991 & 1989; Percy, 2007).

Comments also by Baird, (1996) quotes Duran and Kowalski (p4) on how the counsellor might view the clients concerns:

The abuse is only a problem because of its effects. This distinction, though perhaps semantic, is important. Therapy which seeks to resolve the abuse is inevitably problem-focused and easily leads to the characteristics that we have described as constituting a therapy which promotes a view of self as victim. Since the abuse cannot ever be made to have not happened, a problem defined as the abuse can never truly be resolved.

In the area of sexuality, storylines related to relationships, intimacy, body image are complex and intertwined. Associated with each of these stories is a potential abundance of descriptive possibilities for individuals and couples to reconstruct their preferred view of their unique sexual story (Morgan, 2000; Gershoni, Cramer & Gogol- Ostrowsky, 2008; Percy, 2007). As Freedman & Combs, (1993, p.117) state:

In this work, we hope to privilege the knowledge of the people we work with over ours. For this reason, we think it is very important to be aware of the influence our questions have in setting the direction of the conversation.

## Cognitive Behaviour Therapy

Cognitive Behaviour Therapy (CBT) is one of the most widely researched forms of therapy with strong empirical support (Australian Association for Cognitive and Behaviour Therapy http://www.aacbt.org). It is an individualised approach to problematic issues, that assists the client to identify unhelpful cognitions and behaviours, and formulate and practice, new helpful thoughts and behaviours. It has been found to be effective for a range of issues including depression, anxiety, PTSD, and sexual dysfunction.

When CBT is specifically focussed on the issue of sexual trauma however, it is more effective (Cohen, Deblinger & Mannarino, 2004). The so-called, Trauma-focussed CBT approach assists the individual to examine and more effectively manage symptoms of PTSD, specific to the person. In addition, and importantly, this approach allows the counsellor to address the distorted cognitions of the person, such as those related to self-blame and feelings of betrayal of trust (Cohen, Deblinger, Mannarino & Steer, 2004; Lev-Wiesel, 2008).

Because CBT has a problem-oriented focus, it deals purposely with the psychological, behavioural and emotional sexual symptoms or consequences of child sexual assault, that the woman is experiencing, rather than the abuse per se. The primary aim of CBT is to support the client to understand how their negative, or irrational thoughts are helping to either create or maintain their current level of emotional or behavioural distress (BMJ Group, nd.). The person is then assisted to 'reframe' or create new and more helpful thoughts concerning the sexual issues that are being experienced (Montgomery, 2008).

Cognitive and behavioural issues specific to the individual are usually targeted, including recurring intrusive thoughts or flashbacks, consistent avoidance of situations, generalised anxiety, and feelings of powerlessness, and low self-worth (Lev-Wiesel, 2008). Specific examples of CBT intervention for women with sexual problems related to CSA include: psycho-education of the female sexual response cycle; instruction in the CBT model with both sexual and non-sexual examples; instruction on the process of 'challenging' irrational thoughts and substituting helpful thoughts; and the practice of physical relaxation (Brotto, Brooke, & Rellini, 2012).

While CBT remains one of the primary therapeutic intervention methods for the issue discussed in this paper, some caution should be adopted in its use. Barbara LoFrisco (2010) provided a critical analysis of the use of CBT for the psychological of female sexual pain disorders. She found that all studies found CBT to be effective although she suggests that more research needs to be done to determine longitudinal effectiveness. She also advocates that CBT should be provided within a 'couples-counselling' context, with some studies revealing reduced relationship satisfaction when it was provided in an individual modality (LoFrisco, 2010).

## Conclusion

A history of CSA has been identified as a significant issue and multifaceted in nature with high levels of psychological and physical distress connected with sexual intimacy. Clinical and empirical research confirms that women with a such a history frequently experience difficulty with sexual functioning and intimacy as an adult, as well as a range of other detrimental psychosocial impacts on the individual, relationship and family. This area is worthy of ongoing research; there is still much more to learn, including the development of specific intervention strategies that will enhance the quality of life for these women and their significant others.

Helena is a Clinical Sexologist / Counsellor. She holds Post Graduate qualifications in both Sexology and Counselling, and works in private practice with inSync for life in Perth and Bunbury, Western Australia: www.insyncforlife.com.au

## REFERENCES


Australian Association for Cognitive and Behaviour Therapy. http://www.aacbt.org Australian Bureau of Statistics. www.abs.gov.au/

Bagley, C. and Ramsey, R. (1986), Sexual abuse in childhood: psychological outcomes and implications for social work practice, *Journal of Social Work and Human Sexuality*, 4: 33 – 47.

Baird, F. (1996). A narrative context for conversations with adult survivors of childhood sexual abuse. Retrieved from http://english.12accede.nl/

Bloom, S. (2013). Creating sanctuary (2nd ed.) New York: Routledge BMJ Group, (nd.) http://bestpractice.bmj.com/

Briere, J & Scott, C. (2006). *Principles of Trauma Therapy*. California: Sage Publications

Briere, J., Godbout, N, & Runtz, M. (2012). The Psychological Maltreatment Review (PMR): Initial reliability and association with insecure attachment in adults. *Journal of Aggression, Maltreatment & Trauma*, 21, 300-320.

Bravehearts (2012). http://www.bravehearts.org.au

Brick, N. D. (2005). How childhood sexual abuse affects interpersonal relationships. Retrieved from http://ritualabuse.us/research/sexual-abuse/how-childhood- sexual-abuse-affects-interpersonal-relationships/

Brotto, L. A., Brooke, N. Seal, & Rellini, A. (2012). Pilot study of a brief cognitive behavioral versus mindfulness-based intervention for women with sexual distress and a history of childhood sexual abuse. *Journal of Sex & Marital Therapy*, 38:1–27, 2012. Retrieved from http://www.obgyn.ubc.ca.

Cohen, J. A., Deblinger, E., Mannarino, A. P. & Steer, R. A. (2004). A multisite, randomised controlled trial for children with sexual abuse-related PTSD symptoms. *J Am Acad Child Adolesc Psychiatry*, 43(4):393-402. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15187799

Collin-Vezina, D., Daigneault, I. & Hebert M. (2013). Lessons learned from child sexual abuse research: prevalence, outcomes, and preventive strategies. Retrieved from www.capmh.com

Dominguez, R. Z., Nelke, C. F. & Perry, B. D. (2006). Sexual abuse of children.

American Academy of Experts in Traumatic Stress. Retrieved from http://aaets.org/article124.htm

Dulwichcentre (nd). Narrative therapy. www.dulwichcentre.com.au

Finkelhor, D. & Browne, A. (1985). The traumatic impact of child sexual abuse. *American Journal of Orthopsychiatry*, 55,(4):530–541.

Freedman, J., & Combs, F. (1996). Questions In Narrative therapy: the social construction of preferred realities. New York: Norton.

Gershoni, Y., Cramer, S. & Gogol-Ostrowsky, T. (2008). Addressing sex in narrative therapy: Talking with heterosexual couples about sex, bodies, and relationships. *International Journal of Narrative therapy and community work*. 3:3-11. Retrieved from http://www.scribd.com.

Goldenberg, I. & Goldenberg, H. (2004) Family therapy: An overview, (), (6th ed. p. 343-355). Pacific Grove, CA: Thomson Brooks/Cole.

Gurman, A (2008). *Clinical Handbook of couple therapy*. (p. 229-258). New York: The Guilford Press.

Hartlein, K. M., Weeks, G. R., & Gambescia, N. (2009). *Systemic sex therapy*. New York: Routledge.

Hughes, T.L., Johnson, T.P., Wilsnack, S.C., & Szalacha, L. (2007). Childhood risk factors for alcohol abuse and psychological distress among adult lesbians. *Child Abuse & Neglect*, 31(7), 769-789.

Kleinplatz, P. J. (Ed.) (2012). New Directions in sex therapy. (2nd ed.). New York: Routledge

Langer, S. M. (nd). Solution-focussed brief therapy: What is it and what is the evidence?. Retrieved from http://casat.unr.edu/docs/

Lapides, A. (2011). A gentler Gestalt Therapy: On reducing stimulation in adult survivors of abuse. Retrieved from http://www.integrative- journal.com/index.php/ijip/article/viewFile/41/28.

Leonard LM, Iverson KM, Follette VM. Sexual functioning and sexual satisfaction among women who report a history of childhood and/or adolescent sexual abuse. *Journal of Sex & Marital Therapy*. 2008;34:375–384. doi: 10.1080/00926230802156202

Lev-Wiesel, R. (2008). Child sexual abuse: A critical review of intervention and treatment modalities. *Children and Youth Services Review*, (p. 665-673). Retrieved from http://www.sciencedirect.com.

Littleton, H., Breitkopf, C. R., & Berenson, A. (2007). Sexual and physical abuse history and adult sexual risk behaviours: Relationships among women and potential mediators. Child Abuse Negl. 31(7): 757-768.

Lofrisco, B. (2010). Female sexual pain disorders and cognitive behavioural therapy. *Journal of Sex Research*, 48(6):573-579, DOI: 10.1080/00224499.2010.540682

Maltz, W. (2012). Healing the sexual repercussions of sexual abuse. *New Directions in sex therapy*. (2nd ed.) In P. J. Kleinplatz (Ed.), New York: Routledge.

Marendaz, L-A. & Wood, K. (1999). The effects of childhood sexual abuse on female sexuality: *A model of intervention*. Retrieved from http://www.aic.gov.au/media_library/conferences/rvc/marendaz.pdf

Montgomery, K. A., (2008). Sexual Desire Disorders. *Psychiatry*, 5(6): 50-55.

Morgan, A. (2000). What is narrative therapy? An easy-to-read introduction. Adelaide: *Dulwich Centre Publication*.

Morgan, A. (2002). Beginning to use a narrative approach in therapy. Retrieved from www.dulwichcentre.com.au

Najman, J. M., Dunne, M. P., Purdie, D. M., Boyle, F. M. & Coxeter, M. P. H. (2005). Sexual abuse in childhood and sexual dysfunction in adulthood: An Australian population-based study. *Archives of Sexual Behaviour*, 34(5): 517-526.

Noll, J. G., Trickett, P. K., & Putnam, F. W. (2003). A prospective investigation of the impact of childhood sexual abuse on the development of sexuality. J Consult Clin Psychol. 71(3): 575-586

Payne, M. (2006). Narrative therapy: An introduction for counsellors (2nd ed.). (pp.12-13; pp.37-59). London: Sage Publications.

Percy, I. (2007). Composing our lives together: Narrative therapy with couples. In E. Shaw and J. Crawley (Eds.), Couples therapy in Australia: Issues emerging from practice. Melbourne: Psychoz Publications.

Senn, T. E., Carey, M. P., & Coury-Doniger, P. (2011). Self-defining as sexually abused and adult sexual risk behavior: Results from a cross-sectional survey of women attending an STD clinic. *Child Abuse and Neglect*, 35:353-362.

South Eastern CASA. www.secasa.com.au

Stephenson, K. R., Hughan, C. P. & Meston, C. M. (2012). Childhood sexual abuse moderates the association between sexual functioning and sexual distress in women. *Child Abuse Negl*., 36(2):180-189

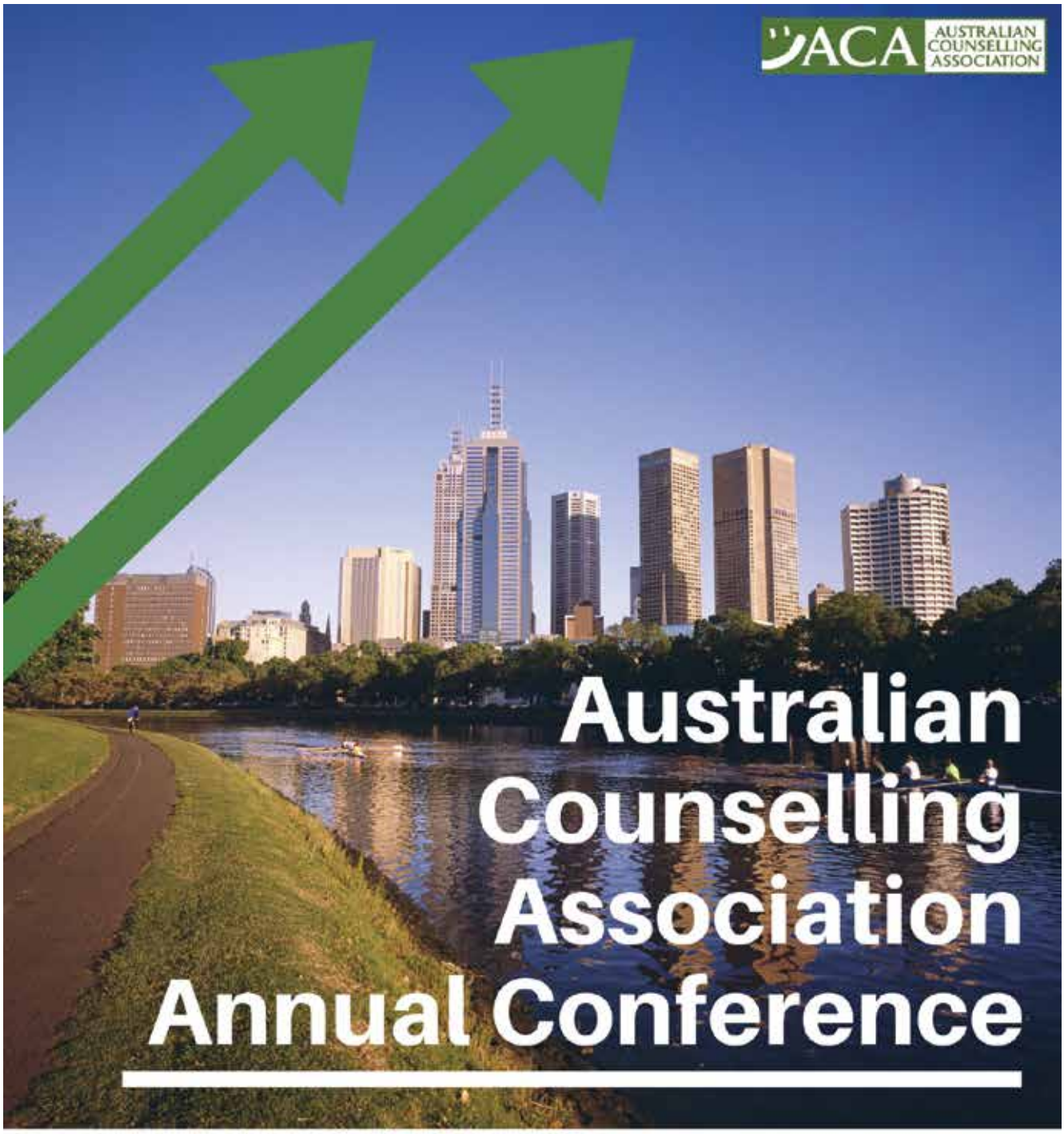
Walsh, K., Fortier, M. & DiLillo D. (2010). Adult coping with childhood sexual abuse: A theoretical and empirical review. Retrieved fromhttp://www.ncbi.nlm.nih.gov/pmc/articles/PMC2796830/

White, M. (1989). 'The externalizing of the problem and the re-authoring of lives and relationships'. In Selected Papers, 5-28. Adelaide: *Dulwich Centre Publications*.

White, M. (1991). Deconstruction and therapy. *Dulwich Centre Newsletter* (3) 21-40.

Zala, S. (2012). Complex couples: Multi-theoretical couples counselling traumatised adults who have a history of child sexual abuse. *The Australian and New Zealand Journal of Family Therapy*, 33(3): 219-231

Zollman, G., Rellini, A. & Desrocher, D. (2013). The mediating effect of daily stress on the sexual arousal function of women with a history of childhood sexual abuse. *Journal of Sex and Marital Therapy*, 39:176-192




# SEPTEMBER 7-9, 2018

## STAMFORD PLAZA, MELBOURNE

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| **AUSTRALIAN CAPITAL TERRITORY** | | | | |
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| **NEW SOUTH WALES** | | | | |
| Fiona Curll | ALBION PARK | 0413 013 915 | Upon enquiry | FTF/PH/WEB |
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| Amanda Robb | ANNANDALE | 0401 224 942 | Upon enquiry | FTF |
| Susan Alexandra Bennett | Balgowlah | 0408 264 053 | Upon enquiry | FTF/GRP/WEB |
| Dr. Toni Tidswell | BANORA POINT | 0467 557 418 | Upon enquiry | FTF/ GRP/ SKP |
| Sandra Bowden | BATEAU BAY/CENTRAL COAST | 0438 291 874 | $70 | FTF |
| Raj Prasad | BELLA VISTA | 0432 800 396 | Upon enquiry | FTF/PH/GRP/WEB |
| Kevin Garth Webb | BELMONT | 0413 692 005 | $100 | FTF/PH/WEB |
| Heide McConkey | BONDI JUNCTION | 0419 430 534 | Upon enquiry | FTF |
| Carol Stuart | BONDI JUNCTION | 02 9387 7355 | $80 pp - % rate<br>$50 for early graduates | FTF/GRP/PH/WEB |
| Linda Taylor | Botany & Miranda | 0411 355 052 | Upon enquiry | FTF/GRP/PH/WEB |
| Maxine Hinton | BROKEN HILL | 0448 117 274 | Upon enquiry | FTF/PH/GRP/WEB |
| Joanie Sanderson | BROKEN HILL | 0413 551 201 | Ind - $70/hr; Grp-$40/hr; Stu - $50/hr | F/F/ PH/ GRP/ WEB |
| Toni Langford | CARINGBAH | 0414 718 338 | $100 /hr FTF/PH/WEB, $80/hr GRP | FTF/PH/WEB |
| Carol-Anne Howlett | CASTLECRAIG | 0413 454 119 | Upon enquiry | F/F/ PH/ GRP |
| Machele Kerzinger | CENTRAL COAST 2258 | 0437 567 820 | $120 | FTF/PH/WEB |
| Grahame Williams | CHARLESTOWN | 0405 508 302 | $100/HR | FTF/WEB |
| John Harradine | CREMONE | 0419 953 389 | $160; GRP $120 | FTF/GRP/WEB |
| Penny Bell | CUMBI UMBI | 0416 043 884 | Upon enquiry | FTF/GRP/PH/WEB |
| Shane Warren | DARLINGHURST | 0418 726 880 | Upon enquiry | FTF |
| Jennifer Perino | DUBBO | 0409 151 646 | $100/hr; Students or new grads $80/hr | FTF/PH/WEB |
| Yun Hee Kim | EASTWOOD | 0416 069 812 | 50 | FTF/WEB |
| David Robert Watkins | ELANORA HEIGHTS | 0404 084 706 | Upon enquiry | FTF |
| Brian Edwards | FORRESTERS BEACH | 0412 912 288 | Upon enquiry | FTF |
| Danny D. Lewis | FORRESTERS BEACH | 0412 468 867 | Upon enquiry | FTF |
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| Leonie Frances Raffan | HAMILTON | 0402 327 712 | 120 | FTF/PH/WEB |
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| Kathryn Jane Quayle | HORNSBY | 0414 322 428 | $95 | FTF/WEB/PH |
| Patricia Cheetham | KENSINGTON | 1300 552 659 | Upon enquiry | FTF |
| Lyndall Briggs | KINGSGROVE | 0402 223 350 | Upon enquiry | FTF |
| Harley Conyer | Kirribilli | 0411 411 103 | Upon Request | F/F/ PH/GRP/WEB |
| Wendy Gibson | KOOLEWONG | 0422 374 906 | Upon enquiry | FTF |
| Michella Wherrett | LAKE MACQUARIE/ NEWCASTLE | 0414 624 513 | $80 | FTF/PH |
| John Philip Helvadjian | LANE COVE | 0420 886 512 | Upon enquiry | F/F/ GRP/PH |
| Rayomand Medhora | LANE COVE | 0413 881 272 | Ind - $150ph : Grp $50 p | F/F/ PH/ GRP/ NET |

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| **NEW SOUTH WALES *CONTINUED*** | | | | |
| Chris Davidson | LISAROW | 0414 321 733 | Upon Request | F/F/ PH/ GRP/ WEB |
| Nigel Jones | Mangerton | 0412 145 554 | $90 ind. Disc for students or volunteer counsellor | FTF/GRP/PH/WEB |
| Lorraine Dailey | MAROOTA | 0416 081 882 | Upon enquiry | FTF/PH/GRP/WEB |
| Kerryn Armor | MT ANNAN | 0409 472 614 | Upon enquiry | FTF |
| Patriciah Catley | NARELLAN | 0401 164 800 | Upon enquiry | FTF |
| Karen Morris | NEWCASTLE/HUNTER VALLEY | 0417233752 | $100 | FTF/GRP/PH/WEB |
| Brian Lamb | NEWCASTLE/LAKE MACQUARIE | 0412 736 240 | $120 (contact for sliding scales) | FTF/GRP/PH |
| Debra Cowen | NEWTOWN | 0414 757 391 | $85per 2hr sess; $60 per 1hr sess; $50 per 3hr grp | FTF/PH/GRP/WEB |
| Katrina Christou | NEWTOWN | 0412 246 416 | Upon enquiry | FTF |
| Michael Morris Cohn | NORTH BONDI | 0413 947 582 | $120 | FTF/GRP/PH/WEB |
| Robert Weeks | PARRAMATTA | 0402139552 | 100 | FTF |
| Denise Warner | PENDLE HILL | 0439 598 649 | Upon Request | F/F/ PH/ GRP/ WEB |
| Jacky Gerald | POTTS POINT | 0406 915 379 | Upon enquiry | FTF |
| Kim Michelle Hansen | Putney | 0412 606 727 | Upon enquiry | FTF |
| Mona Luxton | Rockdale | 0419 288 226 | $100p/h Ind. $70p/h group | FTF/GRP |
| In A Ra | Seven Hills | 0410 061 218 | $50 | FTF/GRP/PH/WEB |
| Grahame Smith | SINGLETON | 0428 218 808 | $66 | FTF/GRP/PH/WEB |
| Judith Reader | STOCKTON | 0421 352 665 | Upon enquiry | FTF |
| Deborah Rollings | SUTHERLAND | 0427 584 554 | Upon enquiry | FTF/PH |
| Heidi Heron | SYDNEY | 02 9264 5418 | Ind - $250; Grp - $79 | F/F/ PH/ GRP/ WEB |
| Sharon Kwiryang Lee | SYDNEY | 0425 330 274 | GRP $40; Ind $80 | F/F/GRP |
| Angela Malone | Tomerong | 0438 822 284 | Upon enquiry | FTF |
| Jessica Mannion | TUMBARUMBA | 0430 153 141 | Ind $70 Group $40; Students $50 | FTF/PH/GRP/WEB |
| Karen Daniel | TURRAMURRA | 0403 773 757 | $125 1hr; $145 1.5hrs | FTF/WEB |
| Darren Garriga-Haywood | WARABROOK | 0432 107 080 | Upon enquiry | FTF |
| Lila Juliette Pesa | Wollstonecraft | 0488 776 851 | Upon enquiry | FTF |
| Michelle Mai-Yin Lam | WOOLLAHRA | 0403 347 596 | Upon enquiry | FTF/PH/GRP/WEB |
| Linda Elsey | WYEE | 0407 257 882 | Upon enquiry | FTF/GRP/PH/WEB |
| **NORTHERN TERRITORY** | | | | |
| Judy Eckermann | ALICE SPRINGS | 0427 551 145 | Upon enquiry | FTF |
| Rachael Moore | ALICE SPRINGS | 0477 422 150 | Upon enquiry | FTF |
| Margaret Lambert | DARWIN | 0414 459 585 | Upon enquiry | FTF/GRP/PH/WEB |
| Rian Rombouts | MILLNER | 0439 768 648 | Upon enquiry | FTF |
| Johanne Goncalves | VIRGINIA | 0417 864 038 | $100p/h;GRP $38p/hr | F/F/PH/GRP/WEB |
| **QUEENSLAND** | | | | |
| 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 |
| Carol Thackray | Algester | 0432 594 889 | Ind. $80 : Group $50 | FTF/PH/GRP |
| Tracey Milson | ARUNDEL | 0408 614 062 | Upon enquiry | FTF |
| Iain Bowman | ASHGROVE | 0402 446 947 | Upon enquiry | FTF/PH/GRP/WEB |

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| **QUEENSLAND *CONTINUED*** | | | | |
| Catherine Dodemont | Ashgrove | 0413 623 162 | Upon enquiry | FTF/PH/WEB/GRP |
| Tracey Janke | BEENLEIGH | 07 3458 1725; 0409 272 115 | $100/hr; $70/hr concession card holders | F/F: PH: WEB |
| David Hamilton | BEENLEIGH | 07 3807 7355 or 0430 512 060 | Indiv $80, Students $60 | FTF/PH/GRP/WEB |
| Laura Banks | BROADBEACH | 0431 713 732 | Upon enquiry | FTF |
| Lyn Patman | BROWNS PLAINS | 0415 385 064 | Upon enquiry | FTF |
| Anne-Marie Houston | BUNDABERG | 0467 900 224 | Upon enquiry | FTF |
| David Lawson | BUNDABERG | 0407 585 497 | $80/hr incl GST | FTF/PH/WEB |
| Christine Perry | BUNDABERG | 0412 604 701 | $70 | FTF/WEB |
| Pamela Thiel-Paul | BUNDALL/GOLD COAST | 0401 205 536 | Upon enquiry | FTF/WEB |
| Sharron Mackison | CABOOLTURE | 07 5497 4610 | Upon enquiry | FTF/PH/GRP/WEB |
| Penelope Richards | CHAPEL HILL | 0409 284 904 | Upon enquiry | FTF |
| Christine Boulter | COOLUM BEACH | 0417 602 448 | Upon enquiry | FTF |
| Emily Rotta | DAISY HILL | 1800 744 568 Or 0414 744 568 | Upon enquiry | FTF/PH/GRP/WEB |
| Rev Peter Gee | EASTERN HEIGHTS/ IPSWICH | 0403 563 467 | $65 | FTF/GRP/PH/WEB |
| Judit Nagy | EMERALD | 0477 297 570 | Upon enquiry | F/F; PH; GRP; WEB |
| Patricia Fernandes | EMERALD/SUNSHINE COAST | 0421 545 994 | $30-$60 | FTF/PH |
| Janice Marshall | FERNY GROVE | 0426 422 553 | $100 | FTF/WEB |
| Robbie Spence | GREENSLOPES | 0435 732 650 | Upon enquiry | F/F |
| Heidi Edwards | GYMPIE | 0466 267 509 | $99 | FTF/WEB |
| Deborah Gray | HERVEY BAY | 0409 295 696 | ftf,skp & grp: $100 + GST/ Grp: $90 | FTF, Ph, Grp, Skp |
| Peter Sondergeld | HIGHFIELDS | 0412325429 | $100 | FTF/GRP/WEB |
| Donna Mahoney | KEWARRA BEACH | 0414 480 934 | 110 P/H | FTF, PH, GRP, SKP |
| Deborah Stevens | KINGAROY | 0411 661 098 | Upon enquiry | FTF |
| Christene Nissen | KINGAROY | 0417 609 595 | $110 + GST | FTF/PH/GRP |
| Jenifer Joy Jensen | Kuranda | 0414 262 040 | Upon enquiry | FTF |
| William James Sidney | LOGANHOLME | 0411 821 755 Or 07 3388 0197 | Upon enquiry | FTF/PH/GRP |
| Gary Noble | LOGANHOLME DC | 0439 909 434 | Upon enquiry | FTF |
| Monika Wilson | MALENY | 0413 962 899 | $100 P/P | FTF, PH |
| Jay Ellul | MANLY WEST | 0415 613 447 | $120 | FTF/PH/GRP/WEB |
| Lynette Baird | MAROOCHYDORE/ SUNSHINE COAST | 07 5451 0555 | Grp $30 or Indiv $90 | FTF/GRP |
| Bruce Hansen | Moorooka | 07 3848 3965 Or 0400 058 001 | FTF $80,Group $40, Stud $50 | FTF, PH, GRP, WEB |
| Michelle Fairbrother | Mount Cotton | 0402 697 874 | $100 | F/F; PH; WEB |
| Jenny Endicott | MT GRAVATT EAST | 0407 411 562 | Upon enquiry | FTF |
| Kirsten Greenwood | MUDGEERABA | 0421 904 340 | Upon enquiry | FTF |
| Sherrie Brook | MURRUMBA DOWNS | 0476 268 165 | Upon enquiry | FTF |
| Robyn Brownlee | NANANGO | 0457 633 770 | | |
| Alison Lee | NOOSA HEADS | 0410 457 208 | Upon Request | F/F; PH; GRP; WEB |

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| **QUEENSLAND *CONTINUED*** | | | | |
| Bernice Botha | ORMEAU | 0449 611 521 | Gp:$50p/h Idv:$90p/h Stu:$75p/h | FTF,Ph,Grp,Skp |
| Christine Cresswell | ORMEAU HILLS | 0439 852 364 | Upon enquiry | F/F; GRP; PH; WEB |
| Beverley Howarth | PADDINGTON | 0420 403 102 | Upon enquiry | FTF/PH/WEB |
| Neil Roger Mellor | PELICAN WATERS | 0409 338 427 | Upon enquiry | FTF |
| Judy Boyland | REDLAND BAY | 0413 358 234 | UPON ENQUIRY | FTF/GRP/PH/WEB |
| Roslyn Price | REDLAND BAY | 0401 266 170 | $80/hr for practitioners $80/hr for students | FTF/PH/GRP/WEB |
| Frances Taylor | REDLAND BAY | 0415 959 267 Or 07 3206 7855 | Upon enquiry | FTF |
| Tanya Haimes | ROCKHAMPTON REGION | 0438 422 077 | $40/hr | F/F; PH; WEB |
| Margaret Newport | SARINA | 0414 562 455 | On enquiry | FTF, Phone, Group & WEB |
| Christine Russell | Scarborough | 0439 437 007 | 80 | FTF/PH/GRP/WEB |
| David Kliese | SIPPY DOWNS/SUNSHINE COAST | 07 5476 8122 | Indiv $80, Grp $40 (2 hours) | FTF/GRP/PH |
| Brenda Purse | SUNSHINE COAST | 0402 069 827 | Upon enquiry | FTF |
| Nancy Grand | SURFERS PARADISE | 0408 450 045 | Upon enquiry | FTF |
| Julia Tilling | TOOWONG | 0410 808 406 | $100 p/p or $50 p/grp | FTF, SKP, PH, GRP |
| Maartje (Boyo) Barter | WAKERLEY | 0421 575 446 | Upon enquiry | FTF |
| Yildiz Sethi | WAKERLEY | 07 3390 8039 | Indiv $90, Grp $45 | FTF/GRP/PH/WEB |
| Yvette Monica Carter | WEIPA | 0429 062 449 | $100/hr | F/F; PH; GROUP; WEB |
| Maggie Maylin | WEST END | 0434 575 610 | Upon enquiry | FTF/PH/GRP/WEB |
| Tanya-Lee M Barich | WONDUNNA | 0458 567 861 | Upon enquiry | FTF |
| Melissa Huestis | Woolloongabba | 0422 924 965 | $120 | FTF/GRP |
| Kim King | YEPPOON | 0434 889 946 | Upon enquiry | FTF |
| **SOUTH AUSTRALIA** | | | | |
| Dr Nadine Pelling | ABERFOYLE PARK | 0402 598 580 | $100.00 | FTF, INDIV, WEB |
| Carolyn Grace | ADELAIDE | 0401 337 448 | Upon enquiry | FTF/PH/WEB |
| Allyson Ions | Adelaide | 0411 446 631 | on application | |
| Emily Lim | ADELAIDE | 0439 547 610; 08 8331 3111 | on application | F/F |
| Susan Turrell | Blakeview | 0404 066 433 | 55 | FTF/GRP/WEB |
| Shelley Murphy | Brooklyn Park | 08 8443 5165; 0407 435 169 | Ind. $80ph; Group - 2hrs - $40 | FTF/PH/GRP/WEB |
| Carol Kerrigan | ENGLFIELD | 0410 567 479 | Upon enquiry | FTF |
| Beverley Dales | Golden Grove | 0413 303 576 | $25 PP | FTF/PH |
| Ellen Turner | HACKHAM WEST | 0411 556 593 | Upon enquiry | FTF |
| Annie Cornish | HENLEY BEACH | 0407 390 677 | Upon enquiry | FTF |
| Niki Gelekis | Magill | 0405 822 566 | $90 (ind) | F/F: PH: NET |
| Chaplain Ken Schmidt | MAWSON LAKES | 0400 398 005 | $80/hr | F/F; GRP; WEB |
| Maxine Kikkert | MT BARKER | 0457 358 874 (w) 0438254 255 (h) | $80; $60 (disc); GRP $30 | FTF/GRP/PH/WEB |
| L'hibou Hornung | NAIRNE : PARKSIDE | 0409 616 532 | $80 | F/F,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*** | | | | |
| Carol Moore | OLD REYNELLA | 08 8297 5111 bus<br>Or SMS 0419 859 844 | Grp $35, Indiv $99 | FTF/PH/GRP/WEB |
| Barry White | Port Adelaide 5015 | 0488 777 459 | Upon enquiry | FTF/PH |
| Bernard Haimes | ROCKHAMPTON REGION | 0419 714 041 | $40 per hour | F/F; GRP; PH |
| Adrienne Jeffries | STONYFELL | 08 8332 5407 | Upon enquiry | FTF/PH/WEB |
| Kerry Turvey | TANUNDA | 0423 329 823 | Upon enquiry | FTF |
| Pamela Mitchell | WATERFALL GULLY | 0418 835 767 | Upon enquiry | FTF |
| Richard Hughes | WILLUNGA | 0409 282 211 | Negotiable | FTF/PH/WEB |
| Annemarie Klingenberg | WOODCROFT/MURRAY BRIDGE | 0458 851 379 | $65 - $75 per hour | F/F; PH; WEB |
| **TASMANIA** | | | | |
| Jane Oakley-Lohm | BLACKSTONE HEIGHTS/ LAUNCESTON | 0438 681 390 | $110 GST inclusive, $80 for new students of one year | FTF/PH/GRP/WEB |
| David Hayden | HOWRAH NORTH | 0417 581 699 | Upon enquiry | FTF |
| Pauline Mary Enright | SANDY BAY | 0409 191 342 | $70 per session: Concession $60 | FTF/PH/WEB |
| **VICTORIA** | | | | |
| Joan Wray | (MOBILE SERVICE) | 0418 574 098 | Upon enquiry | FTF |
| Jacquie Wise | ALBERT PARK | 03 9690 8159<br>Or 0439 969 081 | By Negotiation | FTF, PH, WEB, GRP |
| Mihajlo Glamcevski | ARDEER | 0412 847 228 | Upon enquiry | FTF |
| Ruth Giles | BAIRNSDALE | 0425 726 933 | Inv $70, Grp $40each | FTF, PH, GRP |
| Marie Bajada | BALLARAT | 0409 954 703 | Upon enquiry | FTF |
| ANN MOIR-BUSSY | BALLARAT | 07 5476 9625<br>Or 0400 474 425 | Upon enquiry | FTF/GRP/PH/WEB |
| Jeff Pemberton | BALLARAT | 0422 375 899 | 80 | FTF/PH |
| Keith John Hulstaert | BELGRAVE | 0409 546 549 | Upon enquiry | FTF |
| Roselyn (Lyn) Ruth Crooks | BENDIGO | 0406 500 410<br>Or 03 4444 2511 | $60 | FTF |
| Judith Ayre | BENTLEIGH | 0417 105 444 | Upon enquiry | FTF |
| Carolyn Geer | Bentleigh | 0419 572 970 | Upon enquiry | FTF |
| Kathleen (Kathy) Brennan | BERWICK | 0417 038 983 | Upon enquiry | FTF/GRP/PH/WEB |
| Debra Darbyshire | BERWICK | 0437 735 807 | Upon enquiry | FTF |
| Lynne Rolfe | BERWICK | 03 9768 9902 | Upon enquiry | FTF |
| Robert Lower | BEVERIDGE | 0425 738 093 | Upon enquiry | FTF |
| Gaye Hart | BITTERN | 0409 174 128 | Upon enquiry | FTF |
| Karli Anne Dettman | Blackburn | 0403 922 245 text only | $100 | FTF/GRP/WEB |
| Stephen O'Kane | Blackburn | 0433 143 211 | Negotiable | FTF, GRP |
| Jo-Ellen White | BLACKBURN SOUTH | 0414 487 509 | $100 ind. $50 Group. Stu Dis $80 | FTF, PH, GRP, WEB, Specialising is Autism Spectrum Disorder |
| Natalie Wild | BORONIA | 0415 544 325 | Upon enquiry | FTF |
| Andrea Carrington | Brighton 3186 | (03) 9596 5620<br>Or 0409 596 674 | $90.00 | F/F; PH; GRP; WEB |
| Lindy Chaleyer | BRIGHTON EAST | 0438 013 414 | Upon enquiry | FTF,WEB |
| Deborah Cameron | BRIGHTON/HONG KONG | +65 9186 8952<br>Or 0447 262 130 | Upon enquiry | FTF/GRP/WEB |

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| **Contact** | **SUP Suburb** | **SUP Phone number** | **SUP PP Hourly** | **SUP Medium** |
| **VICTORIA *CONTINUED*** | | | | |
| Anne Meredith Brown | BURWOOD | 0447 330 222 | Upon enquiry | FTF/PH/GRP |
| Lisa Derham | CAMBERWELL | 0402 759 286 | Upon enquiry | FTF/WEB |
| Claire Sargent | CANTERBURY | 0409 438 514 | Upon enquiry | FTF |
| Brian Whiter | CARLTON, MOORABBIN | 0411 308 078 | $100 | FTF |
| Peter F. O'Toole | CAROLINE SPRINGS | 0410 330 865 | Ind.$80, Group $40 | F/F; PH; GRP |
| David Mitchelmore | Carrum | 0414 795 398 | $80/hr : Students $50/hr | F/F; WEB |
| Anna Atkin | CHETLENHAM | 0403 174 390 | Upon enquiry | FTF |
| John Dunn | COLAC SW AREA/MT GAMBIER | 03 5232 2918 | By Negotiation | FTF/GRP/WEB |
| Matt Glover | CROYDON HILLS/EAST DONCASTER | 0478 651 951 | Conc: $70, Full: $90 Group: $30/hour | FTF/PH/GRP/WEB |
| Rosemary Petschack | DIAMOND CREEK | 0407 530 636 | 80 p/h | FTF/PH |
| Sara Edwards | DINGLEY | 0407 774 663 | Upon enquiry | FTF/WEB |
| Lynda M Carlyle | EAST MELBOURNE/ SPRINGVALE SOUTH/ RIPPON LEA | 0425 728 676 | $135 per hour | FTF/PH/WEB |
| Gabrielle Skelsey | ELSTERNWICK | 03 9018 9356 | Upon enquiry | FTF/PH/WEB |
| Daniela Miszkinis | ELTHAM AND FAIRFIELD | 0404665421 | Ind $100/hr; Ind Concess $80/hr; Grp $60/hr | F/F: PH: GRP: WEB |
| Kerryn Maree Knight | FRANKSTON/ MORNINGTON | 03 9770 5670 Or 0450 253 990 | $100 ind, negotiable | F/F: WEB |
| Graeme John Riley | GLADSTONE PARK | 03 9338 6271 Or 0423 194 985 | $85 | FTF/WEB |
| Heather Bunting | GLEN IRIS | 0421 908 424 | Upon enquiry; special rates for students | FTF/PH/GRP/WEB |
| Sheryl Judith Brett | GLEN WAVERLEY | 0421 559 412 | Upon enquiry | FTF |
| Robert McInnes | GLEN WAVERLEY | 0408 579 312 | Indiv $70, Grp $40 (2 hours) | FTF |
| Jeannene Eastaway | GREENSBOROUGH | 0421 012 042 | Upon enquiry | FTF, WEB, GRPwork |
| Lehi Cerna | HALLAM | 0423 557 478 | Upon enquiry | FTF/PH/GRP/WEB |
| Tim Connelly | HEALESVILLE | 0418 336 522 | Upon enquiry | FTF |
| Jenni Harris | KEW | 0406 943 526 | $90 per 3 hr session Small group only | FTF |
| Rosslyn Wilson | KNOXFIELD | 03 9763 0772 Or 03 9763 0033 | Grp $50 pr hr, Indiv $80 | FTF/GRP/PH/WEB |
| Carolyn Ann Burford | KOOYONG | 0402 767 894 | Upon enquiry | F/F; PH;GRP;WEB |
| Linda Davis | LEONGATHA/GIPPSLAND | 0432 448 503 | Upon enquiry | FTF/PH/GRP/WEB |
| Nancye Cottrell | Lysterfield | 0424 739 891 | $50/hr Disc $40/hr | FTF/PH/GRP |
| Katherine Cho | Malvern East | 0402 618 070 | $70/hr (Ind); $40/hr Grp | F/F; PH; GRP; WEB |
| Michelle Wood | MANSFIELD | 0497 037 436 | Upon enquiry | Face to face, phone, group, skype |
| Barbara Matheson | MELBOURNE | 03 9703 2920 Or 0412 977 553 | Upon enquiry | FTF |
| Bridget Pannell | MELBOURNE | 0423 040 718 | Upon enquiry | FTF/PH/GRP/WEB |
| ANDREW REAY | MOORABBIN | 0433 273 799 | Upon enquiry | FTF |
| Judith Beaumont | MORNINGTON | 0412 925 700 | Upon enquiry | FTF/PH/GRP/WEB |
| Sophie Lea | MORNINGTON PENINSULA | 0437 704 611 | Individual $100/hour | FTF, PH, WEB |
| Catherine Ethel Noy | MORWELL | 0477 159 168 | $80 | F/F, PH, GRP, WEB |
| Patricia Reilly | MOUNT MARTHA/ GARDENVALE | 0401 963 099 | Upon enquiry | FTF |

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| **Contact** | **SUP Suburb** | **SUP Phone number** | **SUP PP Hourly** | **SUP Medium** |
| **VICTORIA *CONTINUED*** | | | | |
| Beverley Kuster | NARRE WARREN | 0488 477 566 | Upon enquiry | FTF |
| Brian Johnson | NEERIM SOUTH | 0418 946 604 | Upon enquiry | FTF |
| Suzanne Vidler | NEWPORT | 0411 576 573 | $110 | FTF/PH |
| Bettina Revens | NEWPORT/ WILLIAMSTOWN | (03) 9397 7075 Or 0432 708 019 | $120 indiv | FTF/PH |
| Marguerite Middling | NORTH BALARAT | 0438 744 217 | Upon enquiry | FTF |
| Tess Reilly-Browne | North Melbourne | 0427 220 052 | Upon enquiry | FTF/PH/GRP/WEB |
| Yoo Kyung Moon | Oakleigh South | 03 9551 8814 Or 0411 138 670 | $80 ind: $50 group: $40 students | F/F, PH, GRP; WEB |
| Melissa Harte | PAKENHAM/SOUTH YARRA | 0407 427 172 | $132 to $143 | FTF |
| Gemma Schooneveldt | PARKDALE | 0438 533 332 | Upon Request | F/F; PH; GRP; WEB |
| Joanne Ablett | PHILLIP ISLAND/ MELBOURNE METRO | 0417 078 792 | $120 | FTF/GRP/PH/WEB |
| Tra-ill Dowie | Port Fairy | 0439 494 633 | Upon enquiry | FTF |
| Cheryl Taylor | PORT MELBOURNE | 0421 261 050 | Upon enquiry | FTF |
| Zoe Broomhead | RINGWOOD | 0402 475 333 | Upon enquiry | FTF |
| Dorothy Dullege | RINGWOOD NORTH | 0433 246 848 | Upon enquiry | FTF/PH/GRP/WEB |
| Charlene Pereira | RINGWOOD/YARRAGLEN/ MELBOURNE | 03 9999 7482 Or 0403 099 303 | Ind $160; $100 P/T practitioners; Group POA | FTF/PH/GRP/WEB |
| Shivon Barresi | Roxburgh Park | 0413 568 609 | Ind. $80 ph, Group $60ph | FTF/PH/GRP/WEB |
| Derek Goodlake | SANDRINGHAM | 0403 045 800 | $110 | FTF/PH/WEB |
| Kim Billington | SANDRINGHAM/STKILDA/ ARMIDALE/MENTONE | 0488 284 023 | $110 : 2hr group $60 | FTF/PH/GRP/WEB |
| Michael Woolsey | SEAFORD/FRANKSTON | 0419 545 260 Or 03 9786 8006 | Upon enquiry | FTF |
| Danielle Aitken | SOUTH GIPPSLAND/ MELBOURNE METRO | 0409 332 052 | Upon enquiry | FTF/GRP/PH/WEB |
| Sharon S Erten | South Morang | 0400 345 045 | FTF $80/GRP $40/ WEB&PH $60 | FTF/PH/GRP/WEB |
| Zohar Berchik | SOUTH YARRA | 0425 851 188 | Upon enquiry | FTF |
| Heather Freeman | SUNBURY | 0432 263 194 | Upon Request | F/F; PH; GRP; WEB |
| Petra de Kleijn | TATURA | 0413 824 073 | Upon enquiry | FTF/PH/WEB |
| Snezana Klimovski | THOMASTOWN | 0402 697 450 | Upon enquiry | FTF |
| Rachael Cassell | TORRENSVILLE | 0434 570 992 | $80 1 hour : $120 1.5 hours | FTF |
| Sandra Clough | TRARALGON | 0412 230 181 | Upon enquiry | FTF, PH,GRP, WEB |
| Jenny Anne Field | UPPER FERNTREE GULLY | 0404 492 011 | On Request | FTF, PH, GRP, SKYP |
| Simon Philip Brown | WATSONIA | 03 9434 4161 | Upon enquiry | FTF/PH/GRP |
| Belinda Hulstrom | WILLIAMSTOWN | 04714 331 457 | Upon enquiry | FTF |
| **WESTERN AUSTRALIA** | | | | |
| Cindy Cranswick | ATTADALE | 0408 656 300 | Upon enquiry | FTF |
| Marie-Josee Boulianne | BEACONSFIELD | 0407 315 240 | Upon enquiry | FTF |
| Lynette Cannon | CAREY PARK | 0429 876 525 | Upon enquiry | FTF |
| Genevieve Armson | CARLISLE | 0412 292 999 | Upon enquiry | FTF, GRP, PH, WEB |
| Allison Lord | CLARKSON | 0403 357 656 | Upon enquiry | FTF/PH/GRP |
| Ken Bartlett | CLOVERDALE | 0458 982 803 | $75 (individual) | F/F |

| ACA SUPERVISOR COLLEGE LIST | | Medium key: FTF: Face to face I PH: Phone I GRP: Group I WEB: Skype | | |
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| **Contact** | **SUP Suburb** | **SUP Phone number** | **SUP PP Hourly** | **SUP Medium** |
| **WESTERN AUSTRALIA *CONTINUED*** | | | | |
| Carolyn Midwood | DUNCRAIG | 08 9448 3210 | Indiv $110, Grp $55 | FTF/GRO/PH/WEB |
| Sharon Vivian Blake | FREMANTLE | 0424 951 670 | Indiv $100, Grp $60 | FTF/PH/GRP/WEB |
| Eva Lenz | FREMANTLE/COOGEE | 08 9418 1439<br>Or 0409 405 585 | $85 concession $65 | FTF/PH/GRP/WEB |
| Fiona McKenzie | GERALDTON | 0427 928 505 | Upon enquiry | FTF |
| Clare Robbins | KALAMUNDA | (08) 9293 4668<br>Or 0408 548 838 | $95 individual; $75 Group per person | FTF/GRP |
| Merrilyn Hughes | LEEMING | 08 9256 3663 | Upon enquiry | FTF/PH/GRP/WEB |
| Anne Arrowsmith | MANDURAH | 0458 525 039 | Ind $140 Student $120 | FTF/PH/WEB |
| Narelle Williams | MIDLAND, PERTH | 0429 000 830 | Individual $100<br>Students $85 | FTF/WEB |
| Renee Schultz | MOSMAN PARK | 0458 125 264 | Upon enquiry | F/F; PH; GRP; WEB |
| David Peter Wall | MUNDARING | 0417 939 784 | Upon enquiry | FTF |
| Phillipa Spibey | MUNDIJONG | 0419 040 350 | Upon enquiry | FTF |
| Sally Ann Nevill | NARROGIN | 0407 246 954 | 110 | On request. |
| Trudy McKenna | NEDLANDS | 0438 551 210 | $120 (NEG) Upon enquiry | FTF/PH/GRP/WEB |
| David Fisk | NORTH LAKE | 0412 781 865 | $100 (neg) upon enquiry | FTF/GRP/WEB |
| Victoria Laws | NORTH PERTH | 0415 604 847 | Upon enquiry; student rates available | FTF/GRP/WEB |
| Dr Patricia Sherwood | PERTH/BUNBURY | 0417 977 085<br>Or 08 9731 5022 | $120 | FTF/PH/WEB |
| Heather Williams | ROCKINGHAM | 0407 900 973 | Ind - $100; Group - $50 | FF; PH; GRP; WEB |
| Salome Mbenjele | TAPPING | 0450 103 282 | Upon enquiry | FTF/PH/WEB |
| Alan Furlong | WINTHROP | 0457 324 464 | Upon enquiry | FTF |
| Julie Hall | YANCHEP/BUTLER/<br>JINDALEE/JOONDALUP | 0416 898 034 | $100 | FTF, PH, WEB |

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|---|---|---|---|---|
| **INTERNATIONAL** | | | | |
| **Contact** | **Country** | **SUP Phone number** | **SUP PP Hourly** | **SUP Medium** |
| Deborah Cameron | HONG KONG;VIC | +65 9186 8952 Or 0447 262 130 | Upon enquiry | FTF/GRP/WEB |
| Fiona Man Yan Chang | HONG KONG | +852 9198 4363 | Upon enquiry | FTF |
| Polina Cheng | HONG KONG | +852 9760 8132 | Upon enquiry | FTF |
| Wing Wah Hui | HONG KONG | +852 6028 5833 | Upon enquiry | FTF |
| Cary Hung | HONG KONG | +852 2176 1451 | Upon enquiry | FTF |
| Giovanni Ka Wong Lam | HONG KONG | +852 9200 0075 | Upon enquiry | FTF |
| Yat Chor Wun | HONG KONG | +852 264 35347 | Upon enquiry | FTF |
| Eugene Chong | SINGAPORE | Upon enquiry | +65 6397 1547 | FTF |
| Su Keng Gan | SINGAPORE | Upon enquiry | +65 6289 6679 | FTF |
| Abigail Lee | SINGAPORE | Upon enquiry | N/A | FTF |
| Jeffrey Gim Tee Po | SINGAPORE | $100.00 | +65 9618 8153 | FTF/GRP/PH/WEB |

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**Claudia, AIPC Higher Education Graduate**

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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.

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- Recent Advances in the Psychological Treatment of PTSD
- Culturally Competent Care for Immigrants and Refugees
- Creative Therapies: An Introduction
- Three Things Every Child Needs to Thrive
- Educating Clients About Mental Wellness
- Using Play to Provide Multicultural Trauma Treatment to Adolescents and Kids
- Helping Stressed Clients Relax
- Evidence-Based Cognitive Behavioural Treatments for Phobias
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- Case Studies in Counselling Parents
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