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Betrayal trauma - Working with partners of sex addicts

Effective strategies when working with and supporting male clients through family dispute resolution

The Person of the Counsellor in the Outcome of Counselling: The science of therapist effects and the potential of reform for evidence-based practice

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Letters to the editor should be clearly marked and be a maximum of 250 words. Submissions and letters may be addressed to:

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MBS Clinical Review Committee for Item Numbers

By Philip Armstrong

This quarter has been an exciting time as the MBS Clinical Review Committee for Item Numbers started its work going through submissions in early June. ACA registered a submission arguing that the committee should make a formal recommendation for an item number(s) to be allocated for counsellors to allow them to offer services against Medicare, in other words, a fully rebateable service against Medicare.

In early July I was sent an urgent message advising that the MBS review committee had gone through the 120 or more submissions received. They had shortlisted a certain number of professions from these submissions to evaluate their arguments further. I was advised that the profession of counselling/psychotherapy had been selected and they now wanted a representative from the profession to deliver a ten-minute presentation supporting our argument followed by a ten-minute question time. I had been given the honour of representing counselling/psychotherapy as a representative of ARCAP (Australian Register for Counsellors and Psychotherapists) to ensure the profession as a whole was represented.

I was informed of this on Friday 6th, and the presentation was to be made to the review committee on the following Tuesday morning. I chose two co-presenters, Damien Jones an ACA member who co-wrote the ACA submission with me and Jim Schirmer a lecturer from the University of Queensland, an authority on counselling modalities. At 9.15 am on Tuesday, we made our presentation which was well received by the review committee. I would like to thank both Damien and Jim for their time and energy in helping to make the presentation as dynamic as it was at very short notice. I believe that we are as a profession now closer to being seriously considered for Medicare inclusion than ever before, being asked as a profession to undertake a presentation was not only an honour but also a solid indicator that we must be under consideration.

The following is part of the executive summary of the ACA submission:

Every day, Australians are affected by mental illness whether directly or through loved ones, friends and family. The economic and social impacts of mental illness are wide-ranging, persistent and large. The overall disease burden of mental illness now ranks third, behind cancer and cardiovascular disease.

This proposal prepared by the Australian Counselling Association Inc (ACA) details the delivery of stepped care focussed psychological strategies by Registered counsellors within Better Access Initiative, a key component of the Council of Australian Governments (COAG) National Mental Health Plan that commenced in November 2006. This proposal will focus on the delivery of stepped care within the Better Access Initiative (BAI). At present allied health professionals such as psychologists, mental health social workers and general practitioners deliver focussed psychological strategies through the Medicare Benefits Schedule (MBS). This proposal will limit the discussion of the delivery of MBS to evidence-based therapies and focussed psychological strategies.

Stepped care is central to the Australian Government's mental health reform agenda. Registered Counsellors, as defined in the ACA Scope of Practice for Registered Counsellors document 2016, delivering stepped care focussed psychological strategies will support people, their conditions, and their treatment within their mental health plans, thereby reducing the impact of mental illness on individual patients, their carers and the broader community.

The stepped care model will allow Registered Counsellors to integrate into the existing BAI, supporting existing teamwork approaches to client management, shared between GPs, psychologists, psychiatrists and others. Additionally, the integration of Registered Counsellors will improve treatment outcomes of collaborative care teams, support greater workforce distribution, and improve future service planning and health system design.

The burden of mental illnesses can be managed effectively through stepped care focussed psychological strategies, with better mental health outcomes that support the health and happiness of the community, provide economic opportunities to those who are well, and increased social cohesion.

KEY FINDINGS

From the commencement of the Better Access Initiative (BAI) in 2006 to February 2018, around 2,700,000 Australians now have their own individually tailored mental health care plan (MBS Item 2710). Mental illnesses are very common in Australia, as in most parts of the developed world. About one in five Australians aged 16-85 experience anxiety, affective and/or substance use disorders

over a 12-month period (ABS, 2007).

The four most frequently claimed BAI items account for nearly 90% of all services claimed under the schedule are:

1. GP Mental Health Care Plan (MBS item 2710);
2. GP Mental Health Care Consultation (MBS item 2713);
3. Psychological Therapy Long Consultation (MBS item 80010 provided by clinical psychologists); and
4. Focussed Psychological Strategies Long Consultation (MBS item 80110 provided by registered psychologists).

There has been a significant uptake of identified MBS item 80100 to 80170 (AIHW, 2018) with the demand for Focussed Psychological Strategies continuing to increase from 2012 to 2017 (Appendix A). Benefits paid over the same period have remained stable, with out of pocket expenses in socioeconomically more advantaged areas higher and increases in patient load seen in socioeconomically disadvantaged areas, while expenses across the period have remained stable. A key outcome of the BAI was to encourage the development of a new teamwork approach to client management, shared between GPs, psychologists, psychiatrists and others.

The evidence on Registered Counsellors delivering mental health interventions such as Focussed Psychological Strategies within a stepped care approach can be shown to address systemic issues regarding mental health outcomes, wider health system planning and design, and workforce continuity. Additionally, this approach effectively supports individuals' remission and recovery and support their reintegration into the community, thereby realising their individual potential to contribute to workforce participation, productivity, and support wider social cohesion.

CHINESE CHAPTER

On the 29th of July 2018, ACA held a formal event to launch our new Chinese/Australian Chapter which will be based initially in NSW. Over 50 ACA members and members from the local Chinese community attended the event. Further information on Chapter meetings will be released in September.

ACA is very much aware that mental health issues are different from one community to the other, and in particular communities that have origins whose cultures are very different to Australia's. This is a very important issue in any multicultural country, such as Australia. Many first and second generation Australians are challenged with, at times, conflicting views between their Australian peers and their family of origin. These challenges add complexity as to how mental health issues can be approached and addressed within these communities. To enable ACA to better understand these issues ACA is developing Chapters that can help us to develop strategies to meet these challenges which are unique to each community.

Left to Right: Melody Yun Qu, Yumei Cai, Philip Armstrong.

Left to Right: Melody Yun Qu and Philip Armstrong

PEER REVIEWED ARTICLE

BETRAYAL TRAUMA Working with Partners of Sex Addicts

By Sharalyn Drayton
ARISE Counselling Solutions, Sydney, Australia

ABSTRACT

Imagine being in a car accident. Out of the blue someone smashes into you. You didn't see it coming and you were not to blame yet you are trapped, helpless, not sure who to turn to or what to do next to save yourself. The struggle to make sense of what just happened is overwhelming.

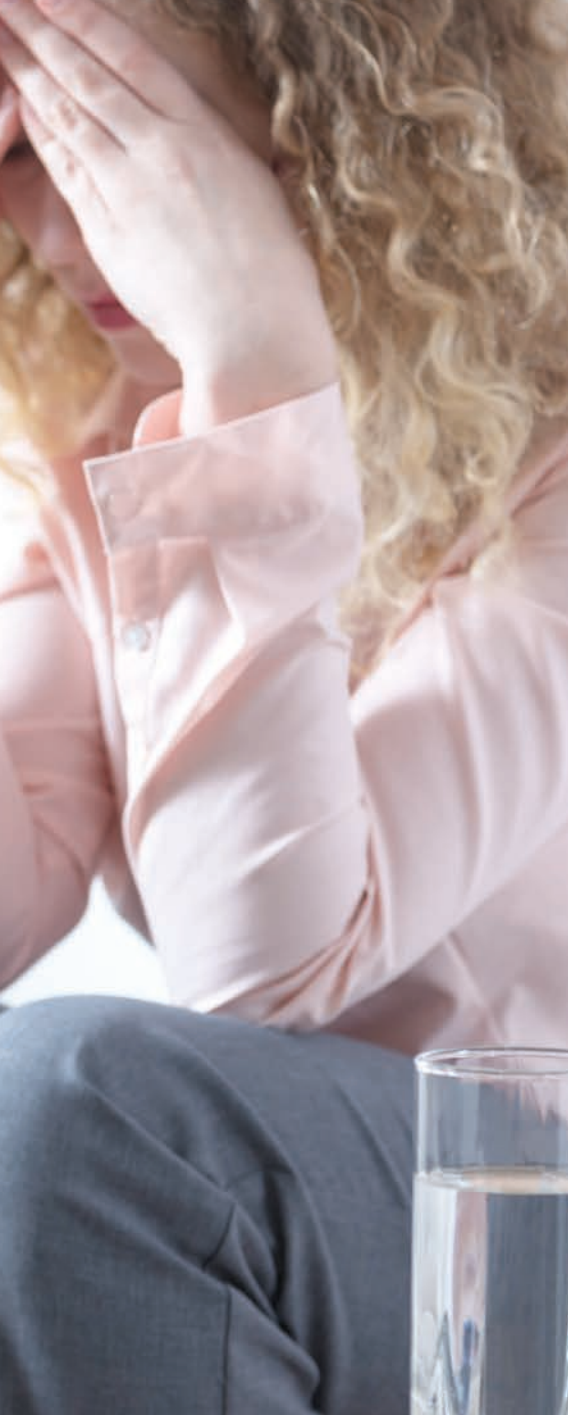
This is pretty much what it feels like for partners of sex addicts when they discover that the person they love and are in relationship with has been acting out with pornography, sex workers or other people. Unlike a car accident the event is just the beginning. For the partner of a sex addict the trauma is increased with each further disclosure around behaviours, finances, people and places, and each new awareness increases the level of confusion, fear, pain and grief.

Partners seek help when they can no longer manage these feelings of pain and the isolation they often lead to. They seek to understand what has happened, for their spouse and for themselves, and how they can survive this. They want to be able to protect and support their family and, if possible, the relationship. Unlike other addictions sex addiction is personal because it undermines everything that was believed about or contracted to in the relationship. Indeed the very person that should be offering support has become the greatest trigger.

With appropriate support from a therapist who understands the impact of betrayal trauma, which is unique to the partners of sex addicts, healing is possible. Partners can break free of the fog of confusion, fear and denial and, in many cases the relationship can not only be repaired but strengthened as each party learns to take responsibility for themselves and their own recovery.

INTRODUCTION

"There are days when you may want to give up and leave. There are nights where you may cry yourself to sleep or stare at the ceiling feeling hopeless and more alone than you can ever remember....There are weeks where you may feel like your life has been shattered into a million little pieces and you want to wake up from this



nightmare. There are moments where you may blame yourself, your family, and God, wanting to scream, WHY ME?"

(*Facing Heartbreak* p.1)

The discovery that the person you are in a long term, committed relationship with has been living a secret life is beyond shocking. Finding out that he has been having an affair is one thing, finding out that he has been sexually active in multiple ways, with multiple people, and/or with pornography over a long period of time is so devastating it is almost beyond comprehension. The "why me" scream comes from somewhere deep inside and brings with it intense feelings of being unsafe, along with feelings of confusion, grief, anger and unbearable pain. Sounds dramatic? It is.

Research has shown that partners of sex addicts often test positive for Post Traumatic Stress Disorder (Steffens and Rennie 2006) and indeed surveys conducted on the sexuality of partners of sex addicts shows a correlation with those who are sexual abuse survivors.

Being lied to, manipulated and methodically deceived over a long period of time by the person that you love and believed to be your life partner results in an experience we now call betrayal trauma.

"When you understand the sexual symptoms experienced by partners of sex addicts, it becomes apparent that the symptoms are strikingly similar to those known to occur from sexual trauma, such as rape, sexual assault, sexual abuse and molestation. When we look at well-established symptoms of sexual trauma and abuse, partners of sex addicts can identify with many or all of them."

(Omar Minwalla in *Mending a Shattered Heart* p.14)

Many partners of sex addicts call the moment of discovery of their spouses betrayal their personal 'D Day' and they recount it in vivid detail and re-experience it with each uninvited intrusive memory, thought, experience and anniversary.

Seeking support is often challenging – after all who do you tell? While it's a struggle for the partner to understand what has happened, and why, it is all but impossible for well meaning friends and family to support the hurting partner without judgement and blame. Subsequently many partners face this nightmare of discovery alone not knowing who to turn to without making the situation worse. Those who chose to stay in the relationship report feelings of shame and inadequacy for not leaving the addict as advised by family and friends, which often creates further stress and isolation.

Working with a therapist who understands sex addiction and the complexity of this form of betrayal will help to normalise the experience for the partner and begin to stabilise the trauma. Knowing that it is possible to recover from the pain and confusion which comes from living with an addict who is compulsively acting out sexually will provide an opportunity for understanding both their own response and the addicts behaviour. This will also provide an opportunity to start to explore the partners own needs and show how this apparently impossible situation can eventually become one of healing and post traumatic growth.

(And just as a point of clarity, this paper refers to the addict as 'him' and the partner as 'her'. This is not to suggest that all sex addicts are male and the partners female. I use this solely for the sake of simplicity for the purposes of this paper.)

WHAT IS BETRAYAL TRAUMA?

"It creeps through the door like a thief in the night and puts all my senses asunder. And the shock's a surprise when with eyes open wide I'm sent reeling and fall to the floor. Then slowly the dawning of reality, yawning, its great gaping mouth open wide and I find that my heart is a smoking divide and my brain is a land mine of warning. And I rant and I rage, broken, unmade, left panting and ravaged and raw."

(Poem written by the partner of a sex addict.)

Being lied to, manipulated and methodically deceived over a long period of time by the person that you love and believed to be your life partner

results in an experience we now call betrayal trauma. It is the shattering of a fundamental relationship attachment bond and for the partner of a sex addict this is a devastating experience where the world as they knew it feels like it has been destroyed. For many they feel that everything about the relationship has been a lie and every experience, memory and dream is now tainted. Partners feel that they don't know who or what to trust, or how to deal with the pain that arises from this situation. For partners who have also experienced other traumas in their lives this betrayal trauma will be even more challenging and painful.

Levine and Kline (2010) write that "...a dilemma of profound consequences is set up if the people who are supposed to love and protect us are also the ones that have hurt, humiliated, and violated us. This 'double-bind' undermines a basic sense of self and trust in ones instincts. In this way ones whole sense of safety and stability becomes weakened".

Partners of sex addicts experience this double bind as the person they have loved and trusted enough to build their lives with has betrayed them at such a fundamental level their sense of self, safety and stability is compromised. Discovering that your spouse has been having an affair with another person is without doubt devastating, however for partners of sex addicts it is so much more. This is not a one off betrayal, but the discovery of a pattern of behaviour which is long term and compulsive and which brings every facet of the relationship (both implicit and explicit) into question.

Partners of sex addicts experience levels of trauma unique amongst addictions. Stephanie Carnes writes that "finding out the person you love is a sex addict is one of the most painful experiences a spouse or partner will ever go through". (*Facing Heartbreak*. 2012) and Claudia Black says that partners are "devastated and overwhelmed and seeking answers for what to do next" (Intimate Treason. 2012). So it's not hard to imagine how impossible it seems for partners who are trying to function in their day to day life when it feels that the framework of their world has so utterly disintegrated. What's more, they are also overwhelmed by their own sense of powerlessness being caught up in something beyond their understanding, and that they often can't talk to anyone about. For a partner discovering that they are in relationship with a sex addict the trauma, pain and confusion experienced often results in a struggle to continue to function in a way that enables them to continue to care for themselves, their relationships and their families. The consequences for all involved can feel overwhelming and insurmountable.

Research carried out by Steffens and Rennies (2006), Omar Minwalla (2009), and Stephanie Carnes (2016), all build on each other to reinforce that partners of sex addicts experience significant trauma responses as a result of discovering their spouses addiction and acting out behaviours. This trauma is complex as it is relational and multi-faceted. Dr Christine Courtois writes on complex betrayal trauma, which she describes as "multiple and repeated experiences of interpersonal trauma" Courtois, C.A. (2014), saying that partners of sex addicts experience both relational and repeated trauma as they are betrayed by someone they have committed to spend their future with. Michelle Mays in her blog PartnerHope expands on the complexity of this type of trauma and shows how the betrayal trauma experienced by partners of sex addicts entwines three distinct types of trauma which are attachment, sexual, emotional and psychological. She explains that attachment trauma is "the overwhelming experience of having the relational bond significantly damaged through sexual behaviour that violates the trust and vulnerability in the relationship", sexual trauma as "the impact to the partner's sexuality resulting from the addicted individual's compulsive pursuit of sex either inside the relationship, outside of the relationship or both" and emotional and psychological trauma as "the confusing experience of being lied to, manipulated, coerced and intimidated by the addicted individual in their efforts to protect their secret behaviour." She goes on to say that "…betrayal trauma makes you feel like you are losing your mind. It yanks your sense of security out from under you and puts you in emotional free fall" (PartnerHope Weekly 2/5/17.)

Understanding the nature of attachment and that in an intimate relationship this attachment bond is significantly ruptured helps us to recognise the overwhelming struggle faced by partners. It also helps us to recognise the importance of establishing safety for the partner, normalising her response and reassuring her that she is not insane.

Many associate trauma with life threatening events and we are more likely to associate the word 'trauma' with an act of violence such as war, sexual assault, motor vehicle accident etc. For partners who often swing between feelings of extreme anger and pain on the one hand and hopelessness and helplessness on the other, the tendency to minimise their traumatic responses to their spouses betrayal further adds to their sense of confusion and they find enormous relief when they come into therapy with someone who understands sex addiction and its impact on partners. They can finally start to see that they are not crazy but experiencing what is a normal response to a highly traumatic event.

Indeed to help highlight just how complex and significant this trauma is, Dr Omar Minwalla from the Institute for Sexual Health developed the 'Thirteen Dimensions of Sex Addiction Induced Trauma (SAIT) among Intimate Partners and Spouses Impacted by Sex Addiction-Compulsivity.' (2014).

These 13 dimensions are:

1. Discovery Trauma
2. Disclosure Trauma
3. Reality-Ego Fragmentation
4. Impact to Body and Medical intersection
5. External Crisis and Destabilisation
6. SAIT Hyper-vigilance and Re-experiencing
7. Dynamics of Perpetration, Violation and Abuse
8. Sexual Trauma
9. Gender Wounds and Gender-Based Trauma
10. Relational Trauma and Attachment Injuries
11. Family, Communal and Social Injuries
12. Treatment-Induced Trauma
13. Existential and Spiritual Trauma

Add to this some of the comments from

partners of sex addicts as they seek to describe their experience which include:

- I can't seem to stop crying. Nothing seems to make sense. I even forget where I am sometimes.
- I feel like a zombie – it's like a big part of me has died, and yet I'm still alive.
- Sometimes, when the pain hits me – it's like a wave that is so powerful it knocks me off my feet.
- Sometimes I even wish he was dead, then at least this nightmare might finally be over.
- It's like I have nothing any more – no future, no dreams – my past has all been a lie and my hope has been shattered.
- I wish he had cancer, at least then I could expect some support from others.
- How do I trust and who? I can't even trust myself – how did I not pick this?

You can see that the betrayal trauma experienced by partners is indeed complex. The trauma is then compounded by the secrecy and shame which go hand in hand with this addiction, and the inability to seek help and support from others for fear of judgement.

In a clinical study of female partners of sex addicts 70% of the study participants met all the symptom requirements for a diagnosis of post traumatic stress disorder (as identified in DSM4). The report goes on to say that even when PTSD is not diagnosed, there is often a recognition by health practitioners that the partner of a sex addict has 'experienced a significant and traumatic life event that produces very painful and often debilitating symptoms'. (Steffens & Rennie, 2006).

Other grief criteria also apply to some partners who can struggle for years to come to terms with their experience.

"....Complicated Grief (CG) and even Disorders of Extreme Stress Not Otherwise Specified (DESNOS) are all issues which may need to be addressed in partners, particularly over the longer term. Many of the symptoms described in the proposed Diagnostic Criteria for Complicated Grief Disorder apply to partners of sex addicts which "includes symptoms of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased (or....sex addict), unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities lasting longer than 12 months."

(S. Drayton (2015)

It's also important to note that for many partners of sex addicts these systems do generally 'last longer that 12 months'. Whether they were aware of some of the acting out behaviours, or have received some level of disclosure, many partners are already experiencing trauma symptoms long before they come for help. For the vast majority who stay in the relationship the struggle to learn to trust their spouse and their own intuition takes time and is compounded by the continuing emotional and physical reaction to triggering events which remind the partner of their spouses betrayal.

... the American Society for Addiction Medicine has declared that sex, eating, and other similar reward producing behaviours can all be classified as addictions.

IS IT SEX ADDICTION?

"Sex addiction is not the same thing as infidelity...Sex addiction progresses, gets out of control, becomes a compulsive pattern, and takes over the addicts life. The illness escalates, and most addicts have a profound shame and despair around their behaviour." (*Mending a Shattered Heart* p9)

Is it really an addiction or is it just an excuse for bad behaviour or mismatched libido?" Debate continues regarding the classification of sexual addiction-compulsivity. Some argue that it should not be classified as an addiction and others argue that it does in fact meet all the criteria for being classified as an addiction.

Following is part of a statement released by IITAP (International Institute for Trauma Addiction Professionals) regarding the validity of sex addiction as a diagnosis.

"the American Society for Addiction Medicine has declared that sex, eating, and other similar reward producing behaviours can all be classified as addictions. In ASAM's 2011 definition of addiction they write:

Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviours. Addiction also affects neurotransmission and interactions between cortical and hippocampal circuits and brain reward structures, such that the memory of previous exposures to rewards (such as food, sex, alcohol and other drugs) leads to a biological and behavioural engagement in addictive behaviours."

(https://www.iitap.com/blog/2016/12/14/response-to-aasect-position-statement)

Add to this the statement released by APSATS – (the Association Partners Sex Addiction Trauma Specialists) which states that:

"To date, over two dozen empirically valid and reliable neurological studies and reviews establish the legitimacy of sexual addiction as a serious problem and public health issue. More than thirty studies reveal decreased relationship and sexual satisfaction when pornography use or sexual compulsivity are present, and seventeen studies associate pornography use and sex addiction with a variety of sexual issues. Additionally, several studies specifically highlight the experience of partners of sex addicts as traumatic, negative and multi-faceted".

(https://apsats.org/.../response-to-recent-aasect-statement-regarding-sexual-addiction)

and it is evident that there is significant research in this area, all of which point to the fact that sex addiction cannot be easily dismissed as anything other than an addiction.

Paula Hall, in her book *Sex Addiction: The Partners Perspective* (2016) sums it up nicely when she says that "while the Professionals decide what to call it, it undoubtedly continues to be a growing problem"(p 8). She goes on to say that "what defines addiction is the dependency on something as a mood regulator, the exact nature of that substance or behaviour is not relevant to the definition" (p10).

What is relevant however, is that for partners, discovering that the person they believed they knew and trusted implicitly has been living a secret life is devastating. Struggling to understand what and why is fraught with challenges, particularly when also confronted with the debate about whether the behaviour exhibited by the spouse is in fact an addiction – and although there will be times when the behaviour does not meet the criteria for sex addiction, for those it does it allows the partner to start to understand that the addiction is something outside of themselves. In other words with education about the nature of addiction and sex addiction in particular, both the partner and the addict, seeking help from appropriately trained professionals, can embark on the long and often arduous path to recovery which begins with understanding what addiction is, how it developed and how it has impacted the addict and their partner.

NOTE: At the time of publication the World Health Organization has added Compulsive Sexual Behaviour as a mental health disorder in the ICD-11. For more information see http://www.sash.net/compulsive-sexual-behavior-diagnosis-in-icd-11/

HELPING PARTNERS

"The discovery...that your partner has betrayed you and your relationship in the most intimate way possible – the sexual bond – is devastating. It turns your world upside down and makes you doubt everything you thought you knew about your partner, your relationship and even yourself.... To choose to stay in a relationship crippled by sexual betrayal and to work through the pain, loss, and uncertainty is no less than heroic, for both the partner and the sex addict." (*Moving Beyond Betrayal* p xvii)

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1 - 2 November 2018, Brisbane CBD
8 - 9 November 2018, Sydney CBD
22 - 23 November 2018, Melbourne CBD
30 - 31 May 2019, Auckland CBD
13 - 14 June 2019, Perth CBD
20 - 21 June 2019, Adelaide CBD
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(minimum numbers must be achieved by 30/4/19 for Darwin)

Clinical skills for treating complex traumatisation

Treating Complex Trauma: Day 3 - 4

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

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***Register securely at our website if you only attend one event.**

Program fee includes GST, program materials, lunches, morning and afternoon teas on both workshop days.

For more details about these offerings and books by Leah Giarratano refer to www.talominbooks.com

Please direct your enquiries to Joshua George, **mail@talominbooks.com**

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No withdrawals are permitted in the eight days prior to the workshop; however positions are transferable to anyone you nominate.

Patrick Carnes identifies six stages of recovery for partners of sex addicts:
The developing stage/pre discovery
partners see that there is a serious problem
Crisis/Decision/Information gathering
partners realise that they can no longer tolerate the problem and seek to understand exactly what has been going on
Shock
partners see how bad things actually are and seek help
Grief/Ambivalence
partners start to connect with the depth of their loss and pain
Repair
partners start to reconstruct how they interact with themselves and others
Growth
partners experience a new depth in their relationships

(*Mending a Shattered Heart* pg242, 243)

When partners come for help they are often in the very early stages of understanding the significance of what has been going on with the person they believed they knew intimately and could trust implicitly. They are confused, often very angry, and in enormous pain. They don't always know the full extent of what is (or has been) going on and they don't understand how they could not have known. They may have reached out to friends or family for support and been told that they should just leave, or "kick him out", so they are often also filled with shame at their own indecision and confusion, and they don't know who to turn to or who to trust....and they certainly don't trust themselves. So how do we help partners?

STABALISING THE TRAUMA AND MANAGING THE CRISIS

Sex addiction is unique amongst addictions in terms of the impact it has on partners and families because it is personal in a way that no other addiction is. It violates everything that has been contracted to in the relationship and turns the world of the partner upside down. For many it feels as if the whole relationship has been a lie and every memory is now tainted by this new knowledge.

Awareness is growing of the traumatic impact on partners and it is being recognised that the way partners respond to the discovery that their spouse is a sex addict is similar to those who have experienced a significant trauma such as a sudden bereavement or assault. (Paula Hall, 2016). Steffens and Rennie point out that the way partners respond to this trauma will depend on the length of time in the relationship and previous traumas experienced, and indeed it can generally be seen by the level of distress that the partner presents with whether or not there have been previous traumas. Connecting with these earlier traumas can also help partners to understand their current level of distress which in itself can help the partner feel more stable.

Developing the therapeutic alliance and normalising the trauma response is the first step toward stabilising the partner. Feeling that they are finally being heard, validated and held will go a long way towards helping the traumatised partner start to settle. Reseach conducted by Corley & Schneider shows that

Many addicts fear the consequences of disclosing their behaviours to their partners

"... partners reported that the most important and useful part of seeing a therapist was being supported and feeling heard. The second most valuable type of advice was to take care of themselves and to recognise that the addict's behaviour was not the partner's fault."

(Corley, M. Deborah; Schneider Jennifer P. (2002)

Sex addiction is about secrecy, lies, manipulation and isolation and as such creates an attachment rupture at a core level. The consequences of the resulting trauma in partners is profound and clients can even present with similar symptoms to Borderline Personality Disorder. Recognising the profound nature of trauma in the partner, and the impact this also has on the coupleship, is essential to ensure that the client receives the correct treatment.

Johnson sums it up when she says

"For traumatised couples, the therapist's goal must be not just to lessen the distress in a survivor's relationship, but to create the secure attachment that promotes active and optimal adaptation to a world that contains danger and terror... Trauma intensifies the need for protective attachments and often, simultaneously, destroys the ability to trust that is the basis of such attachments." (Johnson, S.M. (2005) p10)

Recognising this for partners ensures that the therapists office becomes the safe place where the partner will eventually learn to reconnect to themselves and their world. This helps not just the partner but the addict and wider family. In fact Schnieder's research suggests that if partners receive the right support most relationships will survive the trauma of sex addiction. (Schneider, J. (1998)

Helping traumatised partners through the healing process, looking at the traumatic impact of discovery and providing tools to help manage emotional deregulation resulting from this trauma, along with developing a support network and strategies for self care, will all help to provide a more stable platform from which the partner can begin to move forward. This will then ensure that the partner is supported and that the couple can move into a full therapeutic disclosure which is a pivotal moment in the healing process.

THERAPEUTIC DISCLOSURE

One of the biggest challenges partner and addict alike experience is that of disclosure. It is an integral part of the recovery process for both parties. Disclosure can make or break the relationship and is something which requires the utmost sensitivity and preparation. Although this is something often approached with reluctance by the addict and with a sense of desperation by the partner, the research carried out by Corley & Schneider (2002) revealed that post disclosure 96% of both addicts and partners felt that the disclosure process was the right thing to do. Many addicts fear the consequences of disclosing their behaviours to their partners and that it will have a negative impact, while partners feel that they need to know about all the acting out behaviours as soon as possible. Schneider's research also points out that if handled correctly the disclosure process can be one of healing and in the majority of cases the marriage will survive. Many partners have experienced uncontained and/or staggered disclosure which can contribute significantly to the trauma they experience, so undertaking this process in a safe and contained environment where both parties have the chance to share and be heard can have a profound effect in starting the healing process.

WHAT IS DISCLOSURE?

Disclosure is a 3 fold process which involves the addict disclosing their acting out behaviours and then hearing from their partner how this behaviour has impacted them. The addict then has the opportunity to begin to make emotional restitution by acknowledging this impact and their response to it. Disclosure is the 'line in the sand' moment where the past becomes the past, there are now no more secrets, the impact on the partner has been shared (and heard) and healing for both parties can begin.

Key points for disclosure:

- Disclosure begins the healing process.
- Disclosure should be guided by the partner and what they need to know (they should be given the facts without the gory details)
- Disclosure should be a safe and contained experience facilitated by both the addicts therapist and the partners therapist
- The disclosure process should be well planned and discussed in detail with all parties before the event
- The partner and addict should have a good self care plan following disclosure which includes time with therapists and any support people

EMPOWERING PARTNERS

Although painful and devastating it is possible to heal from the trauma of discovery that your spouse is a sex addict, and while some couples do indeed separate (and this is the right choice for them), others who are fully committed to recovering from their sex addiction and making the relationship work go on to experience post traumatic growth.

Support from outside groups such as SLAA (Sex and Love Addicts Anonymous, www.slaa.org.au) and SAA (Sex Addicts Anonymous, www.saa-sydney.org) for the addict, and partners support groups are also very helpful and can be empowering for partners as they are able to own and share their own stories, experiences and needs. These groups allow partners to connect to others with the same (or similar) experiences. They provide an opportunity for connection where the partners are safe and able to share their story and experiences free from fear of judgement and blame. Members are generally very nurturing and respectful of each other and give each other feedback (rather than advice) which helps normalise their experiences and also keeps them accountable. They also

learn from each others successes (and failures) and come to understand the nature of sex addiction and that, in the end, it is not really even about sex, and it is certainly not about them. As Paula Hall explains "sex addiction is not about fulfilling a sexual need, in the same way that chronic overeating is not about fulfilling hunger" (2016 p10). Addiction is an intimacy disorder and for sex addicts sex it is used to disconnect, creating intensity rather than intimacy. Recovery is therefore about connection and learning to be known at a deep and personal level. This is often a new experience for both the addict and their partners and although often challenging at first, this new intimacy can ultimately become the mainstay of the relationship.

CONCLUSION

"...both the addict and partner need their own recovery before there is any hope for recovery as a couple... Sex addiction exceeds behavioural problems. Addiction is a brain disease. Recovery means healing the brain, healing core wounds, and changing behaviour. Partners need to heal their own wounds of betrayal. They have their own symptoms and core issues."

(*Mending a Shattered Heart* p 245)

Recovery involves restoring trust in self as well as in the addict. Both take time and require good support from others who understand the relational shattering and betrayal trauma which is created by sex addiction. Partners come for help angry and distraught that they find themselves in this distressing situation and that they are having to embrace the awareness of something they never believed was possible. They have zero tolerance with lies, and secrecy (real or perceived) which trigger trauma responses. Creating safety, stabilising the trauma and building the therapeutic alliance goes as long way toward helping the partner of a sex addict start to manage that which has felt absolutely unmanageable.

For those couples who are going to stay in relationship and make it on the recovery journey they will need 100% commitment, 100% honesty and 100% transparency. This may seem impossible but the nature and impact of sex addiction is such that for post traumatic growth to occur and the relationship to survive (and ultimately thrive) both parties need to aspire to this 100% rule. Most partners start from a position of believing that all that is necessary for their emotional well-being is for the addict to stop acting out and all will be right again. However as they gain awareness around the addiction and their own powerlessness over their spouses behaviour and recovery, they also learn that as they didn't cause the addiction, they are also not dependent on the addicts recovery for their future happiness and well-being. With good therapy and support they eventually come to learn that they are responsible for their own safety and growth, and learn to trust that regardless of what happens with the addict they will be able to heal, grow and eventually flourish as they connect with their inner strength and integrity.

Sharalyn started ARISE Counselling Solutions in 2010 where she specialises in working with partners of sex addicts. She also runs PHASE, which is a healing and support group for partners of sex addicts. Sharalyn is Australia's first APSATS Certified Clinical Partner Specialist and is also a Certified Sex Addiction Therapist.

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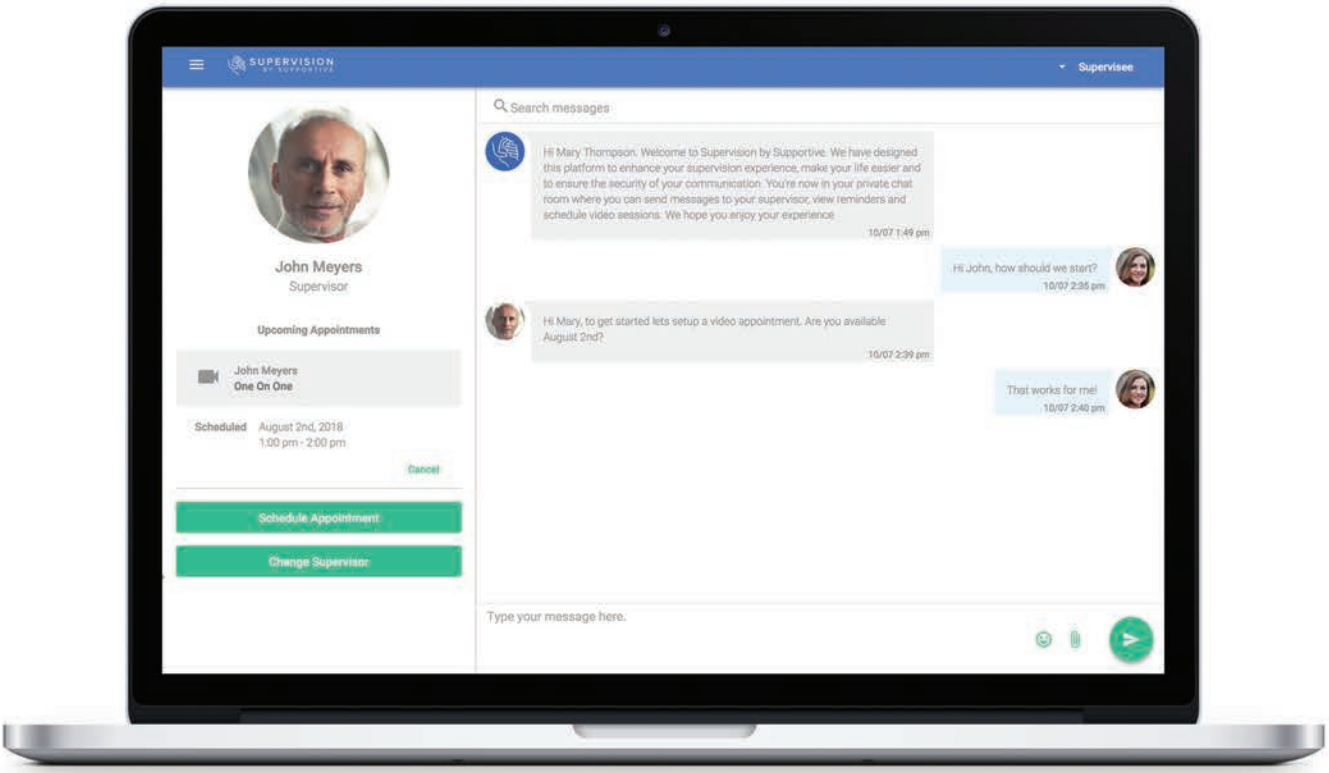

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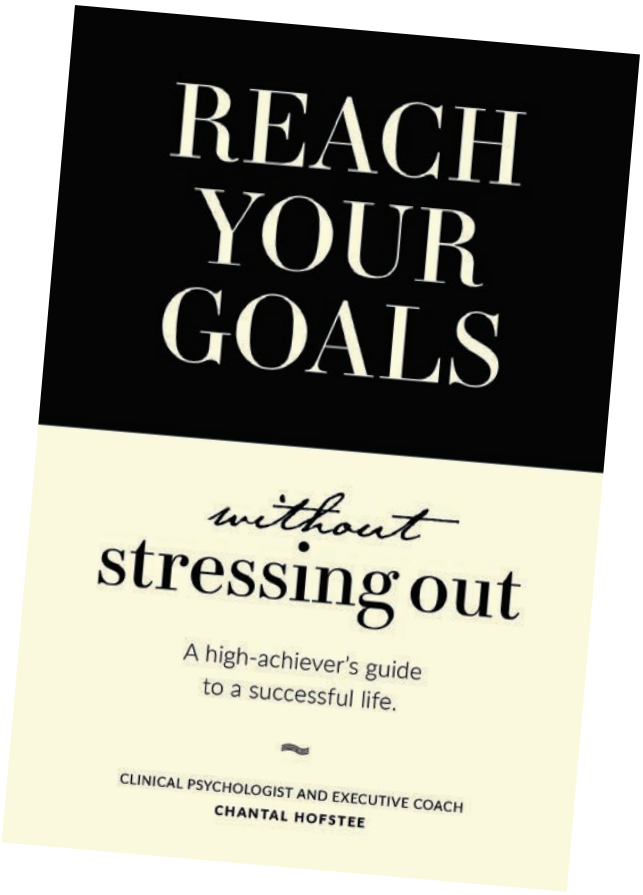
Reach Your Goals Without Stressing Out:

A high achievers guide to a successful life.

Chantal Hofstee (2018).
Exisle Publishing

Reviewed by Simone Potter
School Counsellor. Bachelor Science (Psychology & Human Movement Science), Graduate Diploma Education (Primary), M.A.C.A.



Reach your goals without stressing out is a book that rolls many aspects of wholistic, positive psychology into one easy to read and easy to put into practice manual. Delving into areas such as mindfulness, kind awareness, gratitude, sleep, energy, focus, passion, goal setting, self care and celebrating success, it's ultimate aim is to teach the reader to switch on their 'Green brain', the super power for getting things done and increasing happiness and life satisfaction.

Drawing heavily from her personal experience but also incorporating examples from the lives of her clients, Chantal Hofstee is able to combine in one book a broad and practical overview of many aspects of positive psychology.

At the end of each chapter is a section of insight questions which, when I filled them out, really helped me to consolidate my thinking and to apply the reading to my own life.

It raises the possibility that we can all live from a 'green brain' state, working smarter and not necessarily harder, avoiding burnout and improving the chances of being the best we can be. The section on how and why we can enjoy the process and not just the outcome was my personal favourite part of the book.

The book is not a 'pretty' book, there is no fancy cover design, the beauty resides wholly between the covers.

The only criticism I have is that the important skill of attending with 'kind awareness' is not explained. As this is an important skill and one that does not come naturally to many people, I feel that some focus on explaining it in some depth would have improved the book.

I would recommend this book to anyone striving to achieve great work/life balance in their own lives but the strategies and activities can also be used effectively with counselling clients with mental health issues such as depression and anxiety.

Stepping stones to resilience: Supporting children and adolescents through a life marked by family violence

By Christine Cresswell
Bachelor of Science: Holistic Childcare

Family violence hurts kids, too – even if they don't see it. Evidence shows that living in a family where there is violence – physical or emotional – may have significant traumatic effects on children (Domestic Violence prevention Centre, 2018). As noted by Campo (2015), in the past two decades, empirical evidence about the extent to which children are exposed to domestic and family violence and the negative effect this has on their development has created an impetus for policy responses to this issue. This is reflected in the recognition that exposure to family violence is a form of child abuse in some state and territory child protection frameworks – for example Queensland Child Protection Act 1999, (Office of the Queensland Parliamentary Council, 2005), the Australian Government's National Framework for Protecting Australia's Children 2009–2020 (Council Of Australian Governments [COAG], 2009/2014), and the federal Family Law Act 1975 (Office of Legislative Drafting and Publishing, Attorney-General's Department,1975/2012).

As a result of family violence, children can experience powerful mixed and confusing feelings that may be difficult for them to express. However, despite the horrific emotional, psychological, and somatic impact that family violence has on children and young people, the effects on individual children are not irreversible, if early and effective intervention occurs. Counselling is a safe space where young people can express their feelings and come to terms with their thoughts and life experience (WAVSS, n.d.).

Research has shown that children who have experienced domestic violence are more likely to:

- Exhibit aggressive behaviour
- Experience anxiety
- Exhibit symptoms of depression
- Demonstrate diminished self esteem
- Tell lies, act disobediently, and act destructively
- Reveal reduced social competence skills
- Exhibit emotional distress
- Demonstrate somatic complaints (Irwin, Waugh,& Wilkinson, 2002)

WAVSS (Working Against Violence Support Services) is an NGO based in Queensland with branches in Logan and Redland City. I am their child and youth counsellor. The vision at WAVSS is to:

> … live in a world with a societal non-acceptance of domestic and family violence and to work towards healing and transformation, and the eradication of all forms of violence against WOMAN AND CHILDREN. (WAVSS, 2014)

Their mission is "To become a wave-maker; an incentive element that produces an altering or transforming influence through radical stimulus" (WAVSS, 2014). It's all about making waves.

CREATING POSITIVE CHANGE AND MAKING WAVSS

When an intake is done for children and youth, it is established that they have been witness to abusive relationships within the family system. A child's experience of domestic violence may be through direct witnessing of violent acts and observing the consequences of physical violence: such as broken bones, blood, bruises or broken objects. They may become indirectly involved in the violence by being in close proximity to their mother when she is being abused or when they are intervening to protect her. They may also be directly involved as the subject of abuse by the perpetrator.

For some, there may be responsibility of calling the ambulance or they may react in the moment by mirroring the violent behaviour and trying to stop the perpetrator from hurting the other parent. It is usually noted that the abuse has been continuing for many years and even though the family relationship may have broken down, the abuse is still ongoing in some form. Children tend to become the scapegoat and can be very much caught up in a triangulated web where one parent is judging the other parent to the child and projecting their emotions onto them. I have found children in this situation can be very vulnerable when it comes to taking on those emotions which can send them into feeling confused and overwhelmed by the whole scenario.

They have been traumatised enough over the years with the violence and now they have the separation and the triangulation to try to work through. I see many children who make the comment, "I like both parents and I don't know which side to take or who to choose". On the other hand, I may see children who are caught up emotionally in a battle where the court has given both parents equal share of responsibility for their children but the children do not want to go to the other parent. Young people quite often present this as a huge dilemma in their lives.

When I see the children, it is usually noted that the pattern of violence has been continuing for many years and even though the family relationship may have broken down, the abuse is still ongoing in some form or other and so often, it is evidenced that the cycle is evolving. Before the counselling session with young people, it is not uncommon for the mother to express that, "[Johnny] is acting just like his dad. He is aggressive at home and at school. The teacher says he is not concentrating and is becoming very disruptive in the class room".

The greater the perceived level of hostility or disengagement, the greater the need for me, in the initial stages of intervention, to focus on nothing more than engaging with the child and helping the child to feel that this space is a safe place.

When they begin to feel comfortable, I introduce a modality called, Three-In-One Concepts - One Brain Approach to counselling which uses muscle testing. Three-In-One Concepts was founded and created by the late Gordon Stokes (1929-2006). In 1976, Stokes officially created Three-In-One Concept, Inc. and in 1983, with his partners, Daniel Whiteside (1933-2013) and Candace Callaway (1949-2005), he began to fashion Three-In-One Concepts into its current form: infusing the One Brain method with everything that peaked his interest throughout his life time – from Parent Effectiveness Training to Personology. Three-In-One Concepts developed and expanded to become a multidimensional therapeutic modality, focusing on the integration of Body, Mind, and Spirit as forming the One Brain. The modality was further developed to assist people resolve their personal experiences of emotional stress overwhelm in all areas of their life (Three-In-One Concepts, 2016).

Building on the foundational work of Stokes, Whiteside, and Callaway, Dominic Burke focused his PhD research on understanding student responses to their emotional stress and trauma related issues when sitting for exams (Burke, 2007). Testing took place at the University of Queensland where it was validated that resolving emotional stress and identifying feelings help students to think differently about their emotional experiences.

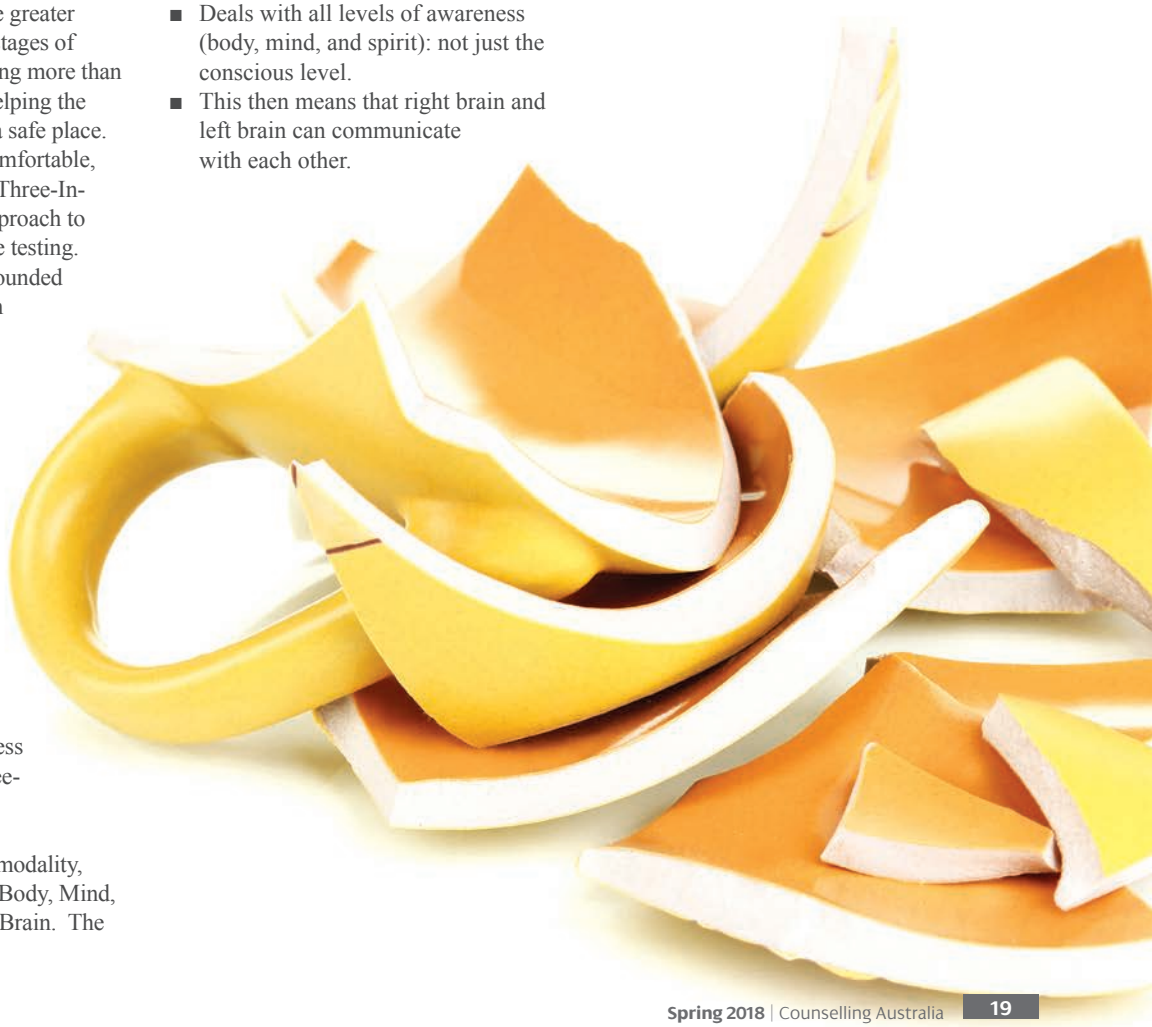
Three-in-One Concepts muscle testing is not testing muscles. It is testing the brain's hemispheres. With both brains working equally, we get an honest reading of how emotion affects the body and how to unblock blocked energy and blocked perception (Stokes, 1996).

HOW DOES IT WORK?

- Biofeedback from the body/brain allows us to identify and defuse the suppressed negative emotions that sabotage the positive changes that we want in our lives.
- Deals with all levels of awareness (body, mind, and spirit): not just the conscious level.
- This then means that right brain and left brain can communicate with each other.
- Connection of all levels allows for integration of the right creative brain and left logic brain.
- Gets more into what is hidden in the sub conscious, rather than what we think we know on the conscious level.
- Deals directly with self-doubt on any issue and the stress overwhelm that restricts clear thinking and freedom of choice.

When I am working with young people, I tend to "go with the flow" and while I am working with the presenting issue I am also working with what the muscle indicates to me at the time. Quite often my clients will say, "Oh yes, that's right! That is what I would like to get the stress off".

The stress may not be to do with the trauma they are experiencing at present, but could be related to something they have experienced in the past and which may feel very similar to the somatic sensation that is happening in the present. However, what is the same, is that there is a contributing critical incident that triggers a stress response that could be either traumatic in the moment or could present as secondary trauma (Wyder & Bland, 2014).



When using the muscle as the indicator, I will "age recess" (in counselling terms, more commonly referred to as age regression). This evokes release of a stored memory back to where the muscle response indicates an appropriate age for healing past trauma. This will be the age at which I will release the stress and re-balance the brain into thinking differently about the emotional experience at that age. I will use the muscle to determine the type of healing the body and mind require.

It is my fundamental belief that every child who enters through my door is their own unique person. What they share is a life overshadowed with the trauma associated with Family Violence. Therefore, while Three-In-One Concepts is my primary "go to", I bring an eclectic approach incorporating modalities such as, reframing, visual association picture and word cards, non-directive sand play, directive sand tray, painting, drawing, feeling faces, visualization, child-centred play, and positive affirmations. I will then use the muscle to bring the new way of thinking up to the present time.

I have found that when working with young people, the way they acknowledge their traumatic experience can be very different. Some demonstrate extraverted behaviour and like to talk about the whole experience. Others can become quite withdrawn and do not like to talk about anything.

In my experience young people love to be muscle tested. They love the experience of seeing how much stress they really have and how the muscle helps them to tell their story. I have had teens call it a "lie detector" as they could be telling me something very different to what the muscle is indicating – the muscle remembers what the brain may choose to forget. Or as Bessel Van der Kolk (2014) might say, "The body keeps the score".

This process keeps the brain in the present rather than focussing on experiences that have happened in the past. I have had children and teens say to their mum and the receptionist, "How does she get all that information from my muscle – this is so cool! When am I coming again?"

From my experience, there does not appear to be a fixed rule on how many sessions a child or youth would require for keeping the brain in the present. I usually allow for eight fortnightly sessions with a tapering down process. After receiving positive feedback from mothers, it is my understanding that children tend to feel very good and balanced after sessions, therefore it is really noticeable when they don't feel good. This is their indicator that they need to have another session.

I believe healing can be an ongoing process. Therefore, the purpose of counselling is to bring children and youth to a level of resilience where they are able to cope and distance themselves from the ongoing impact of critical incidents in this life span. For so many of my clients, it is highly likely that they are still living in an environment where abusive behaviour is the norm and where they are still caught in the web of family violence. I find using the One Brain Approach and muscle testing, combined with expressive therapies, to be the greatest gift in helping young people acknowledge their experience, and the emotions attached to the experience: even if they choose to not talk about it.

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Effective strategies when working with and supporting male clients through family dispute resolution

By Deborah Stevens

ABSTRACT

Family Dispute Resolution Practitioners (FDRP) and Family Relationship Centre (FRC) professionals are those who initially engage male clients, from the first point of contact through to the Family Dispute Resolution (FDR)/mediation process. In conducting the research, interviews were conducted within a regional FRC.
The research examined the phenomenon of how strategy effectiveness is related to their work with and support of male clients, through the FDR/mediation process. Findings proposed both a collective and individual lived experience, encompassing strategy effectiveness, which was subjective within the epistemological values of the individual participants. Further research is required to fully grasp and clarify the many facets that make up the FDR/mediation process and define/evaluate strategy effectiveness.

INTRODUCTION

Since the industrial revolution, to urbanisation, as well as inauguration of the feminist movement, contemporary ideologies concerning marriage, family, and the increase in separation/divorce, as well as societal attitudes to parental care and responsibility for men and women have undergone transformation (Hunter, 2005; Folberg, et.al, 2004; Joakimidis, 2003). This shift or transition in stereotypical gender roles and parental attitudes was thematic throughout the selected literature reviewed. Hawthorne (2002), in his article, writes on how men are pressured to abandon traditional roles considered as patriarchal, in feminist theory, and unacceptable in a gender-sensitive society. According to Hawthorne, this loss of identity creates confusion for men around what characterizes 'good enough' fathering, in the care of children, while society continues to idealise the motherhood archetype ('maternalism'), as the best choice in providing primary care to children (Karpetis, 2010; 2002).

A comprehensive paper, compiled by the Joint Parenting Association, provides a review of child custody decisions/reforms through the centuries, from the 'presumption of father's rights' to the 'tender years presumption', which formed significant foundations in modern court decisions, relating to residence and care of children (Joakimidis, 2003). Joakimidis' review encapsulates cultural, societal and economic changes, which have contributed to the decline of the family unit, particularly in separation/divorce of parents regarding continued responsibility and care in the best interest of their child/ren, as well as other significant pivotal global changes noted by other writers, researchers and academics. Changes noted included, the increase or return of women to the workforce (married/single-due to economic instability) especially during and

following WWII (Hunter, 2005; Maley, 2003); the rise in individualism, defined as a woman's right to self-sufficiency and independence, as stimulated by the feminist movement (Bagshaw, 2008; 2005; Flood, 2004; Hawthorne, 2002); the rise in family instability, with increased divorce rates and the introduction of no-fault divorce (2008; 2005; Folberg, et. al, 2004; 2003; Nicholls & Pike, 2002); and finally the growing control over and diversity in fertility (2005; 2003). Hawthorne (2002) suggests these changes have gradually redefined the traditional father role, from moral teacher, to absent financial provider, to gender role model, to finally at becoming a more nurturing, hands on parental partner.

Men and women who have been estranged through separation or divorce, may at some juncture acknowledge a desire to work toward shared parenting responsibilities; so as to spend time with their children, in a meaningful manner, forgoing relational conflict. If both parties are able too, they may amicably work out a co-parenting agreement/plan through respectful communication, having the needs and best interest of their child/ren as first priority (Stevens, 2012). However parties who, continue to experience post relational animosity, ongoing conflict and are unable to communicate might, either voluntarily or through orders handed down by the Family Law Court, engage in Family Dispute Resolution (FDR)/ mediation (Williams, 2006).

The intent of FDR/mediation is to facilitate change in the resolution of family law disputes, with a goal to discourage disputing parties from entering into time consuming and costly litigation (Stevens, 2012; Bagshaw, Brown, Wendt, Campbell, McInnes, Tinning, Batagol, Sifris, Tyson, Baker, & Fernandez Arias, 2010). It is further intended to encourage and empower parties to negotiate a co-parenting agreement/plan focused on the best interest, as well as reflective on the needs, of their child/ren, who have been caught in the middle of continued adult relational conflict (2012; 2010; 2006).

Family Dispute Resolution Practitioners (FDRPs)/mediators and Family Relationship Centre (FRC) professionals are those who initially engage clients, from first point of contact, to evaluation and education, finally to the completion of FDR/mediation. FDRPs and FRC professionals may enter the practice of mediation, from prior unique vocations (law, psychology, social work, counselling, etc.) and backgrounds, as a result specialist training and skills are elemental to their effectively working with both male and female clients, in FDR/mediation (Littlefield, 2007; Folberg, Milne, & Salem, 2004).

The FDR/mediation process begins when one parent initiates contact with a Family Relationship Centre (FRC), registered private Family Dispute

Resolution Practitioner (FDRP/mediator) or proceeds to resolution through their solicitor. In the case where and FRC is contacted, a first point of contact interview is conducted by an FRC professional (Family Support Officer), to gather initial demographic and immediate needs information, from the initiating parent, who becomes Party A. Party A is provided with information and a brief explanation about the FDR/mediation process, followed by the setting of an intake interview with an FDRP. At the intake the FDRP conducts an assessment interview to gather additional information, to assist in determining suitability for mediation. The FDRP may provide information to Party A about child inclusive mediation, if the children are old enough and wish to participate, and referrals/resources may also be provided, if requested or found to be of benefit. Permission is gained by the FDRP to contact the other parent, at the intake and they are referred to as Party B. Contact is made with Party B, who is asked if they would like to participate, as well as given the opportunity to decline. Should Party B respond in an affirmative manner, they too go through the intake process? Once both parties have completed the intake, and prior to mediation being scheduled, both parents must attend a Parent Information Session (separately) to gain knowledge and understanding of their children's safety, developmental and emotional needs. It is through this process that the FDRP/FRC professional, gains an awareness of how clients, particularly male clients perceive, understand and experience the FDR/mediation process. FDRPs and FRC professionals at this point must be able to engage effective strategies, to work with and support male clients regardless if they are Party A or B.

Current changes, in involvement with and the role of the father in nurturing and caring for their child/ren prior to separation and/or divorce, brings male clients to FDR/mediation with the perception that 50/50 shared care is their right (Stevens, 2012). If the co-parenting agreement/plan does not reflect this belief, fathers then construe their position has been disregarded or invalidated in favour of the mother. Possible causes for this perception, for male clients, may be in their lack of understanding of the *Family Law Act*, disenfranchised loss and grief, an inability to engage with services or programs due to employment, or anxiety that they will be judged as inadequate or uninvolved fathers (Hawthorne, 2002; Pasley & Minton, 1997; Dudley, 1996). A number of factors, identified in literature, research and clinical experience, may have unintentionally contributed to the perceptions and experiences of fathers, after separation and/or divorce; these include, a deep sense of loss and grief (relationship, home, income, identity), distress over no longer being involved in the lives of their child/ren, which lead to significant changes in self-concept (mental health issues), contributing to self-harm, suicide, and continued parental conflict or alienation (Stevens, 2012; Ambrose, Harper, & Pemberton, 1983; Hetherington, Cox, & Cox, 1976).

Changes to the *Family Law Act (Cth) 1975* were formulated to encourage conflicted parents to move from adversarial arbitration, through solicitors and the court, to achieving more personalised resolutions and agreements, in shared parental responsibilities, through use of a neutral third party (FDR mediator). Assistance is provided, by the FDR mediator, to engage both parties in open communication, to make decisions about important issues reflecting the best interest and changing needs of their child/ren (Bickerdike, 2007; Lodge, 2007; Folberg, et. al, 2004).

FDR/mediation has, over the decades since the *Family Law Act 1975 (Cth)*,

evolved into a multidimensional, dynamic system which recognises divorce and/or family cessation, not only in consideration of legal terms, but also as being charged with emotion. As a consequence assistance is now provided to both parties, through a neutral third party, to encourage discussion, explore options and possibilities, while allowing parties to take responsibility in reaching an amicable co-parenting agreement/plan (Bickerdike, 2007; Lodge, 2007; Hunter, 2005; Folberg, et. al, 2004; Maley, 2003).

DESIGN AND METHOD

Ethical approval for the research was gained through application National Ethics Application Form (now the Human Research Ethics Form) and submitted to the Australian College of Applied Psychology-Human Research Ethics Committee.

The research examined current strategies as a way to gain understanding of effectiveness, when working with and supporting male clients through the FDR/ mediation process, by drawing on the knowledge, experience and observations of FDRPs and FRC professionals (Liamputtong, 2009). Two sub-questions were developed, to further study: (a.) the phenomenon of effectiveness of current strategies of FDRPs/FRC Professionals, from their perspective, drawing on their experience and knowledge, when working with and supporting male clients and (b.) exploration of a possible correlation, in how FDRPs/FRC Professionals understand the male clients experience and/or understanding of the FDR/mediation process, and effectiveness in provision of programs and service delivery.

The paradigm and methodology used in the research was based in phenomenology, to study the nature and meaning of strategy effectiveness, in working with and supporting male clients, as practiced and/or experienced by FDRPs and FRC professionals, within a regional FRC (Finlay, 2008). Phenomenology, as applied to qualitative research, is the study of phenomena: their nature and meanings. The focus and aim, is to provide a lens by which to view and understand the way an experience is lived by an individual within their environment (Finlay, 2008). Phenomenology is distinct from other approaches in research because it combines psychological, interpretative, and idiographic components. The use of, participant validation was used to 'prove' and strengthen the validity in this qualitative research project.

A framework approach, accompanied with a Thematic Analysis Matrix, was used to sort themes and present the coded data gained out of participant interview transcripts. Thematic analysis is related to phenomenology, in that it focuses on the lived experience and subjectivity of the selected participants, it is a way of making meaning out of the context of their lived experience (2008). The Analysis Matrix is a spreadsheet used to visually present and summarize coded data for thematic recognition and analysis. The use of this methodology and approach was suited to the nature of the research project, as it "highlighted the complexity, ambiguity and ambivalence of participant's experiences" (Finlay, 2008).

Method

PARTICIPANTS

Participants for the research project comprised Family Dispute Resolution Practitioners (FDRP) and Family Relationship Centre (FRC) Professionals, based at a regional Family Relationship Centre. The number of participants proposed for the research was between 6 and 8; however the number of participants totalled 5, due to some FDRPs and FRC professionals' unavailability or their not wanting to participate. The regional FRC staff who chose to participate included, FDRPs (2), Senior FDRP (1), Child Consultant (1) and Family Support Officer (1). Participant groupings consisted of 4 females and 1 male, with backgrounds and experience in areas such as, counselling/ education/community service (2), solicitor (1), social work (1) and no formal qualifications (1).

Recruitment of participants was carried out via an announcement at a normal staff meeting, with a follow up internal email. Participation in the research project was voluntary, with no professional or personal incentive offered to participants and written consent was procured prior to carrying out interviews, with the FDRPs and FRC professionals. Participants were afforded the opportunity to withdraw from the research project at any time, without infraction to either the research project or the regional FRC, in writing to the researcher.

Data was gathered through face to face, relaxed, conversational interviews conducted by the researcher, at the regional FRC over two days, in order to gain a more subjective view of the participants (n = 5) lived experience of the phenomenon. Through the use of 12 short open ended questions, enlisted to facilitate a relaxed conversational style interview, each interview was recorded and then transcribed, for use in eliciting descriptive data of the lived experiences of the participants. Descriptive representations or themes of the participant lived experience, as related to the phenomenon of effectiveness were coded and placed into an Thematic Analysis Matrix, providing a visual representation of the perspectives of the participants. The questions collected participant information related to, position/role, at the regional FRC and gender, followed by the 12 open-ended questions, to enquire into experience, qualifications/ knowledge and perception of male clients understanding of the FDR/

mediation process, from the participants lived experience and perspective. (See Appendix A)

Participant's responses were then coded and ordered, to synthesise the data into a thematic analysis matrix, (Finlay, 2008) to identify and/or distinguish themes (Framework approach) within the context of the interview transcripts. A central theme, effectiveness of strategies and 4 subthemes: experience and effectiveness, knowledge and effectiveness, gender and effectiveness, as well as perception of male client's experience/understanding and effectiveness, were used to identify cases and variables of the matrix (Finlay, 2008). Coded data snippets, from each participant's interview transcript, were entered to aid in the process of making meaning around the phenomenon of effective strategies used in FDR/mediation, by FDRPs and FRC professionals, when working with and supporting male clients.

The Framework approach, developed at the National Centre for Social Research in the United Kingdom (Bryman, 2008), provided the strategy for data analysis. Each participant interview was transcribed by the researcher and re-read to gain an insight into the participant's perspective and experience in relation to the context of the effectiveness of strategies used in FDR.

Using deductive thematic analysis, participant interview transcripts were re-read a second time, focusing on the identified core theme effectiveness of strategies, in correlation to research sub-questions (a.) phenomenon of effectiveness of current strategies of the FDRPs/FRC Professionals, from their perspective, drawing on their experience and knowledge, when working with and supporting male clients. Snippets of content were then highlighted according to how they related to the FDRPs and FRC professionals perceptions, experience and understanding of the 4 subthemes: experience and effectiveness (orange), knowledge and effectiveness (pink), gender and effectiveness (yellow), and perception of male client's understanding and effectiveness (blue). Content was also highlighted, in green or grey, relative to the research sub-question (b.) exploration of possible link in how FDRPs/FRC Professionals understand the male clients experience and/or understanding of the FDR/mediation process and effectiveness of in provision of programs and service delivery.

Selected highlighted content, of participant interview transcripts, was then placed into the Thematic Analysis Matrix, under the coordinating subtheme, either as quoted or paraphrased to embody the FDRPs and FRC professionals, lived experience and perception, of the phenomenon in effectiveness of current strategies in working with and supporting male clients through the FDR/mediation process. The matrix is set out in a spread sheet where the data themes were coded (by colour) and summerized (by the researcher and checked by the research supervisor), then set out in a visible, straight forward presentation, noting the relevant interview question to support coding and placement. A Copy of the Thematic Analysis Matrix as set out in the original research in Appendix B, can be supplied upon request from the researcher.

FINDINGS

The meaning and perception around effectiveness of current strategies as used by FDRPs and FRC professionals, based at the regional FRC, as illustrated in the Thematic Analysis Matrix, might be described in terms of an individual collective. The 5 participant's individual lived experience in relation to perception of effectiveness of current strategies used in working with and supporting male clients through the FDR/mediation process also reflect a collective lived experience within the regional FRC.

Denotations, within the context of the interview transcripts, imply similarities of experience and perception (collective), in relation to the core theme, as well as the 4 sub-themes as expressed in their (individual) narratives, in response to the interview questions. A compilation, of reflections around effectiveness of strategies, in relation to experience and knowledge, particularly with male clients, was observed in statements such as: "I try to fit the client."; "Yes its very individual."; "I tailor my role to fit the client or try to especially with males."; "…they all have their own idiosyncratic ways of doing mediation."; "…the way mediation is done depends on the practitioner."; "They know what their true model is, but it varies with each person.", show collective lived experience and perception in practice.

Further observation, of statements reflecting a collective experience, was in effectiveness and perception of the male clients experience and understanding, and was expressed in terms of comfortableness; "I want them to feel comfortable."; "It is a

process which is very comfortable."; "… try to make them feel comfortable"; "…so they really feel comfortable."; and values "definitely about values of fatherhood and how you see men.".

Individual meaning and experience about the impact of FDRP's and FRC professional's gender, on effectiveness of strategies was communicated from a more personal perspective, with two participants (1 male and 1 female) stating, "No, it is my personal belief/experience that gender does not impact…". However the remaining participants (3 females) expressed their personal perspective in this way, "I think you've got to be aware of the gender impacting on every particular situation."; "It can do with some men." or "I think at first it does, because it takes them a long time to sort of get to that point where they are comfortable.", indicative of a differing personal lived experience.

In conversation with participants during interviews and in re-reading the interview transcripts, observation of the collective illustrated even though formal qualifications varied (3 under graduate, 1 post graduate, 1certificate level) and work/life experiences (1 lawyer, 1 social worker, 1education/counsellor, 1 counsellor, 1 administration) differed, all participants shared an awareness about strategy effectiveness, in working with and supporting male clients through the FDR/ mediation process as, "hearing both sides of the story", facilitative, educational, and transformative, with a focus on "the best outcome for the children and both parties".

A further collective experience was noted in relation to sub-question (b.) how FDRP and FRC professionals perception/understanding of the male clients experience and/or understanding of the FDR/mediation process and effectiveness in provision of programs and service delivery. The evidence of this was expressed in statements such as, "when we did a little bit of research here, we specifically looked at resources for men and the need for a male counsellor for one day per week, one has recently been put on." and "I do think there is a need for men to discuss things with men . . .and try to get them a men's program, more, gritty, from a man's perspective.".

DISCUSSION

Analysis of data, within the Thematic Analysis Matrix framework, provided insight as well as a robust sense of the phenomenon, which encompasses strategy effectiveness when working with and supporting male clients, through the FDR/ mediation process. Congruent themes compiled and coded from the data, provided an unexpected meaning within the phenomenon between the FDRPs, FRC professionals, a collective lived experience and shared understanding of strategy effectiveness and support of male clients, in practice, within the regional FRC (Liamputtong, 2009). The phenomenon, of the collective lived experience, exemplifies evolution in credibility (academically and professionally), as well as in theoretical paradigms in FDR/mediation, as practiced within the regional FRC, especially when working with and supporting male clients (Tehan& McDonald, 2010; Littlefield, 2007; McIntosh, 2007; Folberg, Milne, & Salem, 2004). Furtherance the collective lived experience, also highlighted genuine understanding and knowledge, of FDRPs and FRC professionals, and their ability to work within the guidelines of the *Family Law Act (Cth) 1975* and *Family Law Amendments (Shared Parental Responsibility) Act 2006 (Cth)* (Lodge, 2007). The individual interviewees openly spoke about being, "non-judgmental or

biased"; their role as a neutral third party in facilitating communication between the parties and as an advocate in the best interest of the children (Bickerdike, 2007; Lodge, 2007; Hunter, 2005; Folberg, et. al., 2004; Maley, 2003).

The phenomenon of strategy effectiveness was shown to be connected with engagement and education of male clients, in areas of parenting and child development, as well as the FDR/mediation process. Hawthorne (2002) addressed this in relation to the redefined traditional role of the father, over time, to be more hands on and involved in the day to day care of the children (Joakimindis, 2003). Perception of FDRPs and FRC professionals, in how men understand and perceive the FDR/mediation process, was evident in the findings, showing awareness, and thus beginning to address issues, validation of the fathering role, provision of a male counsellor, and providing information about the FDR/mediation process with a "masculine friendly format". These actions could be seen as recognition and growth in how, not only the regional FRC, practitioners and professionals provide programs and service delivery to men after separation and/or divorce that can be generalised across other agencies and organisations (McIntosh, 2007; Hawthorne, 2002; Pasley & Minton, 1997; Dudley, 1996).

The findings, while not in entirety, provided credible resolutions in addressing the research question, and also adding too and supporting the body of already existing literature on the topic: Are Family Dispute Practitioners (FDRP)/Family Relationship Centre (FRC) Professionals, using effective strategies, in their work with male clients in the Family Dispute Resolution (FDR) process? Resonance, with previous/current research and literature, in the field of Family Dispute Resolution, was demonstrated in participant responses during face to face interviews, in re-reading the interview transcripts and in coding the data for analysis, which corroborated credibility. The two sub-questions were validated through, coding and discovery of the core theme, effectiveness of strategies and 4sub-themes, experience and effectiveness, knowledge and effectiveness, gender and effectiveness, perception of male clients experience/understanding and effectiveness.

Application from the research findings will enable FDRPs and FRC professionals to generate and develop theories in improvement of practice strategies and skills to better work with and support male clients, in the provision of programs and service delivery, throughout the mediation process. This will further, equip and enrich FDRPs and FRC professionals, therapeutic, practical and professional skills, as well as provide additional effective strategies for use in program and service delivery to male clients.

Development and improvement of current strategies, in work with (engagement), support, education, and empowerment of male clients, as well as the provision of equitable and practical understanding of the FDR/mediation process will assist in building capacity within fathering and co-parenting, while reducing on going parental conflict. An ongoing possibility would be to have the theories, strategies and approaches, to working with and supporting male clients, through the FDR/mediation process, translated into general practice and terminologies that could be used within Family Relationship Centres and/or other community services/agencies, when engaging, supporting and providing programs and deliver services to male clients.

LIMITATIONS

The research undertaken in this project was limited by selection of participants from one Family Relationship Centre (Regional QLD), further by the small number of FDRPs and FRC professionals who volunteered and participated in the face to face interviews. Due to the short time frame (12 weeks) in which to carry out thorough analysis of the data and examine the extensive phenomenon that encompasses effective strategies, not all data could be coded and the findings reported.

Future research could explore the phenomenon of how men experience the FDR/mediation process, what is their perception of FDRPs and FRC professionals, and what men want out of programs and/or service delivery, offered through Family Relationship Centres or community organisations/agencies after separation and or divorce. Further research of effective strategies, not only in how to work with and support male clients, might also include how to engage, re-empower and enable men to build capacity/resilience in their own personal inherent strengths, to co-parent their children without animosity or conflict.

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Appendix A

FDR PRACTITIONER/FRD PROFESSIONAL – INTERVIEW QUESTIONS

INTERVIEW GUIDE

BACKGROUND INFORMATION – ESTABLISHING CONTEXT

FDR practitioners and FRC professionals are those who initially engage male clients, from their first point of contact through to the FDR/mediation, this research project will examine the phenomenon of how effective are current strategies when working with and supporting male clients, from the perspective of FDR practitioners and FRD professionals. The aim of this interview is to examine 'the FDR practitioners/ FRC professionals experience, knowledge and perception' (Liamputtong, 2009) of current strategy effectiveness in work with and support of male clients throughout the FDR/mediation process. Proposed benefits of this research project will be to contribute too and potentially improve skills, strategies, practice and knowledge, in how FDRP's and FRC Professionals work with and support male clients throughout the FDR/mediation process. Further, your perspective as an FDR practitioner and/or an FRC Professionals may provide a link to understanding the phenomenon of how men experience and understand the FDR/mediation process. The potential, as a result of this research, may assist FRC's to facilitate equitable programs and may potentially enable the FRC to construct more effective strategies for working with male clients in service delivery, especially in cases where male clients have failed to engage or participate after separation/divorce. The possible benefit for male clients will be potential development of educational and supportive programs/resources that are specifically relevant to the male experience and understanding of the FDR/mediation process.

This interview will consist of some introductory questions, followed by some more probing, direct and indirect questions, to begin with could you please state your position and gender.

Position:

Gender:

Short structured interview questions: (source of data for thematic analysis)

1. What are your qualifications and experience do you have in working with and supporting clients throughout the FDR/ mediation process?
2. What skills and strategies (models/paradigms) do you use when working with and supporting clients through the FDR process?
3. Could you please expand on and explain how you use your strategies (models/paradigms) in relation to your work with and support of male clients?
4. How effective or ineffective do you believe the strategies (models/paradigms) to be in your work with and/or support of male clients in/through the FDR process?
5. As a practitioner/professional, do you believe your gender impacts on or affects the work and support male clients receive throughout the FDR/mediation process, please expand?
6. In considering this FRC, with a majority of practitioners/ professionals being female, do you see this as impacting on strategic and/or practice dynamics? Could you please explain and/or expand on your answer?
7. In relation to the above question, do you think this may/may not impact on your work with and support of male clients, please expand?
8. If you were able to change any currently used strategies, for work with and support of male clients through the FDR/ mediation process, in order to improve effectiveness, what and how would you go about making the change happen?
9. In your observation/view do you think male clients understand the FDR/mediation process, please explain your answer?
10. Do FRC practitioners/professionals know and understand the process/model/paradigm required for use in mediation at the FRC? How is this communicated to them? (Senior prac/ professional, training, PD, in service, practice, etc. – if so in what way and if not why not?)
11. Is there anything that we have not discussed that you would like to tell me more about?
12. Is there anything you would like to ask me, in relation to the research project or the interview topic, which you believe to be important?

Appendix B

THEMATIC ANALYSIS MATRIX

A form of computation of data in Qualitative Research, to examine similarities and/or differences in participants lived experience and subjectivity in relation to the phenomenon, gained through personal interview.

THE RESEARCH QUESTION

Are Family Dispute Practitioners (FDRP)/Family Relationship Centre (FRC) Professionals, using effective strategies, in their work with male clients in the Family Dispute Resolution (FDR) process?

SUB- QUESTIONS

(a) Phenomenon of effectiveness of current strategies of the FDRPs/FRC Professionals, from their perspective, drawing on their experience and knowledge, when working with and supporting male clients.

(b) Exploration of possible link in how FDRPs/FRC Professionals understand the male clients experience and/or understanding of the FDR/mediation process and effectiveness of in provision of programs and service delivery.

Theme: Effectiveness of Strategies (a)

Participant	Experience & Effectiveness	Knowledge & Effectiveness	Gender & Effectiveness	Perception of male client's experience/understanding & Effectiveness
Interviewee (1)	FDRP for 5 years (Q1) "having worked with men in my previous roles of various forms of counselling was of great help" (Q4)	"I have grown and expanded my knowledge . . . in the beginning I maybe wasn't as effective as I am now." (Q4) Interviewee listed a number of working with male, orientated courses. Registration with Attorney General's Office (AGO); abide by Family Law Act (Q10) Training consisted, basics of mediation, continued training, looking at different models. (Q10) Facilitative, sometimes Transformative (Q 3 & 10) is effective in Child Inclusive (Q12) Qualifications: under graduate university and specific vocational certificate levels	"I don't think mine does." (Q5) "My honest belief is that gender does not …." (Q5)	"There's a percentage that don't have a clue, absolutely no clue at all, about the FDR process." (Q9) "they have an expectation . . ." (Q9) "probably comes from the fact that they are used to the adversarial process . . ." (Q9) "because a lot of men feel that the Family Law is in favour of women" (Q12)
Interviewee (2)	Experience in working within community organisations, service provision, program provider, worked within community sectors, government sectors, education and areas that relate to people and safety of children (Q1) Background in counselling and education. (Q10)	"there's been a consistent build-up of skills . . . I've been gaining the skills each time I've progressed" (Q1) "I've done a number of training programs related to working with men." (Q1) Facilitative, educational, unable to label but felt more a hybrid model (Q2) Feminist framework, Family Law Act, further discussions and training around these frameworks and structures" (Q10) Qualifications: undergraduate, postgraduate university and specific vocational certificate levels	"you have to actually deal with their preconceptions of being female" (Q5,6,7) "It can do with some men." (Q7)	"they don't always understand the process . . . they don't always have the communication skills or ability to express themselves, their thoughts or feelings" (Q9) Example of a male client's perception of a previous mediation, biased against him, etc. (Q5 & 9) "men don't get any help or assistance with this sort of thing" (Q9) "sometimes they want a little bit more direction and guidance" (Q10)

Theme: Effectiveness of Strategies (a) continued				
Participant	**Experience & Effectiveness**	**Knowledge & Effectiveness**	**Gender & Effectiveness**	**Perception of male client's experience/understanding & Effectiveness**
Interviewee (3)	Worked 4 years with the Department of Child Safety (Q1) 20 months in current position at the FRC (Q1) Intensive family support in prevention and intervention. (Q1)	"It would be a getting them back on track sort of role" (Q2 & 3) "just trying to point them in a more positive direction to reduce conflict" (Q3) "focus on positive strategies, communication, being practical, taking the client through the whole of the mediation process" (Q3) "continued training in relevant areas, encouraged to participate in training" (Q2) Systems Theory; values (Q10) Qualifications: undergraduate university level	"it definitely has something to do with it, in the same way as if I was male, it can impact in various ways and you don't know" (Q5,6,7) "Funnily enough for men I don't think it's such as big of an issue as it is for the women to be honest." (Q6 & 7) "I think you've got to be aware of the gender impacting on every particular situation." (Q7)	"don't like conflict but don't know how to move out of it" (Q9) "men sometimes aren't always as knowledgeable about developmental needs of their children"(Q9) "I think men like to know there's a practical good reason" (Q9) "maybe not in depth detail of the process, they definitely have strong goals and are very goal orientated" (Q9) "they'll put up with the process, they don't always like the process, they'll take it if they think it's applicable to their own world and it's achievable " (Q9) "Often men can be quite defensive, they have a preconceived idea about what the mediation process is going to be about" (Q9)
Interviewee (4)	Lawyer for 28 years and a specialist Family Lawyer for 25 years (Q1) "you meet a variety of people and you have to blend your mediation practices and approach to those people" (Q10)	"I take the listening approach" (Q2,3) "I think we're doing evaluative at the moment" (Q3) Intervention and direction (Q2) "Sometimes moves into arbitration" (Q2,3) "I take the view that there can't possibly be a perfect model" (Q2) "the evaluative model's all very good and traditional, I don't think this model works all that well" (Q3) "transformative mediation not only benefits the children but it can benefit the parties" (Q3) Qualifications: under graduate university level	"No" (Q5,6,7) "Oh, well it's just been my experience, that it doesn't seem to make any difference" (Q6,7)	"client's sometimes don't know how to follow the process that much so our mediators and me intervene" (Q3) "I don't think there's much difference between the understanding of the process between men and women" (Q9)

Theme: Effectiveness of Strategies (a) continued

Participant	Experience & Effectiveness	Knowledge & Effectiveness	Gender & Effectiveness	Perception of male client's experience/understanding & Effectiveness
Interviewee (5)	"I relate to people" (Q1) "I have worked with men before" (Q1) "I've worked with different people . . . my aspect and work ethic with how I treat people, I think is what is supported me in getting the role" (Q1) "I also sit in on the mediations." (Q3) "I've been shown how to do the role, it's more the hands on approach in how I've done the role" (Q3) "I tend to find with male clients, they like to know the details, I tend to give them a lot of information" (Q7)	"I may have discussed with clients, making them think and be reflective I how they may be able to change the way they look at something" (Q2,3) "With male clients, I build a trust and get them to think not just on what they're set on, but outside that box." (Q3,4) "I tailer my role to the client or try to especially with males" (Q3,7) "I think the way mediation is actually modelled depends on the practitioner" (Q10) Facilitative, Transformative would take too long , would need to have a case manager" (Q10) Qualifications: Currently completing a Certificate IV in Child, Youth & Family Interventions	"There is a difference" (Q5) "I think at first it does, because it takes them a long time to sort of get to that point where they are comfortable." (Q5)	"They like to know time frames, like to know how it's going to work, you need to make (male clients) comfortable, speak in terms they understand" (Q9) "I think they do, it depends whether they're Party A or Party B; Party A initiate, more aware of process, done a little bit of background information into service, probably not aware that it is a voluntary process; Party B the y don't know what's going on , feel that they are being judged, come in quite angry sometimes, very guarded" (Q9) "Men are the ones that want action, need to explain the process, need to give dates and times" (Q9)

Possible links in FDRP and FRC Professional perception/understanding and delivery of programs/services (b)

Participant	Further comments
Interviewee (1)	"one thing we did flag, when we did a little bit of research here, was the need for a male counsellor; one has been put on and he is booked out; I like the idea of a more case management style" (Q8 & 11)
Interviewee (2)	"As a centre we look at the actual physical environment of our front area, our waiting area and how we work our paper work, our forms and everything to ensure that they are not gender biased or of putting to men." (Q8 &11) "specifically looked at resources for men, recently made it possible to have a male counsellor one day per week" (Q8 & 11)
Interviewee (3)	"I do think there is a need for men to discuss things with men . . .and try to get them a men's program" (Q5) "I think if you have a value about fatherhood you're going to be more happily received by men" (Q10 & 11)
Interviewee (4)	"In the last two years we've done 100 hours each of practice, of training" (Q 10) "we like to look to the future and changes in education , we focus not only on the process but the administration in record keeping" (Q11)
Interviewee (5)	"I see the results; I don't just see part of it and not know what's gone on afterwards, helping them through the process and hopefully a good outcome." (Q4,11) "I would probably like to see some of the Parenting Education tailored more to men, possibly a completely different one, more, gritty, from a man's perspective, coming from men to men."(Q11) "I would like to know how men see the FRC, how are they comfortable; provision of DVDs, pamphlets, etc; evaluation in a more masculine friendly format – tick & flick – also add a component or question on the intake to ask about the role the father has had with the children" (Q12) "fathers roles have changed, they are playing a big role in everything, maybe we should ask that question on the intake form, rather than about parenting style" (Q11, 12)

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The person of the counsellor in the outcome of counselling:

The science of therapist effects and the potential of reform for evidence-based practice

By Jim Schirmer

ABSTRACT

For several decades, the human services profession has operated under the mandate of evidence based practice (EBP). While the justification for EBP to improve client outcomes is sound, in reality it has been over-conflated and consequently reduced to mean empirically supported treatments (EST). During this time, however, the evidence for what works in counselling has consistently found little difference in efficacy between established interventions, while finding that contextual and common factors have a greater impact on outcome than the treatment. One such factor is the impact of the individual counsellor on the outcome of counselling, with research signifying that the therapist who the client sees matters more than the therapy that is chosen. This paper reviews the research on therapist effects presents the evidence of the existence and magnitude of these effects in both research and practice contexts. This article then examines the real-life implications for clients of the human services system, including the potential for improved outcome should the reality of therapist effects be included in concepts of EBP. Finally, the paper will examine some possible steps that both individuals and the profession can take to begin to harness the potential of therapist effects to improve their service to clients.

BACKGROUND

For several decades now, major branches of the human services have adopted and operated under the framework of evidence-based practice (EBP) (Thyer, 2004). While this emphasis has emerged as the result of economic and political realities (Banks, 2011), the ethos of the counselling profession also affirms the need for EBP in order to enhance positive outcomes for the clients they seek serve (Sullivan, 2008).

While most major definitions of EBP describe a complex interaction of research evidence, client values and practitioner expertise (e.g., Sackett et al., 2000), the reality for both researchers and practitioners is that EBP has been conflated with the use of scientifically-verified theories, techniques or interventions, collectively gathered under the heading of empirically supported treatment (EST) (Messer, 2004). The logic of EBP being defined by EST can be traced historically to the development of controlled experimental research in the 1920s (Wampold, Baldwin, Holtforth & Imel, 2017). The application of these experimental techniques to certain areas such as farming and medicine proved to be remarkably successful, given that the controlling of variables could lead to reasonable confidence about a chosen intervention successfully causing a desired change.

While the transfer of this logic into the research on counselling and psychotherapy[1] has been ubiquitous, other research has raised serious questions about the appropriateness of this method as the sole (or even primary) source of evidence for practice. Most significant is the extensive meta-analytic research which has failed to find a significant difference in effect size between different treatments (Wampold & Imel, 2015). In contrast, the variance in outcome in counselling seems to be impacted more by non-specific, common factors than the specific treatment chosen (Messer & Wampold, 2002).

One such common factor is the effect that the individual counsellor has on the outcome of therapy, commonly known as the therapist effect on outcome. The reality of therapist effects runs against the grain of the logic of EST. For example, the successful outcome of empirically supported practices in farming and medicine described above did not rely of which farmer planted the genetically enhanced seed or which doctor injected the new drug (Wampold et al., 2017). Nevertheless, the research consistently points toward the opposite in counselling: the outcome of counselling may depend more upon the therapist seen than the therapy chosen (Wampold & Imel, 2015)

If the profession of counselling is to take

1 Due to the literature that is relevant to this article covering the common areas of counselling and psychotherapy, these terms will be used interchangeably, along with the cognate terms ‘therapy’, ‘therapist’ and ‘counsellor’.

seriously its mandate to maximise client outcomes, then the question of what factors cause successful therapy and how these might be harnessed are perpetual priorities for both research and practice. To this end, this paper will review and summarise the research into therapist effects on the outcome of counselling. Firstly, this article will summarise the research on the nature and the magnitude of therapist effects. It will then outline the details of what would change in our systems and practices if we shifted the focus of EBP from EST toward therapist effects. Finally, the paper will highlight several possible steps that practitioners and the profession could take in order to use this knowledge to improve outcomes for clients.

THE REALITY OF THERAPIST EFFECTS

While the proposition that the person delivering therapy may be more influential on outcome that the therapy itself might seem a progressive position, the study of therapist effects goes back at least as far as the mid-1980s (Luborsky et al., 1986). This research sought to correct what is known at the "uniformity assumption", namely the potentially flawed supposition that every client assigned to counselling will be receiving a uniform treatment (Wampold & Imel, 2015, p. 158). This assumption has meant that the effect of the therapist on the outcome of treatment has not been adequately accounted for in the design and analysis of the majority of counselling outcome studies, and thus the estimation of therapist effects requires a re-analysis of data from such studies (Crits-Christoph & Mintz, 1991; Wampold & Imel, 2015).

Early studies into therapist effect embarked on that very project, and re-analysed existing data to compare the outcomes across the individual therapists who delivered the intervention, finding that the mean outcomes of the individual counsellors indeed differed in comparison to one another, and that this difference has a greater impact on outcome than the intervention chosen (Blatt, Sanislow III, Zuroff, & Pilkonis, 1996; Luborsky et al., 1986; Luborsky, McLellan, Diguer, Woody, & Seligman, 1997). Crits-Christoph et al. (1991) were the first to use meta-analytic methods to quantify the magnitude of therapist effects, estimating that nearly 9% of variance in outcome could be attributed to the particular counsellor a client saw. These discoveries prompted a major expansion of studies into the nature and extent of therapist effects in both research and naturalistic settings, and the findings of the early analyses consistently verified the existence of therapist effects (Project MATCH Research Group, 1998; Kim, Wampold, & Bolt, 2006; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; McKay, Imel, & Wampold, 2006; Saxon & Barkham, 2012).

In using meta-analytic methods to review this extensive literature, Baldwin and Imel (2013) conclude that while individual studies vary in their estimates, the collective evidence allows us to say with reasonable confidence that the particular counsellor a client sees accounts for approximately 5% of the variance in outcome. Furthermore, this rate increases in naturalistic settings that do not have the benefit of research controls, so that in these settings the therapist effects increase to about 7% of variance in outcome, highlighting that for clients seeking help in real-world setting, this variable has a large effect on the success of their treatment (Wampold & Imel, 2015).

While the overall effect of 5% seems small, such a level is similar to other well-established process variables (e.g. the therapeutic alliance) and is much larger than others (e.g. adherence to a particular

treatment) (Baldwin & Imel, 2013). In fact, considering that the very act of attending therapeutic counselling accounts for 20% of outcome, the significance of a variable that accounts for 5-7% of outcome should attract further attention from researchers, practitioners and managers (Imel, Sheng, Baldwin, & Atkins, 2015). The real-life implication of all of this is that for a client seeking help from a counsellor, the successful outcome of their venture depends, at least in part, on which counsellor that person sees (Barkham, Lutz, Lambert, & Saxon, 2017). Given our professional and ethical mandate to act faithfully toward the trust that our vulnerable clients place in us (Pellegrino, 1995), it is imperative that we consider how we might use this knowledge to best serve our clients.

EXPANDING EVIDENCE-BASE PRACTICE TO ACCOUNT FOR 'EVIDENCE-BASED PRACTITIONERS'

The reality of therapist effects highlights the fundamental difficulty in creating a reliable evidence-base around how counselling works, namely that the process of counselling is inherently inseparable from people (Krause, Lutz, & Saunders, 2007). Consequently, when we say that a therapy 'worked', the phenomenon that we are describing is one where people 'worked', inasmuch as the person we call the counsellor and person we call the client did something together that resulted in the achievement of a mutual goal (Bergin, 1997). The irony, of course, is that all major theories and interventions themselves treat the therapist in exactly this way, insofar as they articulate the personal qualities and relational attributes that are most conducive to positive outcome (McConnaughy, 1987). Therefore it is disingenuous for research to treat the counsellor as a variable to managed, when the nature of the person of the therapist is in fact integrated into the intervention to the point of inseparability (Lindgren, Folkesson, & Almqvist, 2010).

Krause et al. (2007) were some of the first to consider the implications of this for the concept of evidence-based practice, and put forward the prospect of recognising evidence-certified psychotherapists along with or instead of evidence-certified treatments. Blow and Karam (2017, p. 718) further develop this concept, and define evidence-based practitioners as "those providers who consistently are able to achieve positive results with their clients." Given the variance of therapist performance that is evidenced in the reality of therapist effects, it is proposed that such a concept would be a better predictor of successful client outcome than which counselling modality or intervention was used (Blow, Sprenkle, & Davis, 2007).

Attention to the possibility of evidence-based practitioners as a central element of evidence-based practice has the potential to redirect the locus of evidence-based practice away from EST and toward the two elements that most consistently contribute to positive outcome, namely client characteristics and therapist expertise (Laska, Gurman, & Wampold, 2014). In practice, this distinction would mean that EBP would primarily consist of a process of matching clients to counsellors, rather than on matching a treatment to a diagnosis (Boswell, Constantino, & Kraus, 2017). Such a shift contains both positive potential and practical implications, both of which will now be examined in turn.

THE POSITIVE POTENTIAL OF 'EVIDENCE-BASED PRACTITIONERS'

If, as the research suggests, there is good reason to shift the focus from therapy to the therapist in the provision of EBP, there are several potential benefits that this shift could have on the provision of professional counselling (Miller, Hubble, & Wampold, 2017).

Firstly, as has already been indicated, knowledge of which counselling practitioners consistently achieve positive outcome could assist in creating client-counsellor matches that lead to better results. Such a practice is possible given significant evidence exists that therapist effectiveness can be accurately predicted from past performance (Kraus et al., 2016). Moreover, there are important variables which increase the likelihood of successful outcome due to the matching of clients with evidence-based counsellors. For example, research consistently shows that a counsellor's effectiveness may be specific to a domain of practice, meaning that an individual counsellor will be more adept in achieving positive outcomes with some issues compared with others (Kraus, Castonguay, Boswell, Nordberg, & Hayes, 2011). Furthermore, the severity of client presentation will impact outcome, with therapist effects most discernible in the outcomes of complex cases (Saxon & Barkham, 2012). Finally, taking account of client preferences and theory of change is naturally also likely to result in a better alliance and outcome (Boswell et al., 2017). While many service managers and supervisors have likely already worked to create strong matches between clients and counsellors on these variables of client issue, severity and preference, this research suggests a more formal use of an individual practitioner's evidence-base in these variables could improve the accuracy of the decision making regarding counsellor-client matching (Boswell et al., 2017).

The second major area of that holds potential for the concept of evidence-based practitioners is the possibility of large scale overall improvement in the counselling outcomes of the client population. While the data on therapist effects affirms that most counsellors achieve a satisfactory level of competence and outcome, there are 15-20% of counsellors at the bottom end of the spectrum whose effectiveness is below average (Barkham et al., 2017). The impact of this group is not neutral, given that clients are not only likely to fail to improve through therapy with these counsellors, but are actually likely to deteriorate as a result of the service (Kraus et al., 2011). The real world implication for a client who has been referred to one of these counsellors is that she or he has half the likelihood of recovery than if they were referred to one of the most effective therapists, and is three times as likely to deteriorate than if they had been referred to an average or above-average counsellor (Saxon & Barkham, 2012).

Saxon and Barkham (2012) calculated that if they removed this segment of the least effective therapists, the population would see a 3% overall improvement in the rate of recovery, which would have equated to better outcomes for 265 clients in their sample. Through a statistically-simulated thought experiment, it is estimated that by repeatedly removing the bottom 5% of therapists (based on outcome) over a 10 year period, a population of 60,000 clients could expect to see at least a further 4,200 people respond positively to therapy who otherwise wouldn't due to therapist variance (Imel et al., 2015). This simulation was actualised by Goldberg et al. (2016), who effectively 'removed' this lower segment of therapists through improving their outcomes with monitoring, feedback and training. The results supported the premise, as overall client outcome improved, and that this improvement was best explained by the within-therapist improvement amongst individual counsellors.

PRACTICAL IMPLICATIONS: STEPS TOWARD ESTABLISHING 'EVIDENCE-BASED PRACTITIONERS'

Given the positive potential for improving client outcomes through better client-counsellor matching and individual counsellor development, it is important to consider some initial steps that the profession could take in moving toward a more central focus on evidence-based practitioners.

The first and most obvious implication would be that for this system to work, it would require individual counsellors to collect and maintain information about their client outcomes (Blow, 2017). It is well known that such routine monitoring of outcome is not uncomplicated due to factors as diverse as resourcing, ethical complications around privacy, and competing demands of stakeholders (Boswell, Kraus, Miller, & Lambert, 2015), not to mention therapists' own attitudes to the vulnerability that this form of accountability entails (Baldwin & Imel, 2013). Consequently any system of outcome monitoring needs to be simple and unobtrusive to use, be benchmarked in such a way to adjust for known variables that influence outcome (such as risk level of the client), tap into the motivation of the practitioner, and be used within a context that is developmental rather than punitive (Boswell et al., 2015).

As evidenced in the study described by Goldberg et al. (2016), the collection of outcome data is not an end in itself, but rather is the catalyst for the question of how to then improve practice in light of this knowledge. While there is research that suggests that the very practice of collecting routine feedback on client progress is in itself likely to improve client outcome (Lambert et al., 2001), this may be moderated by variables such as the practitioner's belief in and commitment to the process (de Jong, van Sluis, Nugter, Heiser, & Spinhoven, 2012). Further research affirms that along with practitioners establishing their baseline and receiving regular feedback on their performance (all of which happens automatically in routine outcome monitoring), actual improvement in outcome requires the counsellor to engage in deliberate practice in the areas requiring improvement (Miller, Hubble, Chow, & Seidel, 2015). Consequently, achieving excellence in counselling is akin to achieving excellence in any other field, insomuch as it relies upon an intentional effort to practice and improve discreet parts of performance (Chow et al., 2015).

While the routine collection of outcome data has the preeminent advantage of improving client outcome through targeting developmental activity to underperforming counsellors, a less obvious advantage is its use in identifying master or expert therapists. In attempting to harness the power of therapist effects, identifying those counsellors who regularly achieve above-average outcomes and studying what may contribute to their success is a notable opportunity (Blow, 2017). While a precise model of expertise or mastery in counselling and psychotherapy remains an elusive subject (Hill, Hoffman, Kivlighan Jr, Spiegel, & Gelso, 2017), several authors propose that the use of outcome data should be a major criterion in the assessment (Goodyear, Wampold, Tracey, & Lichtenberg, 2017; Okiishi et al., 2006). Identifying these individuals holds the promise of identifying qualities that can further inform the development of mastery in the person of the therapist (Norcross & Karpiak, 2017).

Further to the observable skills and techniques that contribute to successful counselling outcome, the literature on therapist effects consistently identifies that the most effective counsellors also exhibit non-specific, less quantifiable personal characteristics that activate the common therapeutic factors that contribute to successful counselling (Ackerman & Hilsenroth, 2003; Jennings & Skovholt, 1999; Laska et al., 2014). For example, Blow and Karam (2017, p. 720) propose qualities such as "flexibility, projecting hope and confidence, patience and pacing in clinical work, self-reflection and insight, curiosity, humor, and… a sensitivity to diverse culture and contexts" are core characteristics required for high performance in counselling.

This finding poses the need for counsellor development to not only include direct practice in competencies, but to also engage in processes that stimulate personal character development (Donati & Watts, 2005). Once again, such an assertion is hardly antithetical to the ethos of counselling, but rather is directly in line with what most major counselling methods already affirm as being essential for their successful implementation (McConnaughy, 1987). This type of development is best understood under the heading of transformative learning, which is defined as learning that results in "deep shifts in ways of knowing and in ways of being" (Hoshmand, 2004, p. 82). Such transformational growth in personality and character is usually the synthesis of an individual's temperament with an encounter with an experience of disequilibrium that provides the requisite stimulus to promote growth of new characteristics or virtues (Neumeister, 2017; Prosek & Michel, 2016). To this end, the normal challenges inherent in the professional work of counsellors may provide sufficient critical incidents to act as the stimulus for transformative learning, which, when harnessed through training and supervision, could provide the catalyst for the personal development required to increase one's professional effectiveness (Howard, Inman & Altman, 2006).

The final implication of the shift of focus toward evidence-based practitioners would be a review and potentially a reform of training programs for counsellors and psychotherapists. Currently, most training providers assess counsellor competence through the clinical judgements of faculty and supervisors, however when the outcomes of trainees are monitored, it is possible to already see the standard patterns of variability in therapist effects in relation to effectiveness, efficiency and client dropout (Banham & Schweitzer, 2016). In this way, in seeking to create evidence-based practitioners, training bodies may extend beyond teaching models, techniques and skills in order to also form the habits and practices of evidence-based practitioners, such as becoming receptive to feedback, engaging in deliberate practice and undertaking transformative learning to develop the personal qualities conducive to therapeutic excellence (Blow & Karam, 2017).

CONCLUSION

The reality of EBP is going to remain as a central priority to the profession of counselling for several reasons, not least being the ethical mandate we have to the vulnerable population that we seek to support in healing and growth. That said, if our attention to evidence has integrity, the profession has to take seriously the resounding research supporting the impact of non-specific factors on the outcome of counselling (Messer & Wampold, 2002). As this article has discussed, our ability to monitor and harness just one of these factors – namely, therapist effects – has the potential to result in more positive outcomes for hundreds, if not thousands, of people through better matching of clients to counsellors, identification and development of under-performing practitioners, and the discovery of the qualities of the experts and the integration of these qualities into standard practice.

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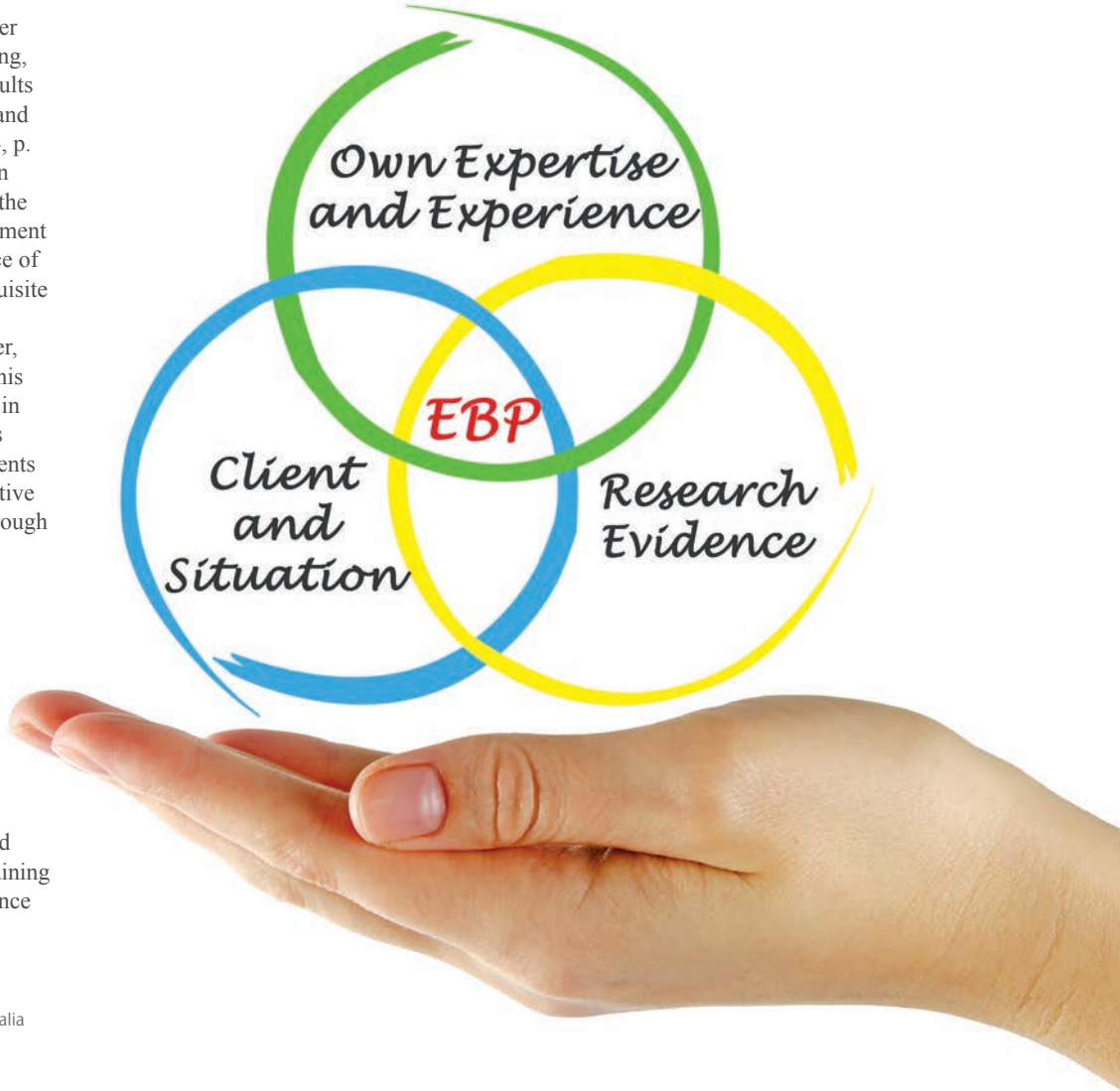

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Deborah Stevens	KINGAROY	0411 661 098	Upon Enquiry	FTF
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Roslyn Price	REDLAND BAY	0401 266 170	80/hr for practitioners $80/hr for students	FTF/PH/GRP/WEB
Frances Taylor	REDLAND BAY	0415 959 267 or 07 3206 7855	Upon Enquiry	FTF
Margaret Newport	Sarina	0414 562 455	On enquiry	Face to Face, Phone, Group & Skype
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
Julianne Cutcliffe	SPRINGFIELD	0425 623 400	$50 Students $60 professionals	Face to Face, Phone, Skype
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 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 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				
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
Penny Adams	BALAKLAVA	0458 549 787	Upon Request	F/F; PH; GRP; WEB

ACA SUPERVISOR COLLEGE LIST		Medium key: FTF: Face to face I PH: Phone I GRP: Group I WEB: Skype		
Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
SOUTH AUSTRALIA *CONTINUED*				
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
Naomi Blake	CLOVELLY PARK	0401 243 757	198	F/F; PH; GRP; WEB
Carol Kerrigan	ENGLFIELD	0410 567 479	Upon Enquiry	FTF
Maxine Litchfield	GAWLER WEST	0438 500 307	Upon Enquiry	FTF
Beverley Dales	Golden Grove	0413 303 576	$25 PP	FTF/PH
Ellen Turner	HACKHAM WEST	0411 556 593	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
Carol Moore	OLD REYNELLA	08 8297 5111 bus 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
Leeanne D'arville	SALISBURY DOWNS	0404 476 530	Upon Enquiry	FTF
Erin Annie Delaney	STIRLING	0477 431 173	Upon Enquiry	FTF
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 ye	FTF/PH/GRP/WEB
Karen Mace	GRINDELWALD	0418 378 123	Upon Request	F/F; PH; GRP; WEB
David Hayden	HOWRAH NORTH	0417 581 699	Upon Enquiry	FTF
Pauline 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 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
ANITA HOARE	BALLARAT	0407 547 410	Upon request	F/F; PH; GRP; WEB
Ann Moir-Bussy	BALLARAT	0400 474 425	Upon Enquiry	FTF/GRP/PH/WEB
Jeff Pemberton	BALLARAT	0422 375 899	80	FTF/PH
Keith Hulstaert	BELGRAVE	0409 546 549	Upon Enquiry	FTF
Roselyn Crooks	BENDIGO	0406 500 410 or 03 4444 2511	$60	FTF
Judith Ayre	BENTLEIGH	0417 105 444	Upon Enquiry	FTF
Kathleen 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
Gayle Stapleton	BERWICK	0459 075 284	100 p/h Negotiable	FTF/PH/GRP/WEB
Robert Lower	BEVERIDGE	0425 738 093	Upon Enquiry	FTF
Gaye Hart	BITTERN	0409 174 128	Upon Enquiry	FTF

ACA SUPERVISOR COLLEGE LIST		Medium key: FTF: Face to face I PH: Phone I GRP: Group I WEB: Skype		
Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
VICTORIA *CONTINUED*				
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; 0409 596 674	$90.00	F/F; PH; GRP; WEB
Lindy Chaleyer	BRIGHTON EAST	0438 013 414	Upon Enquiry	FTF,Skype
Anne 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 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
Bianca Lavorgna	COLLINGWOOD	0428 555 466	Upon Request	F/F; PH; GRP
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 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
Paul Montalto	Fairfield, Fitzroy Nth, Benalla	0415 315 431	Upon Enquiry	FTF
Kerryn Maree Knight	FrankstonMornington	03 9770 5670: 0450 253 990	$100 ind, negotiable	F/F: WEB
Graeme 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 Brett	GLEN WAVERLEY	0421 559 412	Upon Enquiry	FTF
Chen Luo	Glen Waverley	+61404706474	$70	F/F:PH:GRP:WEB
Robert McInnes	GLEN WAVERLEY	0408 579 312	Indiv $70, Grp $40 (2 hours)	FTF
Jeannene Eastaway	GREENSBOROUGH	0421 012 042	Upon Enquiry	FTF, Skype, Groupwork
Lehi Cerna	HALLAM	0423 557 478	Upon Enquiry	FTF/PH/GRP/WEB
Jacqueline Tarabay	HAMPTON	0412 559 569	Upon Request	F/F; PH; GRP;
Tim Connelly	HEALESVILLE	0418 336 522	Upon Enquiry	FTF
Christine Storm	HEIGHTON	0418 432 362	Upon Request	FF; Group, Skype
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 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
Keren Ludski	MALVERN	03 9500 8381 Or 0418 897 894	Upon Enquiry	FTF/PH/WEB
Katherine Cho	MALVERN EAST	0402 618 070	$70/hr (Ind); $40/hr Grp	F/F; PH; GRP; WEB

SUPERVISORS REGISTER

ACA SUPERVISOR COLLEGE LIST		Medium key: FTF: Face to face I PH: Phone I GRP: Group I WEB: Skype		
Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
VICTORIA *CONTINUED*				
Michelle Wood	MANSFIELD	0497 037 436	Upon enquiry	Face to face, phone, group, skype
Sandra Robinson	MANSFIELD	0403 175 555	$110 individual 1 hour session. $50 - group per he	FTF/WEB
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
Catherine Noy	Morwell	0477 159 168	$80	F/F, PH, GRP, WEB
Patricia Reilly	MOUNT MARTHA/ GARDENVALE	0401 963 099	Upon Enquiry	FTF
Beverley Kuster	NARRE WARREN	0488 477 566	Upon Enquiry	FTF
Brian Johnson	NEERIM SOUTH	0418 946 604	Upon Enquiry	FTF
Natalia Burfurd	NEWPORT	0450 721 335	Upon Request	F/F; PH; GRP; WEB
Suzanne Vidler	NEWPORT	0411 576 573	$110	FTF/PH
Bettina Revens	NEWPORT/WILLIAMSTOWN	(03) 9397 7075: 0432 708 019	Upon Request	FTF/PH/GROUP/SKYPE
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: 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; 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
Serife Erten	South Morang	0400 345 045	FTF $80/GRP $40/ WEB&PH $60	FTF/PH/GRP/WEB
Heather Freeman	SUNBURY	0432 263 194	Upon Request	F/F; PH; GRP; WEB
Rosie Barbara	SYDENHAM	0433 277 771	Ind:$110/Grp:$50 each min of 4 hours	FTF/PH/GRP/WEB
Petra de Kleijn	TATURA	0413 824 073	Upon Enquiry	FTF/PH/WEB
Snezana Klimovski	THOMASTOWN	0402 697 450	Upon Enquiry	FTF
Sandra Clough	Traralgon	0412 230 181	Upon Enquiry	FTF, PH,GRP, WEB
Jenny Field	UPPER FERNTREE GULLY	0404 492 011	On Request	FTF, PH, GRP, SKYP
Simon Brown	Watsonia	03 9434 4161	Upon enquiry	FTF/PH/GRP
Belinda Hulstrom	Williamstown	04714 331 457	Upon Enquiry	FTF
WESTERN AUSTRALIA				
Amy Leeder	Alkimos	0433 174 636	$70	F/F : PH : WEB

ACA SUPERVISOR COLLEGE LIST		Medium key: FTF: Face to face I PH: Phone I GRP: Group I WEB: Skype		
Contact	**SUP Suburb**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
WESTERN AUSTRALIA *CONTINUED*				
Evdokimos Christou	Applecross/East Perth	0473 408 991	On Application	FTF/PH/GRP/WEB
Cindy Cranswick	ATTADALE	0408 656 300	Upon Enquiry	FTF,GRP,SKYPE
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
Carolyn Midwood	DUNCRAIG	08 9448 3210	Indiv $110, Grp $55	FTF/GRO/PH/WEB
Sharon Blake	FREMANTLE	0424 951 670	Indiv $100, Grp $60	FTF/PH/GRP/WEB
John Dallimore	FREMANTLE	0437 087 119	Upon Enquiry	Upon Enquiry
Eva Lenz	FREMANTLE/COOGEE	08 9418 1439 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: 0408 548 838	$95 individual; $75 Group per person	FTF/GRP
Anne Arrowsmith	Mandurah	0458 525 039	Ind $140 Student $120	FTF/PH/WEB
Narelle Williams	Midland, Perth	0429 000 830	Individual $100 :Students $85	FTF/WEB
Renee Schultz	Mosman Park	0458 125 264	Upon enquiry	F/F; PH; GRP; WEB
Phillipa Spibey	MUNDIJONG	0419 040 350	Upon Enquiry	FTF
Sally 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
Ligia Emmel Barnett	NORTHAM	0419 954 984	$80.00	Face to Face, Phone
Patricia Sherwood	PERTH/BUNBURY	0417 977 085 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/Jindalee/ Joondalup	0416 898 034	$100	FTF, PH, WEB

INTERNATIONAL				
Contact	**Country**	**SUP Phone number**	**SUP PP Hourly**	**SUP Medium**
Fiona Chang	Hong Kong	+852 9198 4363	Upon Enquiry	FTF
Polina Cheng	Hong Kong	+852 9760 8132	Upon Enquiry	FTF
Wing Hui	Hong Kong	+852 6028 5833	Upon Enquiry	FTF
Cary Hung	Hong Kong	+852 2176 1451	Upon Enquiry	FTF
Giovanni Lam	Hong Kong	+852 9200 0075	Upon Enquiry	FTF
Yat Wun	Hong Kong	+852 264 35347	Upon Enquiry	FTF
Joyce Chan	Hong Kong	(+852) 92507002	$AU90, HKD 550	WEB
Deborah Cameron	BRIGHTON/HONG KONG	+65 9186 8952 Or 0447 262 130	Upon Enquiry	FTF/GRP/WEB
Vasuki Mathivanan	Chennai	91 98407 32055	Upon Enquiry	WEB
Su Gan	SINGAPORE	+65 6289 6679	Upon Enquiry	FTF
Abigail Lee	SINGAPORE	N/A	Upon Enquiry	FTF
Jeffrey Gim Tee Po	SINGAPORE	+65 9618 8153	$100.00	FTF/GRP/PH/WEB
Prem Shanmugam	SINGAPORE	N/A	Upon Enquiry	FTF
Dan Ng Chong Chee	SINGAPORE	N/A	Upon Enquiry	FTF

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Claudia, AIPC Higher Education Graduate

"The Institute has been an exceptional institution to study through. I have studied with a few institutions over the years but the Institute has by far been the best. What I particularly like is the fact that the lecturers manage to afford students a great degree of flexibility in terms of fitting their studies into their day to day lives whilst maintaining an extremely high standard of education."
Will, AIPC Higher Education Graduate

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SUBMISSION GUIDELINES

Want to be published?

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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.

Grow Your Practice Through Telehealth and Message Therapy

Grow Your Practice

Message based therapy and telebehavioral health are tools that provide tremendous growth.

- Attract younger demographics
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