COUNSELLING AUSTRALIA

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Spring 2013

Conflict and couple counselling

Using 'healing inner conflict' principles

Counsellors in the mental health system

Integrated treatment of serious disturbance

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Mental Health Social Support is in collaboration with Australian Institute of Professional Counsellors

Contents

Regulars

Feature articles

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Letters to the Editor should be clearly marked as such and be a maximum of 250 words.

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Special editorial

by Philip Armstrong

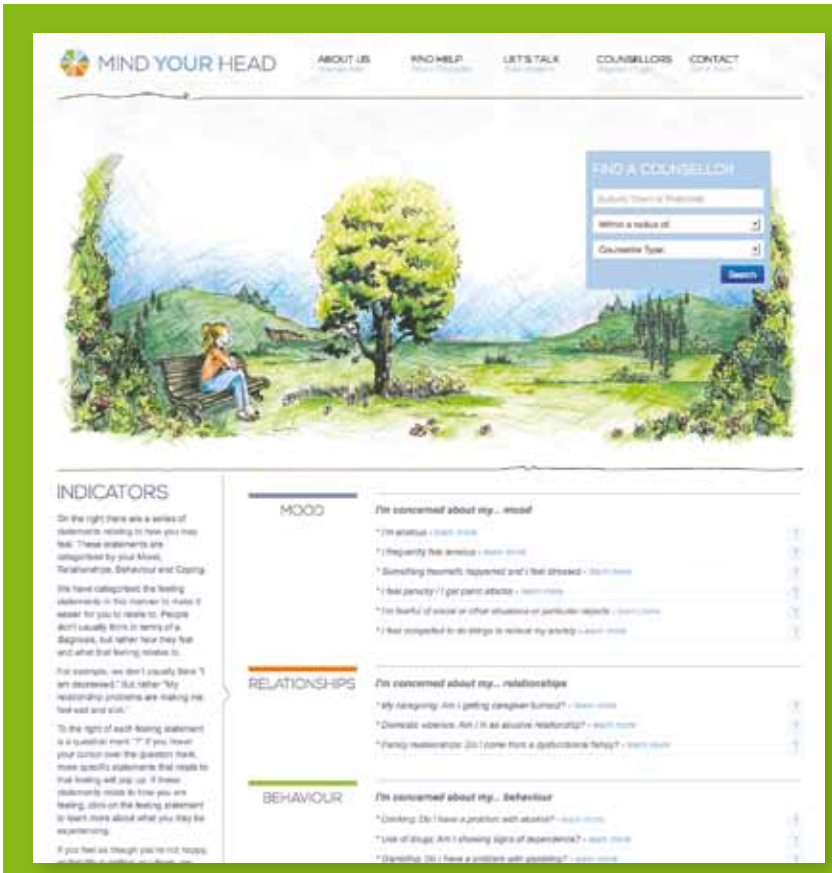
Mind Your Head (MYH): a public portal to access counsellors

One of the most frustrating things that a counsellor must endure is the consumer's lack of understanding of counselling as a process and how to access quality counselling services. This frustration is compounded by consumers being driven like cattle by medical general practitioners (GPs) into what is essentially secondary and tertiary care services when primary care services delivered by counsellors are more appropriate. The two most common reasons why this happens are: GPs are paid to refer to only a narrow band of specialist mental health service providers who mainly deliver secondary and tertiary care services, albeit GPs do not receive payment to refer to any other specialist area; rebates from Medicare are only available to consumers who receive referrals to this narrow band of service providers, albeit these services generally come with large gap payments.

This system, which is most probably going to be reviewed after the election, means that the large majority of consumers seeking help for primary care issues are being overserviced by a narrow band of clinical service providers. These service providers also suffer from a significant field force issue and so are unable to meet demand, particularly in regional and isolated areas. Thus large waiting lists are now the norm for those seeking mental health services in many areas. Yet thousands of registered counsellors are being under-utilised and not sourced by the consumer due to a lack of direction by GPs and a low public profile.

As a profession we have to take some responsibility for allowing this situation to continue. Many individual therapists do their best to increase their local profile through various means, however, there have been no coordinated state or national strategies from the profession to my knowledge. Many counselling and psychotherapy associations charge fees in the hundreds for membership, however, they do not redirect these funds into local and state marketing schemes over and above a website. Many of these websites compete with much larger and better positioned sites and therefore generate few returns for the member. The other major challenge of relying on a website is that if the website itself is not advertised well, which most are not, then the site itself will be ineffective in raising the profile of its members.

I also question the point of an association sitting on a bank account of tens of thousands or more. This may give the association a sense of security, against what who knows, but what does this achieve for current members?



A monthly statement will not improve the bottom line for the member.

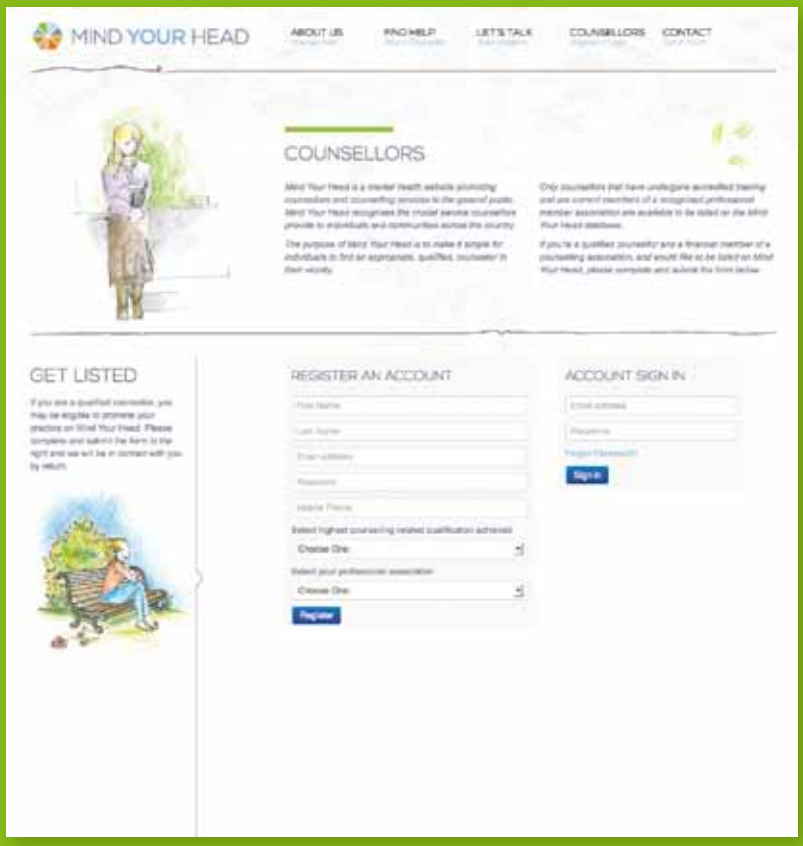
Membership fees that are simply redirected back into the association will also have no long-term benefit for the members in relation to increased demand for therapists or job opportunities. This is particularly the case for state-based or small associations with only a few hundred members. Identity through modality seems to be more important to some therapists who insist on only joining small associations that reflect their modality as opposed to their profession. I respect their choice and need for identity, however, they do this at the expense of mediocrity of the whole profession. Without pooling our resources we have no chance against much larger associations who can market their members to the consumer and government through lobbying organisations and commercial advertising. These larger associations are only larger because they do not compete within their profession with many small, similar associations as we do in counselling and psychotherapy. They are able to identify as a group who specialise with subgroups as opposed to identifying as a subgroup specialist who also belongs to a primary group. The problem with identifying as a subgroup as a primary identity is that this first of all confuses the consumer and secondly in terms of finance and power (read lobbying) this dilutes the primary professions' ability to be effective for the profession.

The inability of the profession to market and educate the consumer has enabled the ignorance that now exists of the questions: 'what is counselling' and 'who and where are counsellors'. The Australian Register of Counsellors and Psychotherapists (ARCAP) has, to a large degree, been able to educate the federal government and does have some influence now. This is only because of a coming-together of the two peak bodies. Unfortunately those who need us most remain, to a large degree, ignorant of our profession and services.

Well, the Australian Counselling Association (ACA) has a reputation of being on the cutting edge and, as an association of action not rhetoric, we have spent our money (as opposed to putting it in the bank) on a national marketing strategy.

This strategy is twofold. All ACA members receive, as part of their membership, a webpage on which their member profile can be entered. This enables members to showcase their qualifications, experience, contact details and specialty areas to anyone searching for a counsellor on the ACA search engine.

www.mindyourhead.com.au



The ACA website now receives several hundred thousand hits a month as we have manoeuvred our site to be a priority site on most search engines; in most cases we are number one. Although the ACA site does lead many consumers to our search engine, which means members do receive referrals from the site, it has not been designed for the consumer seeking mental health services. Rather, the site is designed to attract those looking for information on our members and the industry as a whole, including training. It is also designed to amplify member benefits such as insurance.

This means the ACA website is extremely good at attracting traffic but the traffic is broad in its requirements. Our hit rate reflects that our website is very good at what it is intended for, however, it needs to be more specific if it is to attract consumers looking for services. But if we were to change the website to meet this need, it would then cease to meet its primary function as an association website. What we needed was a specific website designed to attract the consumer and act as a conduit to funnels consumers towards our members. ACA has now put together a website that is different from othersavailable on the web.

It is called Mind Your Head (MYH) — www.mindyourhead.com.au — and is specifically designed for consumer use as

> "Mind Your Head … is specifically designed for consumer use as a public portal to mental health … to talk to the consumer and discuss their issues and to lead them to a resolution through counselling.

a public portal to mental health. It has been designed to talk to the consumer, discuss their issues and lead them to a resolution through counselling.

Unlike most mental health websites that depend on self-diagnosis through fact sheets and filling in assessment forms, this site is designed to engage the consumer, fact language counsellors would appreciate. The site is not designed to offer solutions for self-therapy like many other sites. Instead, the solution is to seek the professional services of a registered counsellor not 'cure thyself'. I know a novel idea!

The Find a Counsellor facility on the site will default directly to the ACA member profile page of the counsellor that the consumer is interested in. This explains all those emails members received asking for them to update their profiles to get them looking professional.

As I have already discussed, a website on its own is rendered redundant amongst many other such sites. This is where the second part of our strategy comes into play. ACA will be spending $100,000 on marketing through radio and search engines. The radio advertising will include advertising on both major regional and city radio stations during peak usage times. These ads will educate and inform listeners in relation to mental health and counselling and then direct listeners to the MYH website. Once on the MYH website the consumer will be engaged and then funnelled to a counsellor of their choosing through the ACA-controlled database.

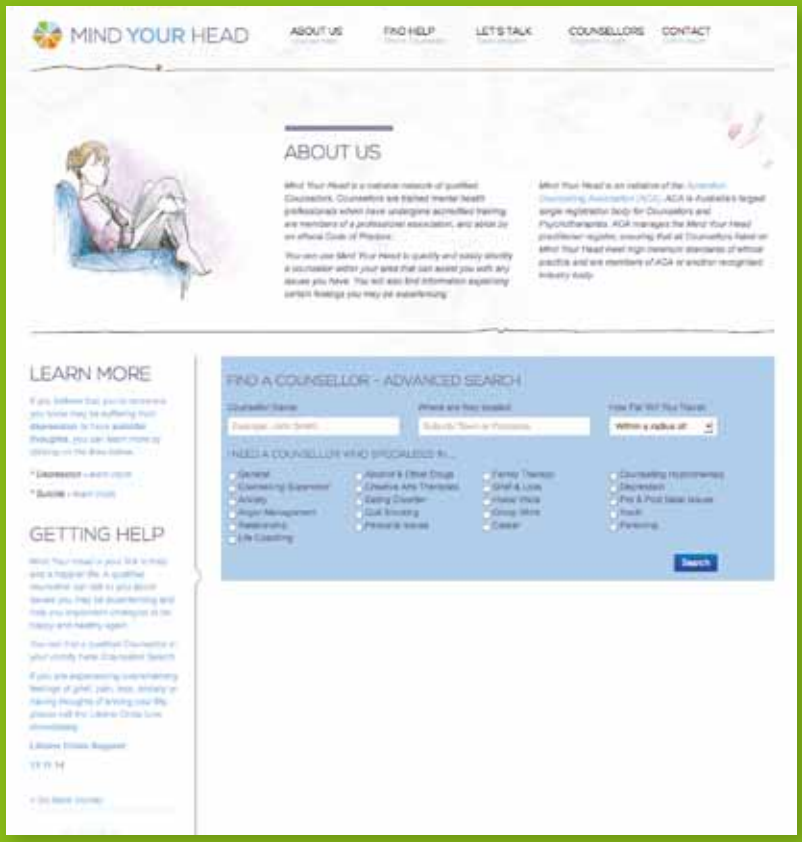
> … radio advertising will include advertising on both major regional and city radio stations during peak usage times. These ads will educate and inform listeners in relation to mental health and counselling and then direct listeners to the MYH website.

The advertising campaign will be run in each state over an initial six-month period. In conjunction with the radio advertising campaign, we will be engaging in a web advertising campaign which should increase traffic from the web and ensure the MYH site gets priority listing within a short period.

ACA did look at television advertising, which is relatively cheap now compared to several years ago. Unfortunately, there is a reason for this: cable TV in conjunction with all the free-to-air TV stations means the viewing audience is no longer concentrated as it was in the past. The audience is now spread over more than 30 channels, which is greater than the radio audience.

Radio also has the advantage of engaging its audience at all times during the day whereas TV only engages our target market in the evening. This makes saturation advertising difficult.

The combined web and radio advertising campaign is due to start in mid-September, after the federal election. It will take a few months before we know of the impact and can assess the viability of continuing or not. In any case, ACA believes that someone needs to take the first step in raising the profile of registered counsellors in a way such as this. I hope members will support us in this endeavour and that our action-orientated thinking will attract new members to us.



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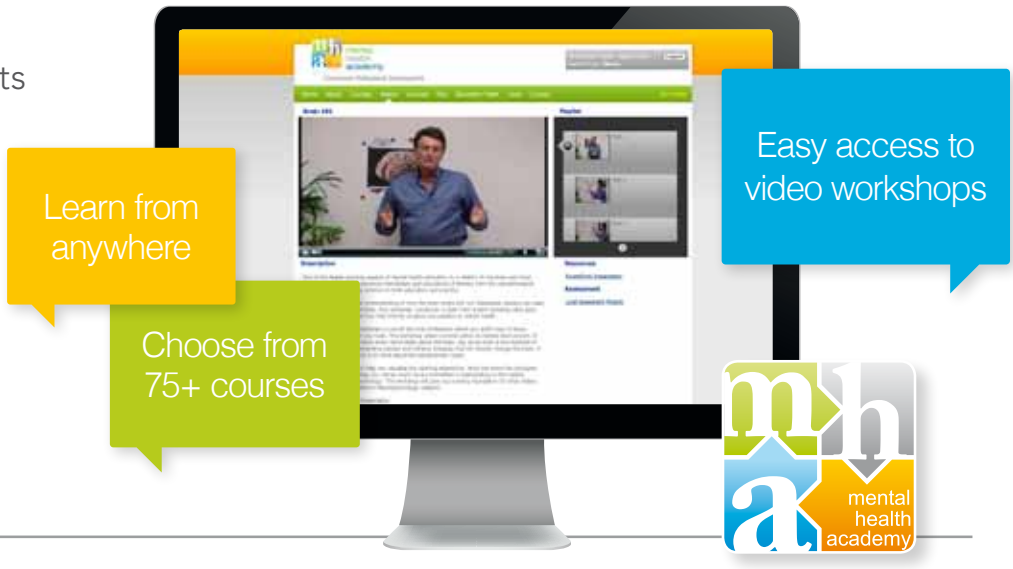

As you know, Ongoing Professional Development (OPD) is a mandatory requirement for continued membership of ACA.

Some members find accessing suitable and cost effective OPD difficult. As part of our commitment to provide members with high quality, low cost professional development opportunities, we have partnered with Mental Health Academy – a leading online provider of OPD for counsellors – to deliver OPD programs to ACA members.

As a Mental Health Academy member you'll have 24/7 online access to over 100 hours of ACA-approved OPD activities, including 75+ professionally developed courses. By completing your OPD through Mental Health Academy, you'll never fall short of your annual mandatory OPD points when renewing your ACA membership.

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3. The Rise and Rise of Depression in a Competitive Winner/Loser World
4. The Counselling Relationship
5. Therapy and the Brain: What has the brain got to do with it?
6. Counselling and the Counselling Process
7. Communication and the Counselling Interview

Learn more and register: www.mentalhealthacademy.com.au/aca

Online and IT resources

with Angela Lewis

HTTP or HTTPS: which is better and what's the difference?

HTTP or HTTPS. It's a tiny difference but hugely important in keeping our sensitive information secure.

In your internet browser, HTTP stands for Hyper Text Transfer Protocol; the language that the internet uses in order to communicate. However, this language can be intercepted and the contents can be copied, which makes it useless for transmitting data that is sensitive.

But the good news is that when you see the extra S, which stands for Secure (it looks like this: HTTPS), it means the HTTP language will be encrypted when it is sent along the internet to its destination, allowing you to feel confident that no malicious third party will be able to intercept its content.

So the difference between HTTP and HTTPS is that one is open for potentially everyone to see and the other is not. Given that piece of news, when you need to enter your credit card details on a website you should check that the start of the address has changed to HTTPS. If it has not you should not enter your details because it isn't safe.

While knowing the difference between HTTP and HTTPS will help you understand whether or not a site is secure, it will not be able to tell you if the website itself is a scam or malicious, so it's always best to conduct a general internet search about the site and research some positive (or negative) reviews beforehand.

Vertical text selection in Word

Usually, we select text horizontally — a word, a series of words, a paragraph — and it is left to right, up or down. But sometimes the selection has to be a vertical column of text, for example, the first letter of each line, like the example below.

Documents
In this section we
objectives and other
within the telephonic
documentation that

To select a column of text in Word:

1. Click where you want to begin selecting.
2. Hold down the alt key.
3. Drag your mouse through the selection.
4. Let go of the alt key and THEN release the mouse (if you let go of the mouse first it won't work and instead you will open the research pane on the right side of the window).
5. Go ahead and format or delete orwhatever it is you wish to do to that highlighted column of text!

Outlook.com

Are you a Hotmail user?

If you are you probably know that Microsoft's new Outlook.com is live. All Hotmail accounts have been changed over to Outlook.com accounts. They're calling it "upgraded," saying that Outlook.com will deliver "a beautiful, fresh and intuitive experience" — whatever that means!

Hotmail users will not lose their user IDs, passwords or contacts.

Forward slash and backslash, all is revealed!

There's a whole lot of slashing going on, but which way is which and does it matter? Well, yes it does…

Forward slash is this: /

**Backslash is this: **

Forward slashes tell your computer you're looking for something external to your system, like web pages, for example, **www.angelalewis.com.au/blog**.

Backslashes tell your computer you're looking for something inside your system, such as a drive or a file, for example, **C:\Programs\MSoffice\Word\letters**.

As always, I welcome your comments so please feel free to email your thoughts after reading.
Warm regards, Angela.

angela@angelalewis.com.au.

Please note that all web addresses were correct at the time of submission to the ACA and that neither Angela Lewis nor the ACA gain any financial benefit from the publication of these site addresses. Readers are advised that websites addresses are provided for information and learning purposes only and to ensure our member base is kept aware of current issues related to and delivered by technology.

More free IT hints are available at www.angelalewis.com.au/blog.

Web resources

Youth health portal
www.tuneinnotout.com
An Australian youth health portal. TINO features videos, stories, blogs, music and fact sheets from services across Australia.

Men's health clearing house
www.mengage.org.au
A project of the Men's Health Information and Resource Centre at the University of Western Sydney. It is funded through the Men's Health Action Plan by the NSW Ministry of Health.

Anxiety clearing house
www.ctclearinghouse.org
An American site that offers a wide range of resources and links related to anxiety.

News and science from around the world

Exercise and diet

Lifestyle change and the prevention of cognitive decline and dementia: what is the evidence?

Martin Lövdén, Weili Xu and Hui-Xin Wang

A recent study has concluded that leaving a sedentary lifestyle in favour of moderate physical activity has beneficial effects on cognitive performance. Recent work indicates that strength training and other physical activities may be at least as beneficial for cognitive performance as activities boosting aerobic fitness. Preliminary evidence also suggests that increases in physical activity may reduce dementia incidence. The evidence on the effects of lifestyle changes towards intellectual engagement on cognitive aging and the incidence of dementia is currently insufficient. Introduction of nutritional supplements may only be beneficial for cognitive performance in groups suffering from deficiencies.

Effects of dietary glycemic index on brain regions related to reward and craving in men.

BS Lennerz, DC Alsop, LM Holsen, E Stern, R Rojas, CB Ebbeling, JM Goldstein, DS Ludwig.

Compared with an isocaloric, low-GI meal, a high-GI meal decreased plasma glucose, increased hunger and selectively stimulated brain regions associated with reward and craving in the late postprandial period, which is a time with special significance to eating behaviour at the next meal.

Midlife eating disorders: a hidden problem

What we see: eating disorders and body image issues don't just affect teenagers.

It was a big surprise when, in 2008, 69-year-old John Prescott, the former British deputy prime minister under Tony Blair, revealed that he was a recovering bulimic. It had begun in his forties and continued for most of his political career, he said. His story, publicised widely in the British press at the time, showed a different side of an issue we've come to associate with being young, female and thin. This wasn't a woman doing battle with body image, but a middle-aged man who'd found relief from the stress of his job in eating and purging.

Prescott's story is recounted in *Midlife Eating Disorders*, a new book by US psychiatrist Cynthia Bulik, which throws light on a hidden problem: middle-aged women and men with eating disorders such as anorexia, bulimia and binge eating disorder (BED). For some, like Prescott, it's a problem that appears for the first time at midlife but for others it's an old problem that's bounced back — or one that never went away. Troubled relationships, the midlife cocktail of turbulent teens and ageing parents, unemployment, menopause and retirement are all possible triggers that can provoke eating disorders at this age, says Bulik, Professor of Eating

Disorders at the University of North Carolina's School of Medicine.

Whatever the cause, the symptoms often go unnoticed, partly because midlife eating disorders aren't on our radar and those who have them no longer live at home with parents looking over their shoulder.

It's a familiar story to psychologist Annabelle Ryburn of Eating Disorders Victoria.

"I've had clients whose eating disorder has resurfaced in middle age often in response to an event like divorce or a difficult family situation," she says. "One client had overcome an eating disorder when she was young but it re-emerged when her children left home and she was faced with a role change that brought back fears about rejection and abandonment."

The important thing to know about treating an eating disorder is that it's not just about getting people to eat more (or less) but to understand the reason why someone may be using eating, purging or restricting food as a coping mechanism, says Ryburn.

"Eating disorders are a sign of a serious mental health problem and if the psychological aspects aren't resolved, people may only partially recover and the eating disorder can be triggered again — or the person may find a different way of attempting to cope, like self-harm or drug and alcohol abuse. People need the tools to manage the underlying issues like anxiety and difficulties with body acceptance and self worth — issues that aren't exclusive to young people."

How common are midlife eating disorders? It's hard to know because they're often hidden, but according to *Paying the Price*, a report produced last year by the Butterfly Foundation, almost 914,000 Australians have the problem, with binge eating disorder being the most common in both men and women. Although the numbers of middle-aged people with anorexia and bulimia are small, around three per cent of women and almost three per cent of men have BED.

As for the cause of these disorders generally, Bulik describes it as a 'soup' of risk factors that include genetic susceptibility and environment, including changes to how we live. 'Big food and big beverage' are creating a binge-friendly environment, she says, and thanks to bigger portion sizes and the fact that we now eat any time and any place, we've lost our compass for normal eating.

For more information go to Eating Disorders Victoria or call the Eating Disorders Helpline is 1300 550236 (this is a national service).

News and science from around the world

Exercise and diet

Could *SKIMMED* milk be contributing to the obesity epidemic?

For years, people have swapped a creamy pint of whole milk for a watery bottle of skimmed to help boost their weight loss efforts. But new research has discovered that drinking skimmed milk might in fact be making us bigger, not smaller.

Government guidelines currently recommend that people consume 'moderate amounts of milk and dairy, choosing reduced-fat versions or eating smaller amounts of full-fat versions or eating them less often.'

But drinking skimmed milk might be making us fat, experts have warned. They say that reduced-fat foods might not be as filling, which could lead consumers to compensate by eating and drinking more. A previous study found that those who drank low-fat milk had a higher chance of being overweight later on in life.

It is generally thought that by drinking skimmed milk you can get whole milk's benefits — vitamin D, calcium and protein amongst others — without the fat and calories. By reducing the fat, the skimmed milk is certainly lower in calories, but the authors of the study, David Ludwig of Boston's Children Hospital and Dr Walter Willett of the Harvard School of Public Health, believe lower calorie beverages do not necessarily mean lower calorie intake.

They say there is very little data to back up the idea that skimmed milk promotes weight loss or management and that because reduced-fat foods might not be as filling, they could lead consumers to compensate by eating and drinking more. A previous study actually found that those who drank low-fat milk had a higher chance of being overweight later on in life, according to *Time Magazine*.

"Our original hypothesis was that children who drank high-fat milk, either whole milk or two per cent, would be heavier because they were consuming more saturated fat calories," said author of the study Dr Mark Daniel DeBoer, an associate professor of pediatric endocrinology at the University of Virgina School of Medicine.

Companies trying to sell low-fat milk often increase sugar levels to make them taste better.

"We were really surprised when we looked at the data and it was very clear that within every ethnicity and every socio-economic strata that it was actually the opposite, that children who drank skim milk and one per cent were heavier than those who drank two per cent and whole."

It should be noted that even full-fat milk only contains three to four per cent fat anyway.

In addition to this, companies trying to sell reduced-fat milk products may also increase sugar levels to make them taste better.

One glass of low-fat chocolate milk contains 158 calories — 68 of them coming from solid fats and added sugars — while a glass of unflavoured, semi-skimmed milk has 122 calories, with 37 of them coming from solid fats and sugars.

"Somehow this low-fat milk has become so entrenched in the nutritional psyche, it persists despite the absence of evidence," said Mr Ludwig. "To the contrary, the evidence that now exists suggests an adverse effect of reduced-fat milk."

Finally, it should not be forgotten that research has shown that skimmed milk also provides less nutrients than whole.

Full-fat dairy is a vital source of the fat-soluble vitamins A, D, E and K as well as calcium and phosphorus, the minerals that work with vitamin D to build strong bones.

But the term 'fat-soluble' means that these vitamins need to be delivered in or with fat for the nutrients to be available to the body. Taking the fat out makes it difficult or even impossible to absorb them.

The new study was published in *JAMA Pediatrics*.

Sleep deprivation linked to junk food cravings

By Yasmin Anwar

A sleepless night makes us more likely to reach for doughnuts or pizza than for wholegrains and leafy green vegetables, suggests a new study from the University of California (UC), Berkeley, that examines the brain regions that control food choices. The findings shed new light on the link between poor sleep and obesity.

Using functional magnetic resonance imaging (fMRI), UC Berkeley researchers scanned the brains of 23 healthy young adults, first after a normal night's sleep and next after a sleepless night. They found impaired activity in the sleep-deprived brain's frontal lobe, which governs complex decision-making, but increased activity in deeper brain centres that respond to rewards. Moreover, the participants favored unhealthy snack and junk foods when they were sleep deprived.

"What we have discovered is that high-level brain regions required for complex judgments and decisions become blunted by a lack of sleep, while more primal brain structures that control motivation and desire are amplified," said Matthew Walker, a UC Berkeley professor of psychology and neuroscience and senior author of the study published in the journal *Nature Communications*.

Moreover, he added, "high-calorie foods also became significantly more desirable when participants were sleep-deprived. This combination of altered brain activity and decision-making may help explain why people who sleep less also tend to be overweight or obese."

Previous studies have linked poor sleep to greater appetites, particularly for sweet and salty foods, but the

latest findings provide a specific brain mechanism explaining why food choices change for the worse following a sleepless night, Walker said.

"These results shed light on how the brain becomes impaired by sleep deprivation, leading to the selection of more unhealthy foods and, ultimately, higher rates of obesity," said Stephanie Greer, a doctoral student in Walker's Sleep and Neuroimaging Laboratory, and lead author of the paper. Another co-author of the study is Andrea Goldstein, also a doctoral student in Walker's lab.

In this newest study, researchers measured brain activity as participants viewed a series of 80 food images that ranged from high-to low-calorie and healthy and unhealthy, and rated their desire for each of the items. As an incentive, they were given the food they most craved after the MRI scan.

Food choices presented in the experiment ranged from fruits and vegetables, such as strawberries, apples and carrots, to high-calorie burgers, pizza and doughnuts. The latter are examples of the more popular choices following a sleepless night.

On a positive note, Walker said, the findings indicate that "getting enough sleep is one factor that can help promote weight control by priming the brain mechanisms governing appropriate food choices."

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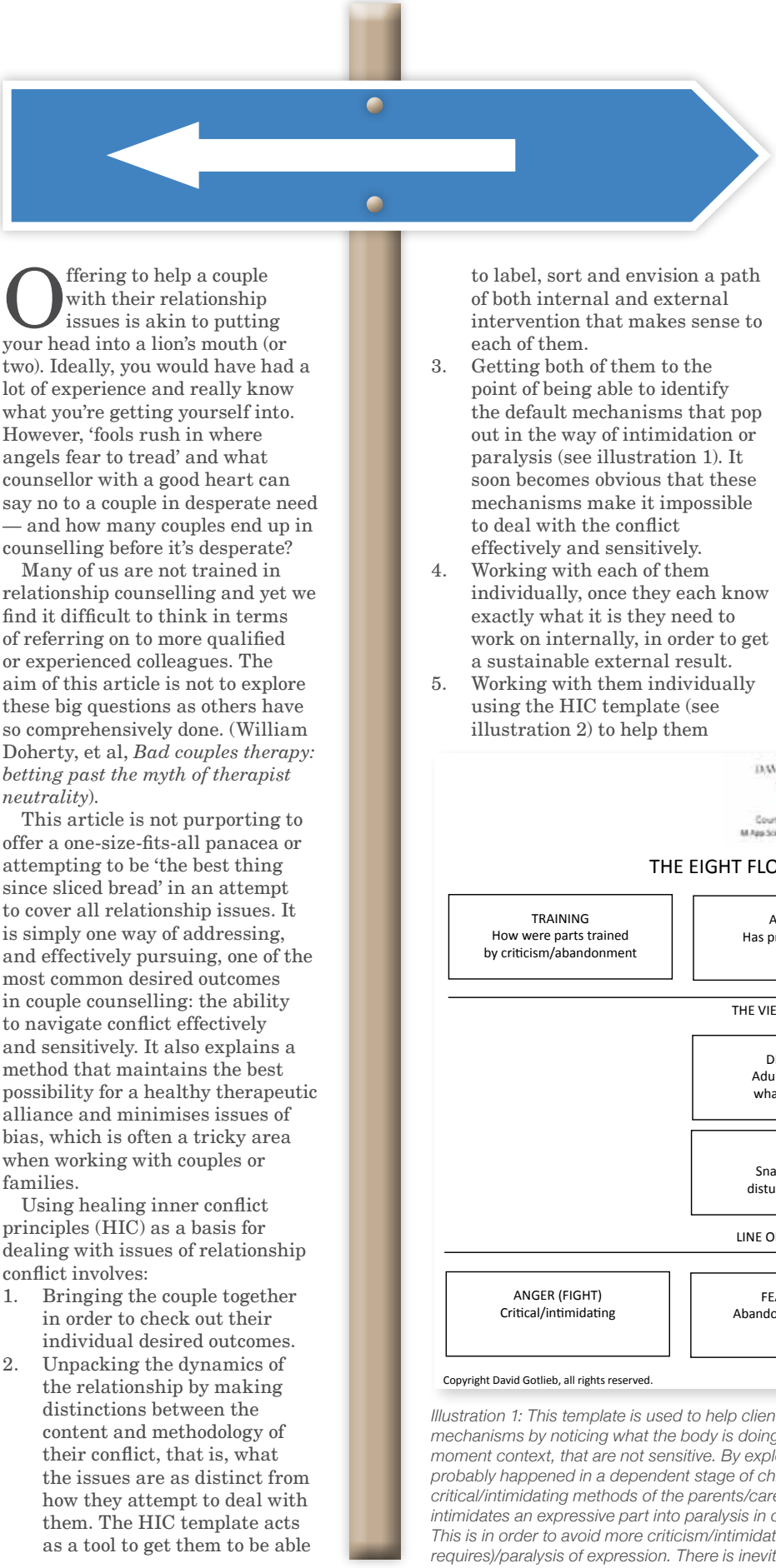
NAVIGATING CONFLICT IN COUPLE COUNSELLING

Relationship work using 'healing inner conflict' (HIC) principles

by David Gotlieb



Offering to help a couple with their relationship issues is akin to putting your head into a lion's mouth (or two). Ideally, you would have had a lot of experience and really know what you're getting yourself into. However, 'fools rush in where angels fear to tread' and what counsellor with a good heart can say no to a couple in desperate need — and how many couples end up in counselling before it's desperate?

Many of us are not trained in relationship counselling and yet we find it difficult to think in terms of referring on to more qualified or experienced colleagues. The aim of this article is not to explore these big questions as others have so comprehensively done. (William Doherty, et al, *Bad couples therapy: betting past the myth of therapist neutrality*).

This article is not purporting to offer a one-size-fits-all panacea or attempting to be 'the best thing since sliced bread' in an attempt to cover all relationship issues. It is simply one way of addressing, and effectively pursuing, one of the most common desired outcomes in couple counselling: the ability to navigate conflict effectively and sensitively. It also explains a method that maintains the best possibility for a healthy therapeutic alliance and minimises issues of bias, which is often a tricky area when working with couples or families.

Using healing inner conflict principles (HIC) as a basis for dealing with issues of relationship conflict involves:

1. Bringing the couple together in order to check out their individual desired outcomes.
2. Unpacking the dynamics of the relationship by making distinctions between the content and methodology of their conflict, that is, what the issues are as distinct from how they attempt to deal with them. The HIC template acts as a tool to get them to be able to label, sort and envision a path of both internal and external intervention that makes sense to each of them.
3. Getting both of them to the point of being able to identify the default mechanisms that pop out in the way of intimidation or paralysis (see illustration 1). It soon becomes obvious that these mechanisms make it impossible to deal with the conflict effectively and sensitively.
4. Working with each of them individually, once they each know exactly what it is they need to work on internally, in order to get a sustainable external result.
5. Working with them individually using the HIC template (see illustration 2) to help them see their default mechanisms and discover the childhood training that made those insensitive behaviours understandable.
6. Bringing awareness to the lack of choice involved in these mechanisms and behaviours and then showing them how to intervene effectively internally with understanding and therefore compassion.
7. In almost all cases they either need to be able to protect themselves from their partners critical/intimidating behaviours using the 'stop, or I'm leaving' technique (explained later) or to effectively grieve the momentary abandonment/loss of relationship when their partner begins to withdraw momentarily or longer term.
8. When both individuals are able to understand and intervene effectively

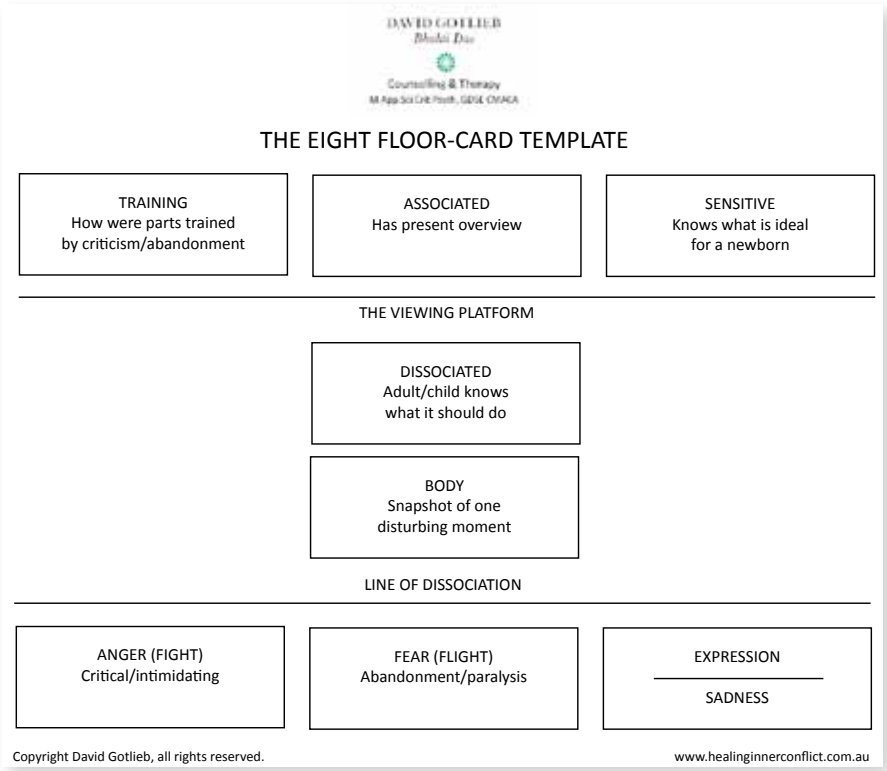


Illustration 1: This template is used to help clients develop an associated view of their disassociated mechanisms by noticing what the body is doing in the way of disturbing behaviours, in the present moment context, that are not sensitive. By exploring this moment, they discover the training that probably happened in a dependent stage of childhood context, which required them to internalise the critical/intimidating methods of the parents/carers. Inevitably, an internalised critical/intimidating part intimidates an expressive part into paralysis in order to pop out a disassociated part that complies. This is in order to avoid more criticism/intimidation that triggers fears of abandonment (which requires)/paralysis of expression. There is inevitably sadness underneath the inability to be expressive.

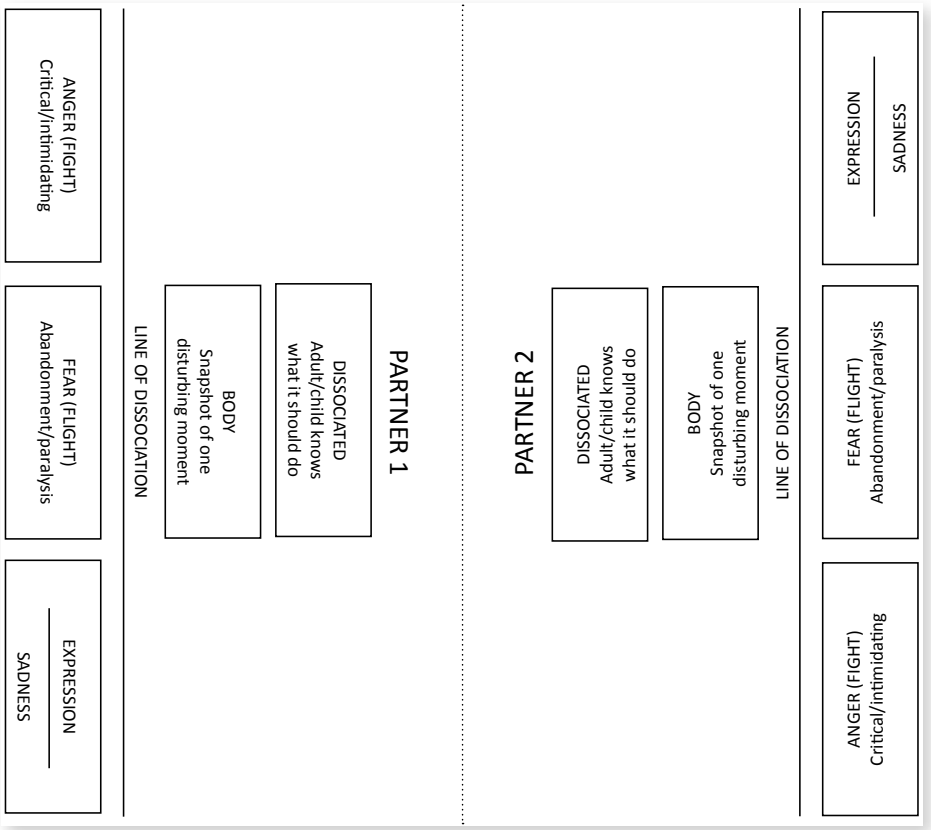


Illustration 2: What most couples look like when they first arrive, from an HIC perspective, and the double template where neither have an associated overview. Thus both partners use various forms of critical/ intimidating or abandonment/paralysis in order to attempt to get their desired outcome of compliance from the other.

internally then they can progress back into the relationship with their partner from a completely different way of being.

9. At this stage, when the couple comes back together, instead of having two dissociated partners unaware of their own triggered default mechanisms (that is, intimidation/ paralysis) you now have a couple who are able to bring self=awareness to their own individual processes (see illustration 3). This helps them develop the ability to have understanding and compassion for their partner's similar or opposite insensitive behaviours, which is only possible when they are able to protect themselves from each other's triggering behaviour by using either 'stop, or I'm leaving' or the 'guide for navigating conflict'.

I use the words 'navigate conflict' because in my experience although all conflicts can be navigated, not all of them can be resolved. I studied with Helena Cornelius and Shoshana Faire in the early days of the Conflict Resolution Network and their work is undoubtedly a huge leap forward in bringing people together in a way that maximises the possibility of resolving conflict. However, it does require that both parties wish to do so, which is not always the case when dealing with couples.

Often, after many years or decades of arguments mostly full of attack and counter-attack, including every insensitive method known to humanity, one or both come to couple counselling disaffected and usually with a large amount of justifiable hopelessness, often somewhat hidden under a thin veil of not wanting to look like they're not trying. Many come with a rational sense of: 'if we can't deal with this stuff ourselves, how the heck are you going to be able to help us?' Unfortunately, in many cases they will be right, including when using HIC as a modality. However, teaching the basic principles of HIC in a couple setting, along with a few additional skills that are simple to learn and practice, at least the couple can develop a clear idea of what is required of each of them individually and both of them collectively if they are going to have a fighting chance at maintaining an effective, sensitive, mutually beneficial relationship. This is regardless of what form the relationship ends up taking, for example, primary, live-together, live-apart, co-parenting, platonic, and so on.

Given that so many couples have children, it is important to point out to them that it's only the form of the relationship that will change. The same issues will arise only through the arena of dealing with issues relating to the children.

Healing outer conflict basics

In order for a couple to get out of the cycle of 'she's a bitch, he's a bastard' it is important they begin to understand the context within which conflict and methods of dealing with them arise.

Helping them to begin to see conflict itself as a completely natural and necessary part of evolution is often enlightening (Crum, Thomas F (1987) *The magic of conflict*; Cornelius, H and Faire, S (2006) *Everyone can win*). However, it is also important to point out the cultural norms that fly in the face of this understanding, whereby we were all somewhat brought up with a notion that if there is conflict in a relationship then there is something going wrong.

The important corollary here is the similarity with our global understanding that grieving loss is a healthy thing, while the cultural perspective most of us were brought up with was a battler mentality definition of consoling — 'no point crying over spilled milk, she'll be right, don't worry about it, big boys and girls don't cry, build a bridge, harden the hell up and get over it'. All the opposite of

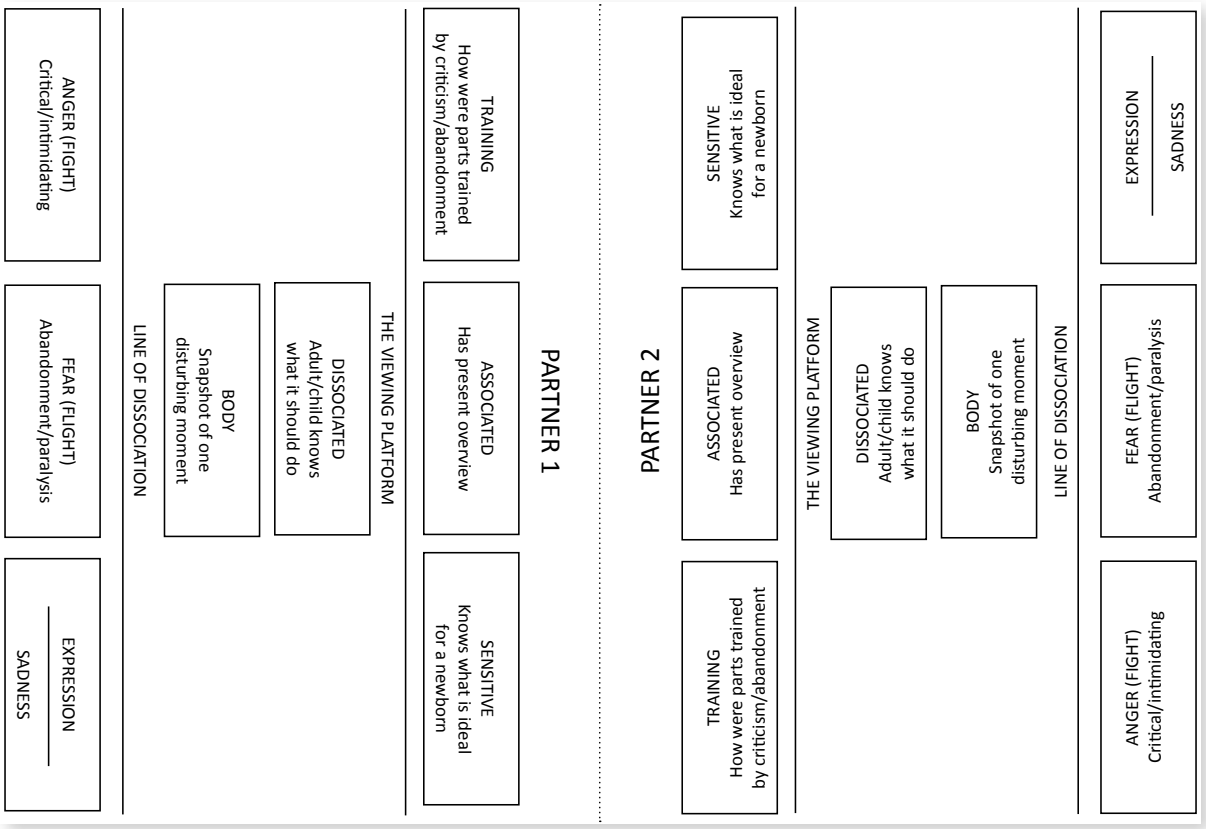


Illustration 3: What most couples look ilke when they have an understanding of HIC principles and their own default mechanism.

what I would call a healthy relationship to sadness. My definition of consoling is 'permission and encouragement for grieving (being sad about, crying over) or whatever feeling that might need to be expressed'. A similar relationship of permission and encouragement for the processes of conflict is required if a long term, mutually beneficial, relationship is to remain sustainable.

There are many default mechanisms we develop in order to avoid the simple process of grieving when life gives us the opposite of what we want. These mechanisms, which are intended to keep us dissociated from grief, become the behaviours that end up being used to protect us from relational grief and stop us from being able to navigate conflict effectively and sensitively.

Using HIC as a modality (see articles *Counselling Australia* December 2012 and *Counselling Australia* March 2013) helps the therapeutic alliance explore four mechanisms, which, when understood, help the individuals in the couple move toward an ability to intervene effectively with the insensitive mechanisms that damage the relationship.

It is essential to understand that what underpins these mechanisms is the autonomic connection between the sadness a child experiences when they are intimidated and the fear of not being able to survive without the parent. This is why in adult life, when all that is required is to simply grieve whatever is going on, the upcoming sadness is perceived, in a child-like context, as completely overwhelming and to be avoided at all cost. Of course the only problem is that the cost is usually our inability to lead an emotionally independent life or to develop true intimacy in relationships due to insensitive behaviours that pop out as a defence mechanism. The usual way these four mechanisms play themselves out in relationship conflicts are as follows.

1. Where they are unable to say what they want for fear of perceived worst-case consequences, usually criticism or abandonment.
   Child mechanism:
   External parental override of child's unique expression. Due to training in childhood by means of parental disciplining using intimidation as means of gaining compliance, the child automatically internalises the intimidating behaviour, which internally intimidates unique expression into paralysis allowing an external silent/compliant yet dissociated child persona to emerge in order to minimise external criticism/intimidation.

2. Where they end up using hurtful/insensitive behaviours as a way to try to get their partner to change such as shouting or the silent treatment.
   Adolescent mechanism:
   When the body grows and the adolescent feels less dependent on the parents they see no more need to internalise the intimidation to override unique expression hence they externalise the intimidation right back at the parent: 'up yours' and leaving home in that 'I'll show you' way. This is the insensitive version of 'stop or I'm leaving', that is, 'stop or I'll shout louder' or 'stop or I'll punish you with my absence'.

3. Where they are sitting on a volcano of anger, trying their best to be on good behaviour, or being passively aggressive as the anger pops out through the cracks.
   Adult mechanism:

With more experience in the adult world they are able to override the adolescent desire to tell the parent, boss or partner to 'get nicked' as they are aware that there is too much at stake. If they haven't been taught healthy ways to express anger independently then the likelihood is that they will either hurt themselves or someone else when the anger eventually becomes an insensitive behaviour.

4. Where they attempt to feel good some of the time. Substances and/or repetitive activities are used to distract themselves from the sadness lying underneath the anger and/or fear, for example, getting drunk or always being busy.
   Self-medication mechanism: When they have one or two, and often three, mechanisms of override going on internally or externally they are going to experience a lot of internal disturbances that, without an effective ability to intervene with them, will require self-medication to keep the sadness 'wolf' from the door.

Helping the indivuals notice their internal mechanisms involves running them through the HIC 8 card template, as seen in illustration 1.

Before they understand this material and can intervene effectively their relationship dynamics will look like illustration 2.

After they have some awareness of their own triggers and have begun to be able to intervene internally, and to some degree externally, then their dynamics will look more like illustration 3 where there is a level of association, awareness and understanding of their own training that precipitates their insensitive behaviours.

Conflict in this case is the trigger of the disturbances that each of them individually experience. The individual disturbances are the signals which are ideally followed in order to discover what individual healing is trying to happen. The relational conflict is the relationship's way of attempting to bring attention to that which needs healing in the relationship. This is exactly the same way that physical pain draws our attention toward that which needs healing in the body.

HIC offers the client a template for understanding their own disturbing behaviours. Using HIC in a relationship context uses the template but expands it to include the other person and the interacting between the two disturbing behaviours (illustrations 2 then 3).

Being a holistic modality, HIC makes a distinction between the intention and methodology of the insenstive behaviours. From an HIC perspective the behaviour is a default mechanism packed in the individual's behavioural 'tool kit' long before they begin to have anything resembling a choice. The issue for a couple therefore becomes to be able to label, set and enforce limits around insensitive behaviours.

> "Helping … individuals understand their individual triggers and work with them to the point of effectiveness is what will make the micro skills and improved behavioural methods sustainable.

A brief explanation of limit settling and enforcing, in the form of 'stop, or I'm leaving'

An example of this particular micro skill looks like partner 1 starting to raise their voice and partner 2 labelling the behaviour as voice raising and saying "Stop raising your voice or I'm leaving". If partner 1 stops the voice-raising, the conversation continues. If they don't then partner 2 leaves the room/house/property (whatever has been pre-determined) until partner 1 stops the voice raising.

Of course, the reasons why people are not able to use these skills effectively is that they get triggered which precipitates behaviours like intimidation or paralysis.

Helping these individuals understand their individual triggers and work with them to the point of effectiveness is what will make the micro skills and improved behavioural methods sustainable ('stop or I'm leaving' and guidelines for navigating conflict).

Guidelines for navigating conflict

(To be agreed upon beforehand and pointed out to whoever forgets by labelling in a neutral tone.)

Regardless of how strongly I disagree, how angry or hurt I feel, I will refrain from:

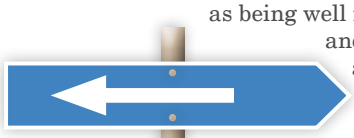
- Putting down, name-calling, sarcasm or belittling.
- Using my voice or body in an intimidating manner, such as yelling or pointing.
- Threatening in any way, standing over and invading personal space.
- Blaming or shaming statements.
- Bringing up past incidents to prove a point.

- Using my feelings to manipulate or emotionally blackmail.

I will:

- Remain respectful.
- Listen and refrain from interrupting.
- Commit to working towards a mutually satisfying solution.
- Apologise and/or make amends for mistakes I have made.
- Be honest.
- Respect the need to temporarily end the discussion. If I need to, then I will let you know the reasons why I am ending the discussion and will indicate my long-term willingness by making a time that is mutually convenient for the continuation. If it is you who needs to end the discussion, I will give you space knowing that it is a necessary yet temporary pause.
- Do my best, wherever possible, to thank you for what you do and don't do that helps us navigate this conflict.

(Adapted by David Gotlieb from Paymar, Michael (2000) Violent No More)



I've rarely had to do more than one or two sessions with a couple once they come back together in session. Each of them is now able to see their own and their partner's default mechanisms with understanding and compassion as well as being well resourced internally and externally to set limits around insensitive behaviours. This does not fix all the problems in their relationship, it simply gives them an ability to deal with that they lacked previously.

About the author

David Gotlieb (aka Bhakti Das) will be presenting a hands-on workshop on 'Healing Inner Conflict' at the 2013 ACA Conference.

He has a Masters of Applied Science in Critical Psychology and a Graduate Diploma in Social Ecology and is a full member of ACA.

He has over thirty years of experience and currently offers counselling, supervision and workshops in Bowral, Sydney and online.

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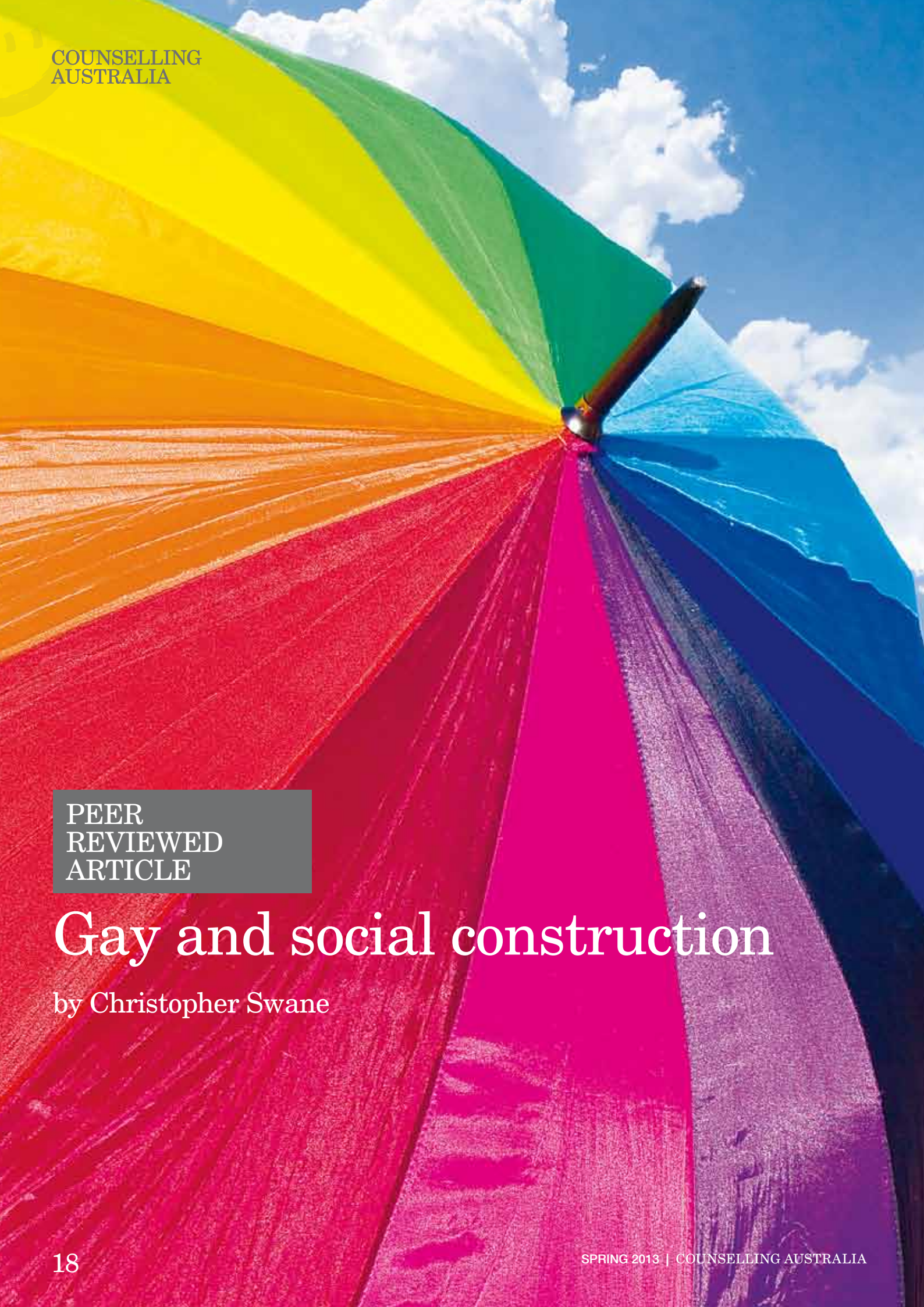

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Gay and social construction

by Christopher Swane

Post-structuralist thinking and its relationship to narrative therapy has become increasingly important in understanding how society, culture, language and discourse impacts on individuals. But do these post-structuralist concepts also impact on minority groups? Through this article I explore how a minority group may have changed from its original objectives and desires to offer a new but equally important role for its members. In this instance I will explore how the change from gay liberation until today may offer a new and alternative role for its self-identifying members.

To understand the importance of the word 'gay' and how it may have impacted on the homosexual community a brief history of its meaning and use of the word in this context is necessary.

The word gay probably came into use as far back as the 13th century (Hiskey 2010). During the 17th century, the word began to be associated with immorality, a person who was addicted to pleasure or loose and immoral life (Hiskey 2010). During the 19th century 'gay' referred to a female prostitute or 'pretty woman' and a 'gay male' was a man who had sex with many women including prostitutes (Hiskey 2010). In the 1920s gay began to take a significant change of interpretation; the 'gay cat' was a young male itinerant worker who offered sexual favours to older men for their protection and knowledge (Wilton 2006). 'Gay cat' was a derogatory term. By the late 1920s the term gay had become a slang word used between homosexual men as a way of identifying each other (Wilton 2009, Hiskey 2010). After the Stonewall riots and gay liberation of the 1960 and 1970s, the word came into common use to identify homosexual men. Gay is a general term for both men and women but more frequently refers to men.

Post-structuralist thinking and narrative therapy suggest that there is no real self and that our reality is socially constructed through discourse that it is ever changing (Corey 2009, p. 10, McNamee 2004, p. 3) suggests that we create our world from the language that we use and that language is symbolic and we use it to represent our world. McNamee (2004, p. 3) also suggests that we attempt to claim the truth by the accuracy of the language we employ.

Language can symbolise reality, for instance if a person has a tendency to view objects, events and people in terms of how they are talked about, rather than how they are, DeVeito (2007, p. 104) describes this as "intensional orientation". DeVeito (2007, p. 104) also implies that there is an opposite to intensional orientation called extensional orientation, whereby a person will have a tendency to look at the object, event or people rather than the way they are talked about or labelled.

Franz Boas suggested that language and discourse are a fundamental aspect of a person's culture (in the Columbia Encyclopaedia 2012). Each culture develops local knowledge and meaning through discourse and historic social constructs (Van Wyk 2008, p. 4). Even those who share a similar language develop their own locally and socially constructed meaning. For example, even when people speak English there are many different words to describe the same thing. One example is confectionery; in Australia it's a lolly, in Britain it's a sweet and in the USA it's a candy (Waddell, Cummings and Worley 2007, p. 409). Winch, (1959, p. 15), strongly stated, "Our idea of what belongs to the realm of reality is given for us in the language that we use." (Waddell, Cummings and Worley 2007. p. 410), suggest that when words and meaning are missing from a culture and language it can change the very conceptual understanding of a community's world. When a culture has many words to describe, for example, snow, their world view may be very different to a culture and language which has never experienced snow, in essence their discourse and social construct would be very different from each other (Waddell, Cummings and Worley 2007. pp. 409-410).

Lee, (2004, p. 1) argues that discourses are socially constructed; constituted through language; organised and maintained through narratives; and there are no essential truths. Discourses have also been defined as practices with shared common values, which incorporate statements that have linguistic and non-linguistic aspects and have an institutional structure (Hare-Mustin 1994, p. 19). Stolz, (2000, p. 1) suggests that groups of people construct reality through discourse with each other over a prolonged period of time, and reality is informed by experience and conversations.

My interest in the concepts of discourse and its relationship to social construction comes from being a gay man. I have always assumed that the term 'gay man' was biological and that my sexual orientation was the foundation of why I identified as being gay. Looking at my sexual orientation through the narrative therapy lens, I began to question this belief. Was being gay more a social construct than just a sexual orientation? It seems fairly unlikely that a heterosexual male would identify with being gay, but then not all same sex attracted (SSA) people do either. Rosik (2003, p. 1), an SSA male declares, "I realised then that I didn't want to be affirmed as being gay; I wanted to be affirmed as a man."

The homosexual community gained increased agency after the Stonewall riots and the gay liberation movement of the 1960s and 1970s. Prior to gay liberation the dominant story for many in the gay community during the 1950s and 1960s was one of oppression, vilification and social persecution (Willett 2000, p. 3).

So what is gay today? Chamberlain and Comogyi, (2006, p. 1) suggest that it is a shared political activism with a sense of community; it is not just limited to a sex act. Language and discourse is a central and critical component of gay culture (Haggerty 2000, p. 373). Historically, language has assisted gay men when manoeuvring between their public and private realm, for example Rock Hudson, an SSA movie star would ask a close friend if an attractive male was "musical" to confirm their sexual orientation. Chauncey (1994, p. 286) argues that gay men had developed a rich language of communication based on slang. Prior to gay liberation, some gay men would use female names to move their private discourse into the public realm (Norton 2011). Peter would be interchangeable with Pauline, "Pauline is such a bitch, and she gets all the men."

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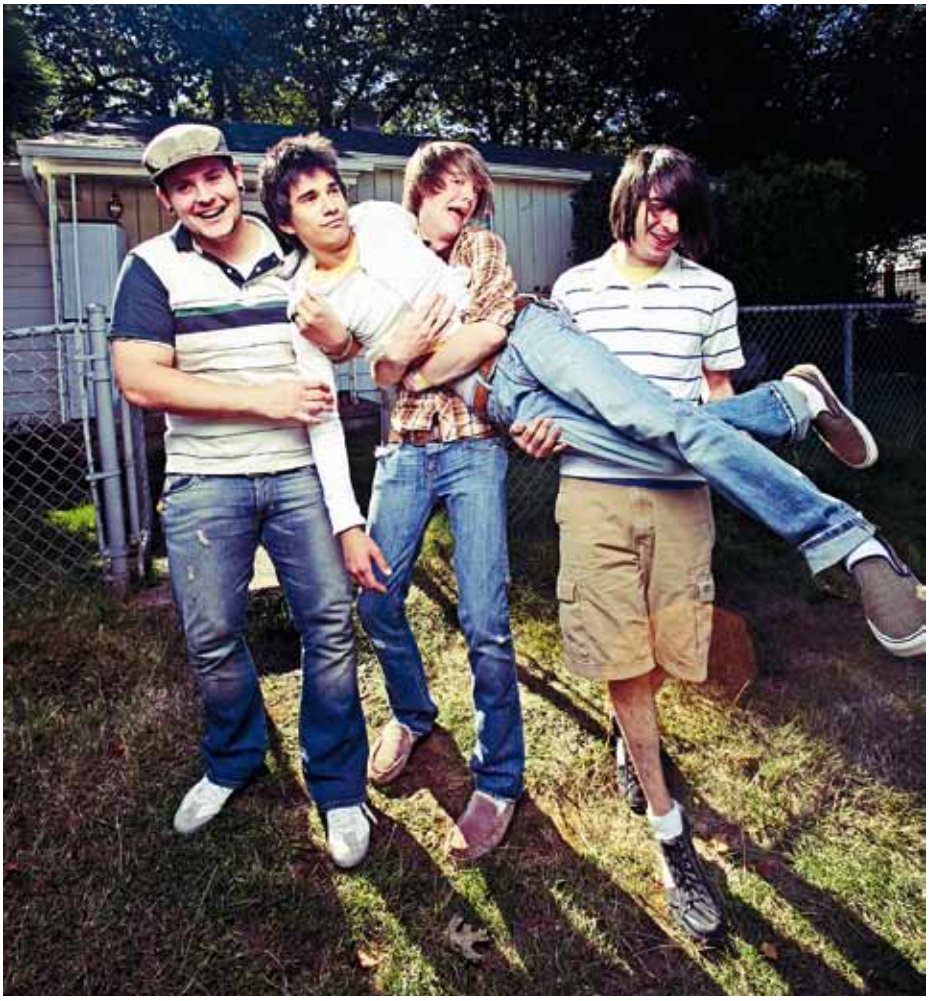

Gay men have socially constructed known areas of common interests, values and language that can easily identify the individual as being gay and help to create common interests to develop friendships (Haggerty 2000, p. 374). These common areas of interest and language may also allow the speaker to privately out themselves to the knowing recipient in the public domain (Haggerty 2000, p. 374). This outing was originally called "dropping pins," another slang term (Haggerty 2000, p. 374).

Traditionally I have held the belief that being gay was predominately based around sexual orientation that was biological in nature, and that I don't choose to be gay, I just am. If there was any social construction it was connected with my emotional state. An example is the coming out process which can be seen as a form of individuation and acceptance of being an SSA male (Plummer 1992, p. 79). I have listened to and believed the totalising stories, which have been drawn from the gay liberation movement and health professionals, that have always linked being gay primarily with sexual orientation. I now believe that most of what I experience as being gay is socially constructed and socially chosen. As an SSA male I choose to identify with being gay, because the social construct of 'gay' holds many values, beliefs, common interests and language. It also allows me to have an identifiable group to belong to.

I have been personally shaped by being an SSA male who identifies with being gay. It has become part of my schema of understanding my world view, and how I fit into this world. By revaluating this schema, I can allow myself to see that the coming out process is not directly linked to being gay. I had made a choice, even though possibly not consciously in identifying with being gay rather than identifying with being queer or simply SSA. The term queer has been more traditionally connected with counterculture, reflecting its interest in alternative life styles and radical politics (*Act Up*, Rhoads 1994, p. 139). Queer politics are identified as an alternative to the socially orientated gay scene.

The social construct of being gay may also be directly connected to the theory of power relationships as defined in narrative therapy. Schreiner (2012), describes power relationships as an imbalance of power, which is implicitly sanctioned and maintained in our culture against minority groups (Schreiner, 2012). Schreiner (2012) suggests that racism has been changed from direct to indirect, where now the imbalance of power is more insidious. Calhoun, (2002, p. 46), argues that heterosexuals have power and exercise power through institutionalised heterosexuality over SSA people. Institutionalised heterosexuality implies that the natural order is where there is pairing of male and female while the social, economic and legal structures reflect this state (Calhoun 2002, p. 46). Society only offers heterosexual sex education which is maintained through the linguistic constructions of boyfriend-girlfriend and husband-wife (Calhoun 2002, p. 46). Even in 2013 there still appears to be ambiguity in sex education and its inclusion of linguistic construction of boyfriend-boyfriend or girlfriend-girlfriend. Through power imbalance SSA people have socially constructed their world as secondary to heterosexuals. At the same time the SSA community has their human rights bestowed upon them by a heterosexually dominated parliament.

The 'normalising gaze', as theorised by Michel Foucault suggests that individuals self-regulate by examining themselves in relationship to the crowd, and are pressured to comply with social norms and that the gaze is disciplinary, Cohen, (1997, p. 89). There has been a change in the normalising gaze and its impact on SSA men since gay liberation. After gay liberation in the 1970s many SSA men took on the hyper-masculine identities that relied on the working class blue collar aesthetic (Clarkson 2006, p. 1). An example of this working class aesthetic can be seen in the SSA pop group of the time, The Village People, with the characters of construction worker, policeman, soldier, Native American, cowboy and biker. SSA men adopted the social construct of the hyper-masculine working class aesthetic as a hegemonic response to the long-time accepted view that gay men were effeminate and thus not equal to the heterosexual male (Clarkson 2006, p. 1). More recently the normative gaze has increasingly influenced SSA to fit into a socially constructed masculinity. There are now websites where SSA-identifying masculine men can distance themselves from what they perceive as SSA effeminate men (Clarkson 2006, p. 1). The discourse that pervades these sites allows the individuals to raise their social status by oppressing effeminate SSA men, for example, "straight acting men only, no fems, fatties or Asians" (Clarkson 2006, p. 1). This type of discourse may suggest internalised homophobia that glorifies normative masculine standards (Clarkson 2006, p. 1). Gay men appear to

> Even in 2013 there still appears to be ambiguity in sex education and its inclusion of linguistic construction of boyfriend-boyfriend or girlfriend-girlfriend. Through power imbalance SSA people have socially constructed their world as secondary to heterosexuals. At the same time the SSA community has their human rights bestowed upon them by a heterosexually dominated parliament.

be creating a distinct division between those that are perceived as gay masculine and those that are perceived as gay feminine. The discourse that socially constructs the hyper-masculine male pits those who should be allies against the normative gaze against each other.

How has this new understanding changed my therapeutic practice? If a SSA person enters therapy with the conviction they are not gay, it is my responsibility as a therapist to support them with their choice. Historically, gay men have held the belief that when a person acknowledges SSA it is the first step to coming out as gay (Rhoads 1994, p. 70). I have also held this belief. This new perspective may also influence my therapy with non-SSA people. Clients, who I experience as displaying unhealthy behaviour, may wish to maintain their behaviour. As a therapist I should respect their wishes and support them in their choice of action. The belief is supported in narrative therapy theory that the client is the authority on themselves; the therapist is not the expert with special knowledge (Van Wyk 2008, p. 2).

In conclusion, language, discourse and social construction may have influenced the gay community and how it perceives itself, its values, beliefs and community. Can this be similar for other minority groups? Do other minority groups experience similar social constructions around language and discourse? Understanding the potential effect of how social construction impacts on clients from different minority groups may be paramount in understanding the therapeutic process. A minority group could be ethnic, religious, social, economic or disabilities. Being sensitive to a personal social construction and its relationship to a minority group during therapy may assist the therapist to gain greater insight into their client's problems and how they manifest in the client's world.

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Christopher Swane holds a Bachelor of Applied Social Science (Counselling) and is currently completing a Masters of Applied Psychotherapy. Christopher is a registered counsellor and member of ACA.

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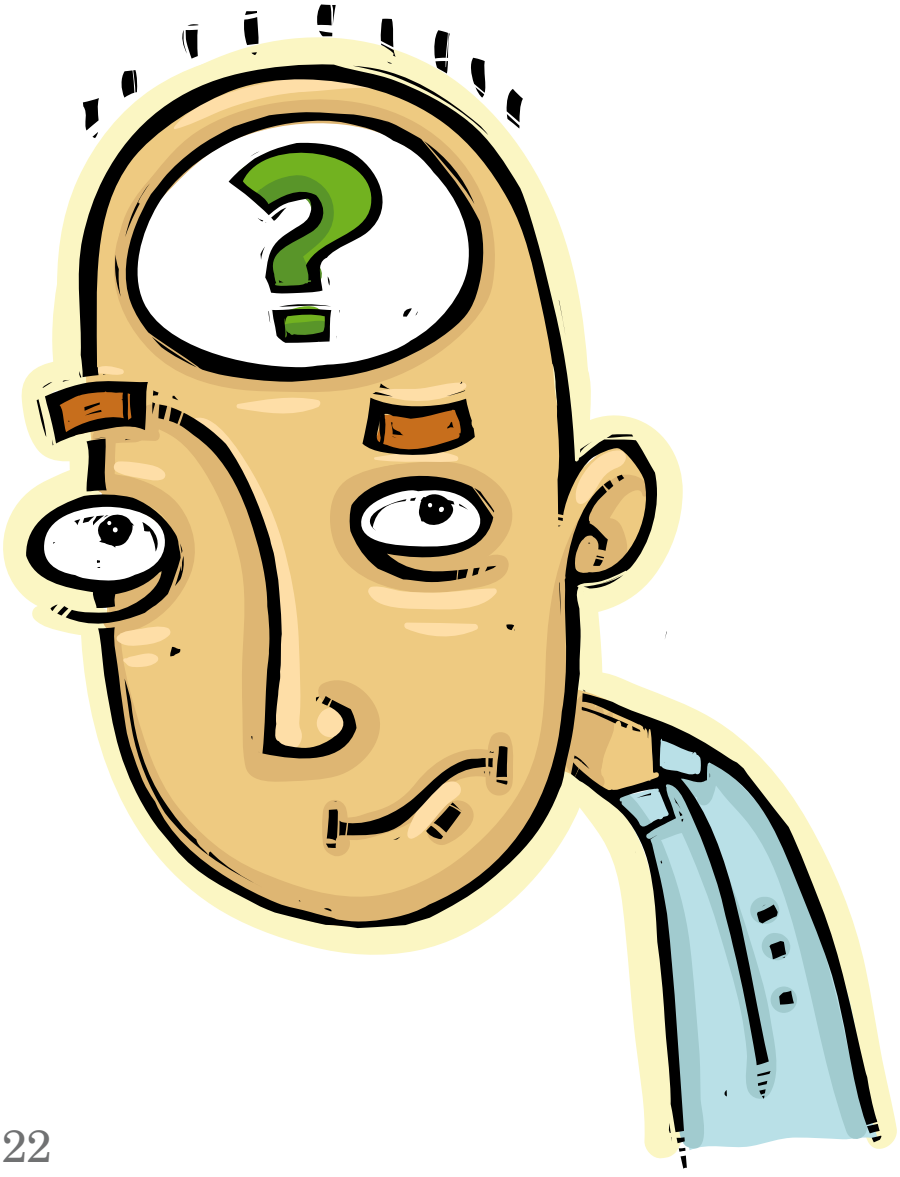
ARTICLE

THE CENTRALITY OF COUNSELLORS IN THE MENTAL HEALTH SYSTEM

The clinical staging model for integrated treatment of serious disturbance

by Allen E. Ivey and Mary Bradford Ivey



Counselling is a preventive profession as it typically works with issues and challenges that our clients face daily. However, client concerns often lie at deeper levels and counselling process often shades into therapy. Whether it is a medicated elementary child, who has been deemed ADHD or a depressed teenager whose family is unable to afford private treatment, counsellors often end up the key mental health resource. Of necessity, we often work with clients who have no other realistic source for treatment. For example, a teen may return to high school after a stay in a psychiatric or drug treatment facility. A child or adult may need care, but no referral sources are available.

As counsellors, every day you are encountering youth who may be at risk. The impact and effect of your work is vital not only with the 'normal' issues you face, but also with potentially more disturbed youth. The American National Institute of Mental Health estimates that 26 per cent of the US population has the possibility of a diagnosis during a given year, while six per cent face diagnosis of serious mental illness. 65 per cent of serious mental conditions (anxiety and affective disorders) appear before age 21, thus emphasising the importance of early counselling intervention. Children and adolescents are increasingly being diagnosed, along with overuse of sometimes-dangerous medications. *Science Daily* reports a 62 per cent increase in the use of antipsychotic drugs with publicly-insured children in America, while two thirds of these potentially dangerous drugs are off-label prescriptions. There is research evidence that these medications shrink the amount of gray matter in children.

The very concept of diagnosis (for example, borderline, major depression, schizophrenia) is being challenged by Professor Patrick McGorry, MD, PhD, the world expert on young people at risk for psychosis. He points out that DSM-IV and DSM-5 diagnostic categories are "endpoints" with little or no attention to etiology and developmental issues. For example, subclinical youth may show signs of decreased functioning. We may see affective dysregulation and other signs, but clear diagnosis is usually impossible. "Persistence and severity are key dimensions setting the bar for care, irrespective of the specific set of features" (McGorry, 2013). He speaks of a "soft entry" to treatment, rather than arbitrary categories that all too often lead to overmedication and overtreatment.

McGorry makes it clear that all "disorders" have early clinical features or prodomes. Prodome is the term given to at-risk youth whose functioning is significantly decreasing, and one third or more of these will become psychotic within three years. However, it is important to separate the true prodome from those who may be suffering from grief or trauma, the major effects of which pass over time.

In comparison, the research appendix of DSM 5 names the prodome as attenuated psychosis syndrome (APS). Research is clear that preventive treatment programs, often such as those we see in schools, significantly reduce reversion to psychosis. Rather than one third becoming psychotic, research has demonstrated that early intervention preventive programs reduce that figure so that five to 10 per cent develop psychosis. Even if psychosis does not appear, those considered at risk continue to have significant life challenges, often requiring some form of counselling throughout their lives.

This is an important issue and the question remains — how can we work effectively to prevent psychosis in young people? So we visited Australia to meet Prof. McGorry. There we saw programs in operation that make a true difference for preventing serious disturbance in youth at high risk. Rather than the potentially damaging APS label, McGorry uses the terms high risk and ultra high risk (UHR). His program focuses on early prevention and specifically avoids medication as much as possible. He worries that the APS label as used in the USA will likely lead to overuse of unnecessary medication. As we all know, psychiatry does not give much attention to prevention or early intervention. If the ATP diagnosis as formulated in DSM-5 is accepted, we can expect preventive research to be ignored and we would see a vast increase in dangerous medications for youth.

Counsellors often are the first to observe young people's behaviours indicative of high risk. The diagnostic risk factors include, first of all, noticeable decrease of functioning. But effective counselling can make a difference and the need for further help may not be required. The endpoint features of DSM-5 APA include these following symptoms, which may appear only occasionally, while most of the time these youth function normally in society. The APS diagnosis looks for odd beliefs or magical thinking, perceptual disturbance or some paranoid ideation, along with occasional disconnection from reality. The youth's appearance may be 'different' or there may be a change in self-care.

Prof. McCorry's clinical staging model is designed to work for patient, clinician, family and researcher. It is rooted in model of normalisation and prevention. Clinical staging is the method used in his Early Psychosis Prevention and Intervention Centre (EPPIC), which focuses on youth at risk with specific recommendations for treatment at each clinical level (see the following table). The diagnosis is for level of need and

treatment, not for a specific category. Clients/patients are first viewed in two general categories — those who appear to be working with 'normal' difficulties and those who may be at risk, high risk, or even ultra high risk (UHR) for a life of becoming constantly depressed, bi-polar, or schizophrenic. Typically, the first group represents clinical stages 0 and 1 and is treated using concepts that are well known and integral to the counselling movement. It is here that we see the counselling profession overlapping with in-depth psychiatry. Furthermore, it is obvious that counsellors have an important part to play in working with at-risk youth.

Traditional diagnostic endpoints do not lead to treatment recommendations, clinical staging does. The scaling and normalisation of youth concerns leads to a newly integrated form of counselling and therapy.

McGorry's original research has been replicated in many settings internationally and in the US. There is clear short-term and long-term evidence that the clinical staging framework (or variations on that theme) reduce the chances of youth reverting to psychosis. Those youth who may never revert to psychosis receive the benefit of quality treatment and are not labelled as suffering from attenuated psychosis syndrome.

Why are counsellors so important in this process? Let us look at the mental health workforce in the US. The *Occupational Outlook Handbook* shows more than a million helping professionals and lists only 21,140 psychiatrists, although other estimates range as high as 36,000. Even if we take the larger figure, psychiatry represents approximately 3.5 per cent of professionals able to meet the mental health needs of the nation. It is patently clear that members of the American Counseling Association will continue to have a major role. The primary and secondary treatment options listed in the table below have long been considered major roles. Not only are counsellors needed, they have the skills and

McGorry clinical staging model for differential youth treatment

CLINICAL STAGE DEFINITION	WHO PROVIDES THE CARE?	POTENTIAL INTERVENTIONS
0 **Increased risk of anxiety or depression.** Continuing daily stressors that may interfere with full functioning but no clearly defining serious symptoms.	School counsellors, mental health counsellors, volunteer and peer helpers, social workers, pastors, community agencies	Primary intervention. Improved mental health literacy, psychoeducation for young person and family, effective counselling and guidance programs, listening skills, community action and social justice interventions.
1a **Possible prodome.** Mild or non-specific symptoms of depression or anxiety, including neurocognitive deficits. Moderate functional change or decline indicating risk. **1b** **Prodome and high risk of psychosis** shown by significant drop in daily functioning.	Referral to medical personnel, but above staff likely to continue supportive treatment. EPPIC has specialised staff to work and consult at this level.	Increased primary intervention and counselling with prevention focus. Policy of avoiding medications. All of the above with more intensity plus improved mental health literacy, family education and therapy, drug education, CBT and motivational interviewing and other appropriate theoretical approaches. Therapeutic life skills (TLC) education and support. Relapse prevention becomes central.
2 **Ultra high risk (UHR) acute.** First episode of major depression or psychotic disorder with expected early recovery.	Medical and psychiatric staff take charge and/or supervise counsellors and other staff. EPPIC treatment plans are coordinated with original referring staff.	Secondary and tertiary treatment and prevention: medication still avoided, but mood stabilisers as necessary, particularly anti-depressants. Above treatments continue at a more intensive level, omega-3 fatty acids, substance abuse reduction, relapse prevention. Vocational rehabilitation may be necessary to assist families cope with illness. Welfare agencies may be brought in as well as drug and alcohol services.
3a, 3b **Late/incomplete recovery or remission from first episode of care.** Note positive emphasis on that word "recovery".	The team approach above continues but primary and specialist care becomes key in guiding the process.	Tertiary interventions: same early prevention services as above, but with additional emphasis on relapse prevention plus medical and psychoeducational strategies to achieve full remission. Antipsychotics avoided or used carefully due to dangerous side effects and potential loss of gray and white matter as well as brain volume, thus producing a reinforcing cycle of illness.
3c **Recurrent relapse of psychosis.** This may stabilise with treatment, but there is residual dysfunction below best level after first episode.	Specialist care becomes more central with consultation with other agencies.	Tertiary interventions: same as above with efforts directed toward long-term stabilisation. Counsellors external to the specialist will be helpful through frequent contact with the patient in the family (for example, community clinics or school systems). Considerable family support and psychoeducation needed.
4 **Chronicity.** Severe, persistent, unremitting illness as judged by symptoms, neurocognitive deficits, and disability.	Specialist care with consultation with other agencies.	Tertiary treatment: above methods, but markedly increased emphasis on social participation, increased use of medications and antipsychotics (with awareness of long-term dangers). Medication remains as limited as possible.

Source: Adapted from McGorry, P. (2010), Early Intervention, Clinical Staging in Youth Mental Health. http://www.youtube.com/watch?v=gYTX7lQU_Ag. (This is a full presentation of the model in its most current form.)

> Traditional diagnostic endpoints do not lead to treatment recommendations, clinical staging does. The scaling and normalization of youth concerns leads to a newly integrated form of counseling and therapy.

experience to work with these youth.

Coordination in mental health services is key to the EPPIC model — infant, child, adolescent and adult in individual, family, group, school and community context. Furthermore all mental health issues from typical daily concerns to serious illness such as autism and schizophrenia fall within this framework. Professor McGorry seeks to see that medications are avoided as much as possible, while focusing on psychoeducation and a focused cognitive behavioural therapy including typical counselling interventions such as stress management, anger management, family counselling and job placement with support, all with an extensive emphasis on relapse prevention. Neuroscience and biomarkers have taken an important place in EPPIC. It has been found that the patterns of many so-called disorder (or endpoints) are quite similar, further challenging the idea of DSM-5 endless category systems.

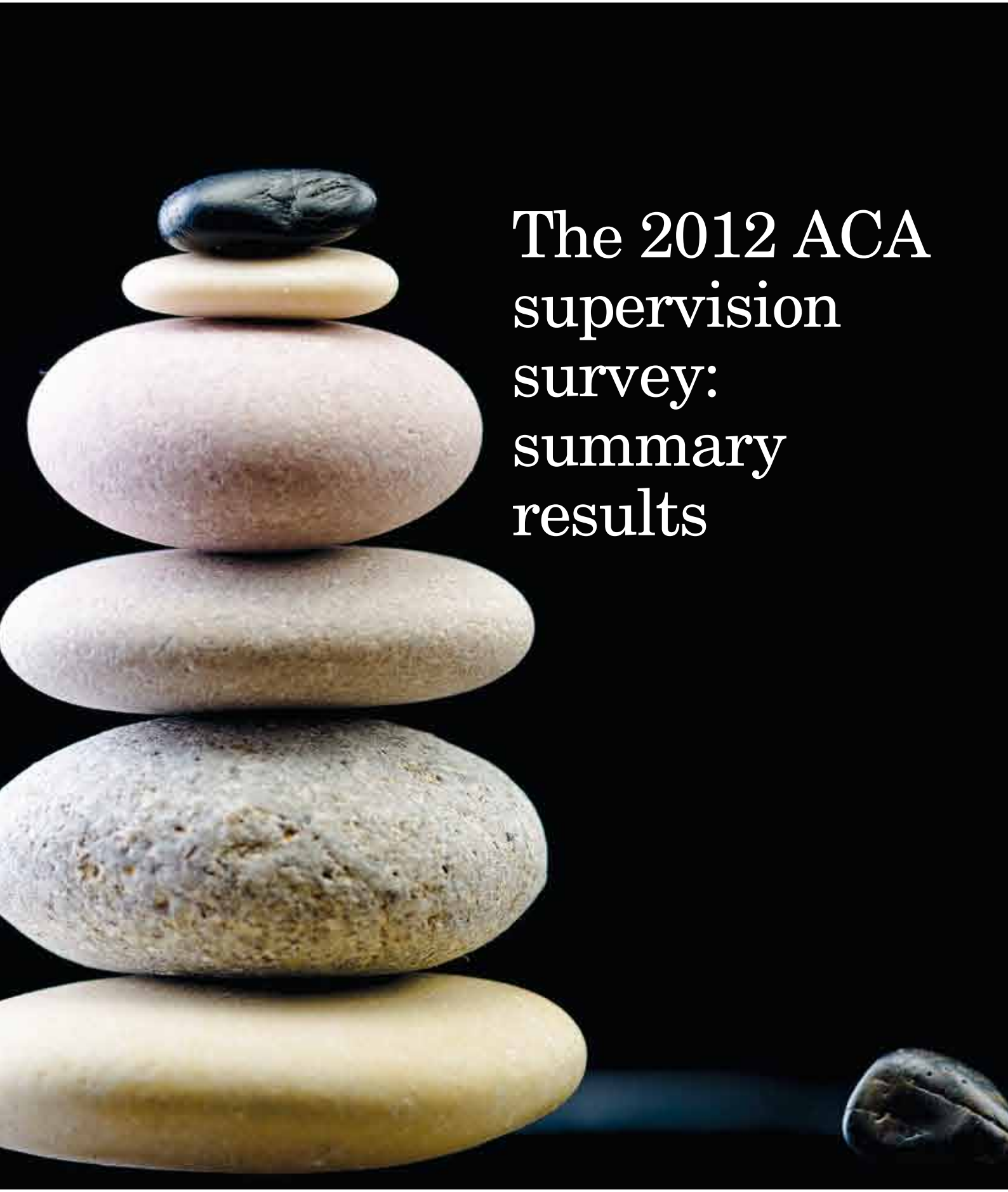
The counselling and guidance program of Massachusetts Wellesley High School illustrates how the clinical staging model is related to counselling practice. Under the leadership of Principal Andrew Keough, Wellesley High School states that "schools are more like families than like business and every member needs a voice". To build the family community, students for all four years meet daily (and a half hour once a month) in advisory groups of eight to 10 to ensure that every teen has personal contact with a teacher, counsellor or administrator. Groups are randomly chosen to enlarge acquaintance in the large school. There is a daily check-in, typically followed with short discussions such as 'what was the highlight of the weekend' or a school issue. There is often enough time for brief trivia contests or discussion of personal issues.

Further regular student contact over four years is made twice weekly through small group (of 12 to 15) guidance seminars, taught by counselling staff. The first year covers study skills and school adjustment and then in later years is followed by decisional skills and issues in positive mental health as well as identifying symptoms of anxiety and depression. These programs make it possible to know all students and encourage self-referrals to counselling staff; they are important components of levels 1 and 2 of the clinical staging model. Counselling, of course, covers the full range of academic and personal issues, including the ability to support more challenged students.

There is a student support team that meets weekly to discuss student issues. For clinical staging level 3 students, who are more distressed and may have been released from a hospital or drug treatment program, small groups ranging from three to five provide support and the leader often works in concert with the treatment facility. These groups also serve as transition teams to gradually place these and other troubled students once again in the regular classroom. Another preventive program, designed to further community, is after school enrichment/recreation program primarily, but not exclusively, for students who are not in the many formal school groups and athletic teams. Students are encouraged to define their own desires for a group experience supported by an interested teacher. Examples include time in the gym or on the athletic field for those who did not make school teams, a computer group where developing apps is taught, karate and boxing groups, clay and art workshops and many others.

Somewhat parallel to the Wellesley program, Prof. Dr. McGorry has originated the Headspace program which seeks to work with youth where 'things are not quite right'. There are currently 45 centres throughout Australia with 90 planned by 2015. They function as combination community centres for youth with a counselling focus. Supportive counselling is available and a major effort for parent involvement is included. Headspace emphasises positive mental health and therapeutic lifestyle changes (TLC) such as exercise, socialisation skills, meditation and relaxation, drug prevention, adequate sleep and nutrition as personally and multiculturally appropriate. These centres offer similar services to those of Wellesley High School, but in a separate setting. Headspace also includes a youth access team (YAT), a 24-hour, 7 day a week group that provides triage, assessment and crisis response. The central function of these programs is to enable the youth to stay in the community, prevent more serious issues and provide counselling support as appropriate.

For more information and specifics, visit the EPPIC website for additional information, including the outpatient programs where you can download information and methods, systems and practice (www.orygen.com). We'd also recommend that you seek to obtain EPPIC's 2010 *Cognitive-behavioral management in early psychosis: a Handbook* (http://oyh.org.au/online-store/cognitive-behavioural-case-management-early-psychosis-handbook). Extensive information on Headspace may be found by Googling Headspace on the Internet, as well as many useful and important videos on YouTube, where you see will real clients and counsellors discussing issues such as bullying and depression. Information on Wellesley High School may be found at http://www.wellesley.k12.ma.us/whs/.



The 2012 ACA supervision survey: summary results

In late 2012 the Australian Counselling Association decided to survey its membership regarding their supervision wants and needs and membership viewpoints regarding approved supervisor requirements.

Researcher Dr Nadine Pelling at the University of South Australia was contacted to design and implement such a survey. As a result, 41 questions were posed to the ACA Membership via an anonymous Survey Monkey survey.

A total of 405 individuals completed the survey including level 1 counsellors (33 per cent), level 2 counsellors (38 per cent), level 3 counsellors (10 per cent) and level 4 counsellors (15 per cent). ACA approved supervisors accounted for 11 per cent of the respondents.

Those surveyed indicated that one level of approved supervisor credential should be made available (53 per cent) and a minority 6 per cent indicated that no credential should be needed to supervise. Most respondents (32 per cent) indicated that this credential should be limited to level 2, 3, and 4 counsellors.

Respondents were split in regards to what level of counselling-specific education one should hold to be an approved supervisor: 29 per cent stated a diploma level should be required and 29 per cent indicated that a bachelor degree should be required for one to be an approved supervisor.

Regarding experience as a counsellor, 29 per cent of respondents indicated that five years of experience should be required for an approved supervisor.

Those surveyed (39 per cent) indicated that five days or 40 hours of training in supervision should be required for one to be an approved supervisor. The top three areas of supervisory training deemed most important included ethical issues in supervision (endorsed by 89 per cent of respondents), the supervisory relationship (endorsed by 84 per cent of respondents) and counsellor competence (endorsed by 80 per cent of respondents). Respondents noted that a written work sample related to a supervision case study noting knowledge was sufficient to indicate competence and this was closely followed by the view that a live/video demonstration of supervision and supervisory skill should be required (52.8 per cent and 52.5 per cent respectively).

Those surveyed indicated that very new supervisors should have their supervision supervised but varied in the amount of supervision recommended.

Supervision was seen as appropriately occurring in person and via video-conferencing/Skype/Facetime and telephone. Few indicated supervision via email, chat room/instant messaging and via the mail service/fax was appropriate.

Most counsellors indicated that as practice amounts vary there should be no minimum number of supervision hours in which they should engage on a weekly or longer basis (54 per cent). However, 47 per cent did indicated that a minimum number of supervision hours should be maintained.

Personal qualities of supervisors were also deemed important and the membership indicated that supervisors should be approachable, challenging, collaborative, competent, honest and knowledgeable as well as be able to build rapport and a warm supervisory relationship.

The membership indicated that they did not wish for the ACA to link any specific education program to any new supervision credential but allow for a variety of supervisory education avenues that could move towards being an accredited supervisor.

Details regarding the survey are expected to be published in the *International Journal for the Advancement of Counselling* special issue on Australian counselling: advancements and challenges (special guest editor: Nadine Pelling) in early 2014. For details go to www.australianspecialissues.net.

ACA College of Supervisors (COS) Register

Name	Suburb	Contact number	Per person hourly rate	Medium
Australian Capital Territory				
Karen Rendall	**Barton**	0431 083 847	Upon enquiry	Face to face
Brenda Searle	**Canberra region**	02 6241 2765 0406 376 302	Upon enquiry	Face to face
New South Wales				
Yvonne Aldred	**Albury**	02 6041 1941	Upon enquiry	Face to face
Lyndall Briggs	**Kingsgrove**	02 9024 5182	Upon enquiry	Face to face
Patriciah Catley	**Narellan**	02 9606 4390	Upon enquiry	Face to face
Leon Cowen	**Lindfield**	02 9415 6500	Upon enquiry	Face to face Group Phone Long distance Skype
Lorraine Dailey	**Maroota**	0416 081 882	Upon enquiry	Face to face
Karen Daniel	**Turramurra**	02 9449 7121 0403 773 757	Upon enquiry	Face to face
Karen Davey-Phillip	**Lake Munmorah**	0418 216 836	Upon enquiry	Face to face
Brian Edwards	**Forresters Beach**	02 4385 1773	Upon enquiry	Face to face
Kim Michelle Hansen	**Putney**	02 9809 5989 0412 606 727	Upon enquiry	Face to face
Brian Lamb	**Newcastle** **Lake Macquarie**	0412 736 240	$120 *(contact for sliding scales)*	Face to face Group Phone Long distance
Anne Larcombe	**Wagga Wagga**	02 6921 22 95 0448 212 295	Upon enquiry	Face to face Group Phone Skype
Gwenyth Lavis	**Albury**	0428 440 677	$95	Face to face Phone
Heide McConkey	**Bondi Junction**	02 9386 5656	Upon enquiry	Face to face
Kathryn Quayle	**Hornsby**	0414 322 428	$90	Face to face Phone Skype
Deborah Rollings	**Grays Point** **Cronulla**	02 9525 6292 0404 884 895	Upon enquiry	Face to face
Megan Shiell	**Tweed Heads**	0417 084 846	Upon enquiry	Face to face
Grahame Smith	**Singleton**	0428 218 808	$66	Face to face Group Phone Long distance Skype
Carol Stuart	**Bondi Junction**	0293 877 752	$80 (*discount rate: $50 early graduates*)	Face to face Group Phone Skype
Northern Territory				
Margaret Lambert	**Darwin**	08 8945 9588 0414 459 585	Upon enquiry	Face to face Group Phone Long distance Skype
Rian Rombouts	**Millner**	0439 768 648	Upon enquiry	Face to face
Queensland				
Lynette Baird	**Maroochydore** **Sunshine Coast**	07 5451 0555	$30 Group $90 Individual	Face to face Group
Maartje Barter	**Wakerley**	0421 575 446	Upon enquiry	Face to face

Name	Suburb	Contact number	Per person hourly rate	Medium
Elaine Bartlett	**Toowoomba**	0431 304 970	$90	Face to face
Judy Boyland	**Springwood**	0413 358 234	$100	Face to face, Phone Long distance Skype
Jennifer Bye	**Victoria Point**	0418 880 460	Upon enquiry	Face to face
Myra Cummings	**Inala**	0412 537 647	$66	Face to face Phone
Catherine Dodemont	**Grange**	0413 623 162	$40 Group $100 Individual	Face to face Group Phone Skype
Patricia Fernandes	**Emerald** **Sunshine Coast**	0421 545 994	$30-$60	Face to face Phone
Rev Peter Gee	**Eastern Heights** **Ipswich**	0403 563 467	$65	Face to face Phone Skype
Nancy Grand	**Surfers Paradise**	0408 450 045	Upon enquiry	Face to face
David Hamilton	**Beenleigh**	07 3807 7355 0430 512 060	Upon enquiry	Face to face
Roni Harvey	**Springwood**	07 3299 2284	$70 ACA members *($90 non-ACA members)*	Face to face Group Phone Skype
Valerie Holden	**Peregian Springs**	0403 292 885	Upon enquiry	Face to face
Beverley Howarth	**Mitchelton**	07 3876 2100	Upon enquiry	Face to face
David Kliese	**Sippy Downs** **Sunshine Coast**	07 5476 8122	80	Face to face Group Phone
Kaye Laemmle	**Helensvale**	0410 618 330	Upon enquiry	Face to face
Stacey Lloyd	**Mount Gravatt**	07 3420 4127	Upon enquiry	Face to face
Sharron Mackison	**Caboolture**	07 5497 4610	Upon enquiry	Face to face
Neil Mellor	**Pelican Waters**	0409 338 427	Upon enquiry	Face to face
Ann Moir-Bussy	**Sippy Downs**	07 5476 9625 0400 474 425	Upon enquiry	Face to face Group Phone Long distance Skype
Judith Morgan	**Toowoomba**	07 4635 1303	Upon enquiry	Face to face
Diane Newman	**Bundaberg**	07 4159 3383	Upon enquiry	Face to face
Kate Oosthuizen	**Worongary**	0411 469 222	Upon enquiry	Face to face Skype
Christine Perry	**Beerwah**	0412 604 701	Upon enquiry	Face to face Group Phone
Brenda Purse	**Sunshine Coast**	0402 069 827	Upon enquiry	Face to face
Dorothy Ratnarajah	**Point Vernon**	0400 824 358	Upon enquiry	Face to face Phone
Virginia Roesner	**Kawungan**	07 4194 0240	Upon enquiry	Face to face
Yildiz Sethi	**Hamilton**	07 3268 6016	$45 Group $90 Individual	Face to face Group Phone Skype
Frances Taylor	**Redland Bay**	0415 959 267 07 3206 7855	Upon enquiry	Face to face
Pamela Thiel-Paul	**Pacific Fair**	0411 610 242	Upon enquiry	Face to face
Menaka Thomas	**Moorooka**	0421 345 699	Upon enquiry	Face to face

Name	Suburb	Contact number	Per person hourly rate	Medium
South Australia				
Adrienne Jeffries	**Stonyfell**	08 83325407	Upon enquiry	Face to face
Pamela Mitchell	**Waterfall Gully**	08 8338 6960	Upon enquiry	Face to face
Carol Moore	**Old Reynella**	08 8297 5111 (bus hrs) 0419 859 844 (SMS)	$35 Group $99 Individual	Face to face Group Phone
Christopher White	**Gilberton**	08 8344 3837 0414 884 637	$75 *(discount rate: 30% off for students)*	Face to face Group Phone Long distance Skype
Tasmania				
Michael Beaumont-Connop	**Newstead**	0429 905 386	$60	Face to face Phone Skype
David Richard Hayden	**Howrah North**	0417 581 699	Upon enquiry	Face to face Group Phone
Victoria				
Joanne Ablett	**Phillip Island**	0417 078 792	$100	Face to face Group Phone Long distance Skype
Anna Atkin	**Berwick**	0432 331 361	Upon enquiry	Face to face
Anna Atkin	**Cheltenham**	0403 174 390	Upon enquiry	Face to face
Judith Ayre	**Bentleigh**	0417 105 444	Upon enquiry	Face to face
Zohar Berchik	**South Yarra**	0425 851 188	Upon enquiry	Face to face
Sandra Bowden	**Lysterfield**	0438 291 874	Upon enquiry	Face to face
Sheryl Brosnan	**Carlton North** **Melbourne**	03 8319 0975 0419 884 793	Upon enquiry	Face to face Group Phone Skype
Sandra Brown	**Frankston** **Mount Eliza**	03 9787 5494 0414 545 218	$90	Face to face Group Phone Skype
Molly Carlile	**Inverloch**	0419 579 960	Upon enquiry	Face to face
Rosemary Carracedo-Santos	**Ocean Grove**	03 5221 2767	Upon enquiry	Face to face
Tim Connelly	**Healesville**	0418 336 522	Upon enquiry	Face to face
Roselyn Crooks	**Brookfield**	0406 500 410	$60	Face to face
Patricia Dawson-Davis	**Mooroolbark**	0424 515 124	$60 Group (one and half to two hours) $80 Individual (per hour)	Face to face Group Phone Skype
Lisa Derham	**Camberwell**	0402 759 286	Upon enquiry	Face to face Skype
John Dunn	**Colac** **Mt Gambier**	03 5232 2918	Upon enquiry	Face to face
Sara Edwards	**Dingley**	0407 774 663	Upon enquiry	Face to face
Jenni Harris	**Kew**	0406 943 526	small grp only: $90 per 3 hr session	Face to Face
Melissa Harte	**Pakenham** **South Yarra**	0407 427 172	$132 to $143	Face to face
Paul Huxford	**Yarraville**	0432 046 515	Upon enquiry	Face to face
Keren Ludski	**Malvern**	03 9500 8381 0418 897 894	Upon enquiry	Face to face Phone Skype
Barbara Matheson	**Narre Warren**	03 9703 2920	Upon enquiry	Face to Face
Robert McInnes	**Wheelers Hill**	0408 579 312	Upon enquiry	Face to face
Jennifer Reynolds	**Lower Templestowe**	0425 714 677	Upon enquiry	Face to face
Graeme John Riley	**Gladstone Park**	03 9338 6271 0423 194 985	$85	Face to face Skype

Name	Suburb	Contact number	Per person hourly rate	Medium
Lynne Rolfe	**Berwick**	03 9768 9902	Upon enquiry	Face to face
Claire Sargent	**Canterbury**	0409 438 514	Upon enquiry	Face to face
Hans Schmid	**Knoxfield**	03 9763 8561	$70	Face to face Phone
Kenneth Scott	**Bunyip**	03 5629 5775	Upon enquiry	Face to face
Gabby Skelsey	**Elsternwick**	03 9018 9356	Upon enquiry	Face to face Phone Skype
Cheryl Taylor	**Port Melbourne**	0421 281 050	Upon enquiry	Face to face
Suzanne Vidler	**Newport**	0411 576 573	$110	Face to face Phone
Cas Willow	**Newport** **Traralgon**	03 9327 2293 0428 655 270	$130	Face to face Phone Skype
Rosslyn Wilson	**Knoxfield**	03 9763 0772 03 9763 0033	Group $40 Individual $70	Face to face Group Phone Long distance Skype
Michael Woolsey	**Seaford** **Frankston**	0419 545 260 03 9786 8006	Upon enquiry	Face to face
Joan Wray	**Mobile Service**	0418 574 098	Upon enquiry	Face to face
Western Australia				
Deidree Brereton	**Canning Vale**	0409 901 351	Upon enquiry	Face to face
Amanda Lambros	**East Victoria Park**	0423 151 743	Upon enquiry	Face to face Group Phone Skype
Eva Lenz	**South Fremantle**	0409 405 585	Upon enquiry	Face to face
Salome Mazikana-Mbenjele	**South Headland**	08 9138 3000 08 9172 2212	Upon enquiry	Face to face
Carolyn Midwood	**Duncraig**	08 9448 3210	Indiv $110 pr hr, Grp $44	Face to face Group Phone Skype
Patricia Sherwood	**Boyanup**	08 97261505	Upon enquiry	Face to face
Lillian Wolfinger	**Yokine**	08 9345 0387 0401 555 140	$60.00	Face to face Phone
International				
Deborah Cameron	**Singpore**	+65 9770 3568	$100	Face to face Group Phone Long distance Skype
Eugene Chong	**Singpore**	+65 6397 1547	Upon enquiry	Face to face
Jeffrey Gim Tee Po	**Singpore**	64-9618 8153	$100.00	Face to face Group Phone Skype
David Kan Kum Fatt	**Singpore**	+65 9770 3568	Upon enquiry	Face to face
Cecilia Lee Ching Hoon	**Singpore**	+65 9029 6543	Upon enquiry	Face to face
Ruby Murty	**Malaysia**	[60] 166809499	Upon enquiry	Face to face
Nadia Rahimtoola	**Singpore**	+65 9647 1864	Upon enquiry	Face to face
Gan Su Keng	**Singpore**	+65 6289 6679	Upon enquiry	Face to face
Robert Tai Lee Lieh	**Singpore**	65-9631 8622	$95	Face to face Phone
Emilia Yee	**Singpore**	+65 9183 5007	Upon enquiry	Face to face

Submission guidelines

Want to be published?

THEN SUBMIT AN ARTICLE TO *COUNSELLING AUSTRALIA*

Contributor's guidelines

Why? Get publishing points on the board! Being published is part of most career advancements for professional counsellors/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* is now calling for articles and papers for publication. *Counselling Australia* is a peer reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285).

Counselling Australia is designed to inform and discuss relevant industry issues for practicing counsellors, students, and members of the Australian Counselling Association.

Note publishing dates: The journal is published quarterly every March, June, September and December.

Counselling Australia 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.

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

Conditions

- References are required to support argument 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 published in the next cycle.

Gain Entry Into An ACA Professional College

With An ACA Accredited Specialty Vocational Graduate Diploma

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

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

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

Get Direct Entry Into A Professional College

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

Flexible And Cost Effective

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

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

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

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

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

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We are accepting enrolments and expressions of interest into our Bachelor of Counselling. If you want to gain a Bachelor of Counselling qualification you should act now as places are being filled very fast.

You can gain up to a full year's academic credit (and save up to $8,700.00 with RPL) with your Diploma qualification. And with Fee- Help you don't have to pay your subject fees upfront.

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- Can study externally with individualised personal support.
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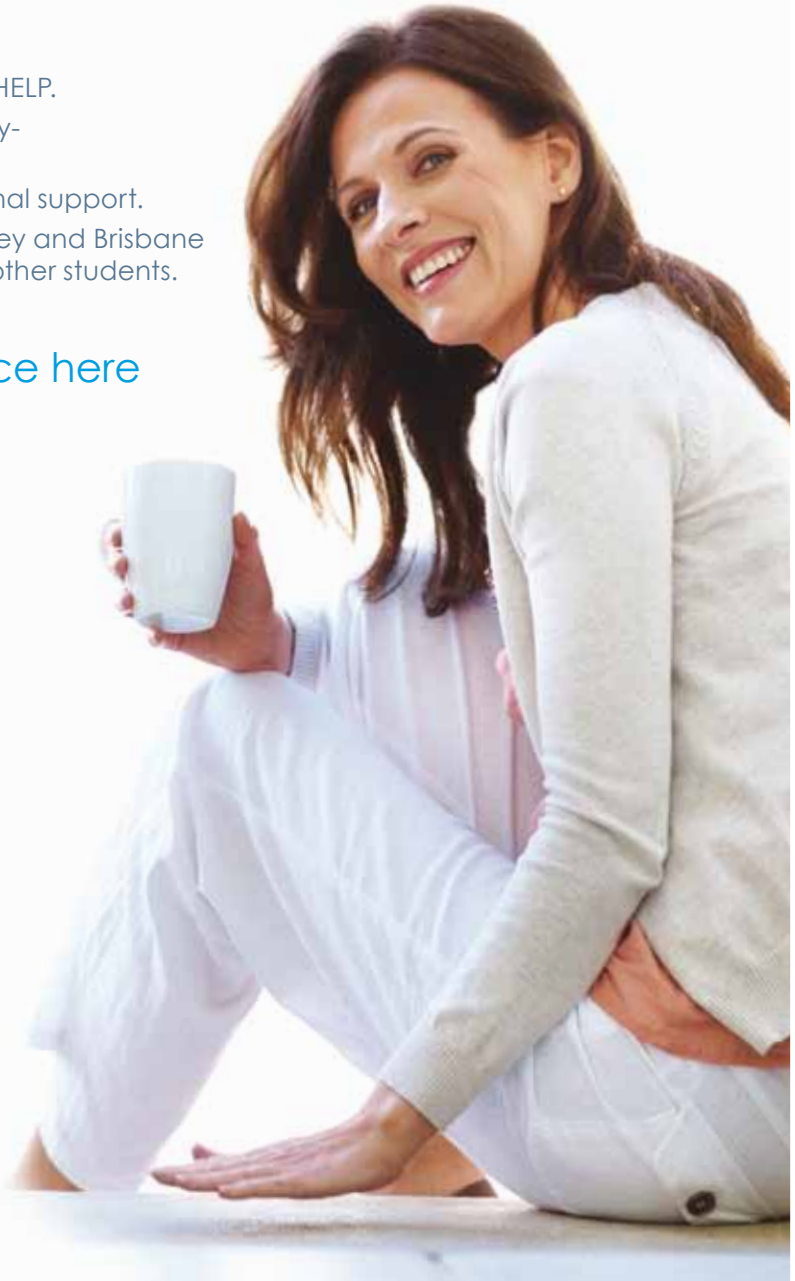

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Gold Coast	|	1800 625 329
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