# COUNSELLING AUSTRALIA

Volume 15
Number 3
Spring 2015

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## How to talk about sex addiction

## Ethical considerations for facially distinctive counsellors

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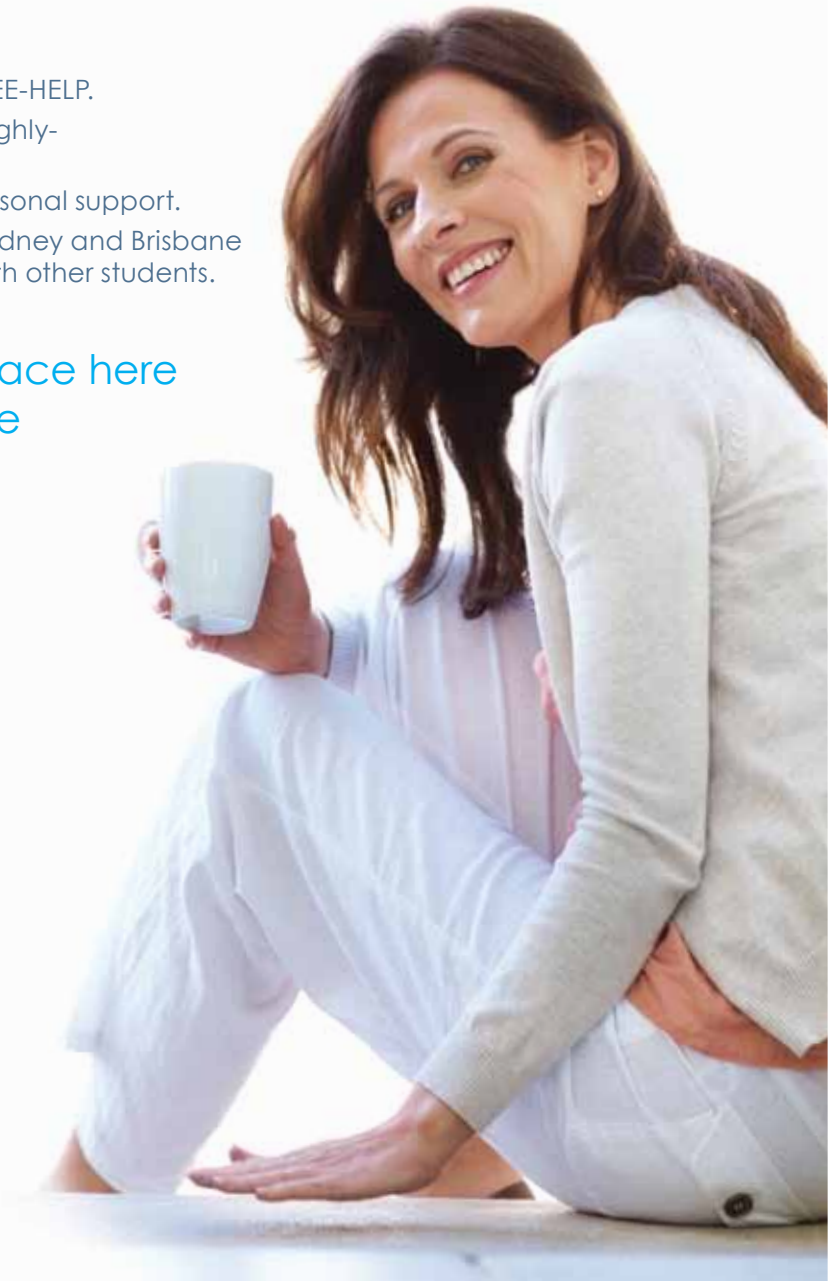

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See page 40 for peer-reviewed article submission guidelines.

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# PRESIDENT REPORT 2015

## MEMBERSHIP

Membership recruitment for calendar year 2015 has been the strongest in ACA's history. Member renewal rates and retention has also been strong. Resultantly, this year we expect ACA will surpass 4,000 members for the first time in its history.

## FINANCES

With record new member recruitment and high retention, as well as various operational and administrative efficiencies introduced over the last 12-months, the association finances are in good shape.

For the 2014/15 Financial Year, income from membership fees was over $100,000 greater than last year and income as a whole over $80,000 greater.

This increase in income has enabled ACA to invest in several member centric activities as detailed below, as well as cover items such as staffing long service liabilities.

## OPERATIONS

Over the coming months ACA is implementing several strategies that will further strengthen its position as the leading association in the industry, add further member value, create operational efficiencies and provide member practice development opportunities.

## INDUSTRY LIAISON

For some time the board has recognised the need to strengthen the relationships and connections between training providers, our association, and industry. This vertical integration between training, industry and employment is fundamental to counselling advancing as a profession. This year we introduced a new position to the team, Industry Liaison. The Industry Liaison position is responsible for the connectivity of this vertical integration. Our Industry Liaison, Tom Parker, networks with training providers, employers and professional peer groups, building critical networks and pathways.

It's these networks and pathways that establish ACA as the association of choice by training providers for course accreditation, educate industry as to ACA member standards and create employment opportunities for members.

## PROFILE BUILDING & EDUCATION

What we do matters. And that's the message we want to promote to the public, government and professional groups. Our members are impacting lives across the country on a daily basis. They're working tirelessly in their communities, often without the recognition that their professional peers attract. This needs to change and we're taking steps to change it.

ACA is developing a website: What We Do Matters. The purpose of the website is to educate the public (and government) as to the integral role registered counsellors play in providing primary care mental health services to the Australian public. We aim to do that via vignettes and testimony of clients of members - giving them a voice to tell how counselling has helped their lives. The What We Do Matters website will serve as a positive propaganda hub - attracting prospective clients, whilst telling our story to the public, media and government.

*Our members are impacting lives across the country on a daily basis.*

This year ACA also attended the national General Practitioner events where we had a stand and represented registered counsellors to GP's across Australia. As the key mental health referral hub, it's extremely important that GP's are educated about the services and standards of ACA registered counsellors. Our representation reached thousands of GP's across the country.

## PRACTICE EFFICACY APPLICATION

ACA is currently in the investigative phase of developing an application for members that would track the efficacy of services provided, through a simple client self reporting process. This would be a handy tool for practitioners and would also assist ACA in its lobbying endeavours, supporting the quality and efficacy of services delivered.

PHOTO: 123RF.COM

## MEMBER PRACTICE SUPPORT

We are in the process of developing a service that will allow members to register walks in their community. The service will be "Walks With Support," whereby people in the community that are having personal challenges can join the walks, providing them with a network of social support, and the ACA member convening the walk an opportunity to talk with potential new clients.

## ACA MEMBER WEBSITE TEMPLATES

Whilst we all know how important it is to have a website presence, anyone that has investigated having a quality website developed also knows how costly it can be. To assist members with this issue, ACA has had three high quality website templates developed, which members will be able to buy for under $100 from the ACA Shop. Members will be able to set up these templates, with minimal work from a web developer, for under $500. This will provide members with the opportunity to establish a quality website presence for their practice for a very reasonable investment.

## WEBSITE UPDATES

We continue to invest in website and system updates to streamline operational efficiencies and member services. These updates will continue to roll out over coming months.

## LOBBYING

As usual, ACA lobbied strongly throughout the year. Last year ACA made a submission to the National Mental Health Commission Review of Mental Health Programmes and Services 2014. This year we followed that up by attending, by invitation, the Stakeholders Workshop in Canberra in August.

Philip has also met with numerous politicians, including Minister for Health, Hon. Sussan Ley.

## STAFF

I would again like to personally commend the ACA staff for their dedication. Their efforts and professionalism is a key factor that differentiates ACA from other associations.

## FUTURE

Based on the last 12 months it looks as though 2016 will be a very positive year. We will continue our focus lobbying and expanding member services and membership value.

Kind Regards,

Simon Clarke
President,
Australian Counselling Association Inc.

# 2014/15 ACA AGM CEO REPORT

The last 12 months has seen ACA reach new bench marks in relation to membership numbers and finances. We continue to set new annual records in relation to new member numbers, lowering our attrition rates. Financially we have also once again increased our turn over. Consistent with ACA policy and as a not for profit entity all monies earned have been re-invested back into member benefits: keeping membership registration costs low, implementing strategies that increase employment potential for members and lobbying State and Federal government.

This year ACA has raised two new membership levels to meet new membership demands. Provisional has been raised for graduates of non ACA accredited courses in counselling, this level is entry level and leads to level 1 after an 18 month supervised practice period. Venerable (definition adj: accorded a great deal of respect, especially because of age, wisdom, or character) has been raised to allow retiring members a way to maintain contact with other ACA members and also act as mentors to less experienced members. This new membership level also mitigates the loss of substantial knowledge and experience that these members take with them when they retire.

Our lobbying activities have been very active over the last 12 months resulting in several meetings with the Hon Susan Ley the Minister for Health (and Mental Health) and her senior staff on several occasions to discuss the underutilisation of registered counsellors by the Department and the sad price paid by the public due to not being able to access services by registered counsellors under Medicare and MBS.



These meetings led to my being invited to attend the Stakeholder Workshop being run to assist the Department to respond to the National Mental Health Commission's Review of Mental Health Programmes and Services. Attendance was by Departmental invitation only and I was the sole spokesperson for counsellors and psychotherapists. I was extremely honoured to carry the banner on behalf of the profession. Without sounding like a broken record I believe these small steps definitely have us heading in the right direction and albeit requiring patience we are slowly being taken notice of. The fact I as CEO of ACA was invited shows tangible evidence that counsellors are on the radar and ACA is now a part of the bigger government picture.

This year one of our many effective investments made has been in raising the position of Industry Liaison Officer. Tom Parker has filled this position and has been very active in meeting with major employer groups in Victoria, South Australia, Western Australia, Queensland and New South Wales raising the profile of ACA registered members. Tom has been so successful at promoting ACA members that many of these employers want to advertise positions through ACA. ACA is now investing in a web employment portal to be placed on the ACA web site so as these employers can advertise directly to ACA members. Tom has also visited with several training providers which has significantly increased our student membership numbers. Tom will be focusing on further meetings which will include Tasmania and the Northern Territory. The Presidents report outlines several other new strategies that we are working towards such as the new "What we do counts" website.

In relation to the ACA website we have made substantial changes this year to simplify searches. The most recent upgrade has been to the Supervisors search engine where we are adding a new independent tab "Supervisors" which incorporates all the information on Supervisors such as training standards, policy and search function. Members will have noticed the new design for our monthly Ezine, it is far more streamlined and clean. It is important members read the monthly Ezine as it will keep you up to date with ACA movements and I believe there will be some important news coming over the next few months.

I would like to sincerely thank all the ACA staff, Jovana, Karita, Majella, Tom and Catherine for their dedicated hard work and diligence. I would also like to thank the ACA board, Simon Clarke, Dr Ann Moir-Bussy, Dr Nadine Pelling, Adrian Hellwig, Di Wilson, Lyndall Briggs and Dr Travis Gee for their contributions over the last 12 months.

The next 12 months will prove to be a very exciting time with employability prospects rising for our members and greater benefits and services for our private practitioner members. ACA will also be working hard to commit resources towards our growing number of student members.

In remembrance: Steven Dimitriadis from Perth, our thoughts and wishes go out to his family and friends.

Philip Armstrong FACA
CEO

## With Technology Advisor Dr Angela Lewis


# Windows 10

Given the big news that the Microsoft operating system Windows 10 was released at the end of July this year, I thought we would focus this issue on taking at look at what it is and what it offers.

### Websites aimed specifically at seniors

www.goldenyearsgeek.com/
http://www.yourlifechoices.com.au/
http://www.healthdirect.gov.au/seniors-health

### And a few emoticons to finish off this issue:

| | |
|---|---|
| [ ] | – Hugs |
| <3 | – Love |
| :* | – Kisses |
| :< | – What? |
| :Q | – What? |
| :,( | – Crying |
| :D | – Laughter |
| :-@ | – Screaming |

PS: LOL (the acronym for laughing out loud), is no longer 'in fashion'. Evidently the hip way to signify your laughter now days is to simply type 'haha' or 'hehe' – the more things change the more they remain the same!

### What is Windows 10?

Windows 10 is an entirely new version of the Windows Operating as we have experienced it to date, working on more of a tablet-type interface using tiles, as shown above. With this release Microsoft intends to ultimately replace all previous Windows versions currently used worldwide.

### Upgrading to Windows 10

If you have Windows 7, you'll need to make sure you meet the system requirements recommended below:

- 1 gigahertz (GHz) or faster
- RAM: 1 gigabyte (GB) (32-bit) or 2 GB (64-bit)
- Free hard disk space: 16 GB
- Graphics card: Microsoft DirectX 9 graphics device with WDDM driver
- A Microsoft account and Internet access

If you have a device with Windows XP or Windows Vista on it, you'll need to do a clean install as well as meeting the system requirements above.

If you're on a version of Windows that can be upgraded (7 or a version of 8) you might have seen an icon appear on your desktop via Windows Update (assuming your PC is up-to-date). Clicking this icon launches a window that enables you to reserve your place in the queue to download the free upgrade and you'll be notified when it's ready to install.

There is a load of information online regarding this upgrade, so make sure you do your own due diligence and read up on it thoroughly before going ahead – perhaps starting with the Wikipedia rundown: https://en.wikipedia.org/wiki/Windows_10.

### Add a Program to your Start Menu or Taskbar

If it's a program you use very frequently, you may wish to add it to your Start Menu or your Taskbar. Here's how do an add in Windows 7, given that this is still the most common operating system people are using:

1. Search for the name of the program in your search box. (Fig 1)
2. Right-click and you'll see options to pin to the Taskbar and Start Menu. (Fig 2)
3. Choose Pin to Taskbar and it will always appear on your taskbar for easy access.
4. Selecting Pin to Start Menu and it will appear when you click the Start button.

FIGURE 1

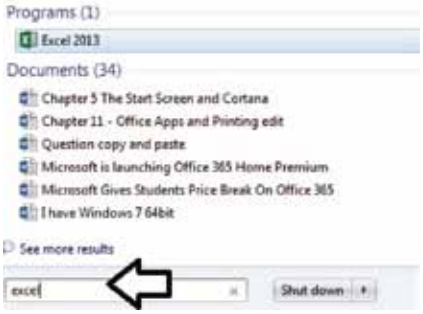
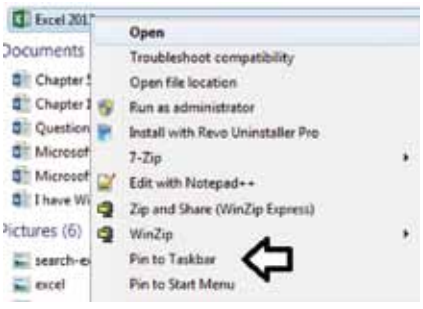



FIGURE 2




**For more tips, hints and reference material on technology and social media, visit me anytime at www.angelalewis.com.au or follow me on Twitter, @AngeLewisMelb.**

# Life behind a Different Veil

## By Dr Angela Lewis

www.myotherself.com.au

I was recently fortunate enough to complete an interview with a man whose secret passion is women wearing veils or masks. As I had not been able to find much information on this interest when doing earlier research on fetishes and non-mainstream sexual interests, I was delighted when Mark came forward to volunteer for this interview.

Mark is in his in mid-sixties and married with adult children. He is a retired engineer who lives in Washington USA and who enjoys the simple things in life, including his morning coffee ritual, watching the garden wildlife, hiking and reading spy novels. His rather less than mainstream interest is in veiled or masked women, which he now generously shares with us.

**Q: What exactly appeals so strongly to you about women who have their faces hidden?**

A: Veils and masks have had an extraordinarily seductive, erotic appeal and have intrigued me for almost as long as I can remember. The image of a masked or veiled woman is, for me, at the core of feminine allure. It is hard to define, but it's a combination of mystery - the most potent and most ancient of all seductions - and the intrigue of the unseen, the hidden beauty. This combination of mystery and intrigue is the basis of my attraction as it awakens in me a sense of wonder, fascination, yearning, curiosity, desire and lust: I call it pure magic.

There is of course also the sensual aspect. When I see, or think about a woman whose face is covered, I cannot help but wonder about what she is feeling, what she is sensing - the face is after all such an exquisitely sensitive erogenous zone. I speculate on her feelings and her emotions and in a perfect world, that she would be as intensely aroused as I am.

**Q: Do you have any thoughts on what sparked your passion for veils and masks?**

A: There were many factors, I'm sure, but two things really stand out vividly. The first was when I was around 14 or 15 years old and attending a dance production at the local high school. There were several girls around my age performing and I knew them all as classmates. I was astounded to see them in their costumes and makeup - they looked so beautiful and exotic!

One of the dances was entitled 'Shadows' and some of the girls danced in full-body 'zentai style' leotards made of stretchy black velvet which absorbed the light and emphasised their "shadow" look. The whole thing was so stunning - the dancers were featured, but my eyes were irresistibly drawn to, and fixated on those fantastic shadows. After their number ended I noticed two "shadow" girls still with their hoods on and faces covered having great fun there in the semi-darkness of the balcony. The teachers, parents and others kept "shushing" them. They saw me sitting there squirming and blushing in the back row and came right up and sat down in both seats next to me!

I almost died from pure fright/arousal/shock. I couldn't begin to understand my own reactions, as they sat there so close, giggling from behind inscrutable black velvet masks, poking me with their gloved fingertips, as they learned in towards me, tilting their heads, whispering "hi Mark" and other various nonsense in my ears. I was delighted, confused and shocked at the mystical power of enchantment and seduction I was experiencing. That was a formative moment in my psyche, a watershed moment if there ever was one, and since then the allure of the mask, the veil, the "mystery woman" has remained with me.

The second major moment for me was a few years later when I discovered a painting titled "Les Amants" (The Lovers) by the artist Magritte, which made a profound impression on me This image of the two lovers, their faces completely covered by their cloth masks while kissing one another struck me then (and still does), as intensely erotic, sensual and mysterious as well as exquisitely intimate. I can do no better than Magritte himself, who said (in regard to his painting 'Son of Man' which also hides the face):

> "Everything we see hides another thing; we always want to see what is hidden by what we see. There is an interest in that which is hidden and which the visible does not show us. This interest can take the form of a quite intense feeling, a sort of conflict, one might say, between the visible that is hidden and the visible that is present."
> "Visible things can be invisible. However, our powers of thought grasp both the visible and the invisible – and I make use of painting to render thoughts visible."
> "We are surrounded by curtains. We only perceive the world behind a curtain of semblance. At the same time, an object needs to be covered in order to be recognized at all."

**Q: There is an enormous variation in masks: from the full or partial rubber mask favoured by the BDSM and rubberist communities to frivolous Venetian styles masks. Is there a particular style of face-covering you favour and if so why?**

A: The kinds of masks/veils I feel most attracted to are made from materials that I find sensual, and that give pleasure to wear. Soft things: silk, velvet, fur; soft knits like mohair, angora, merino wool, alpaca... I'm fascinated by masks completely obscuring the face - eyes, nose, mouth, everything. Women wearing multiple masks/veils have an extraordinary appeal, e.g. a veil, bandanna, balaclavas in mohair or angora; velvet bondage hood, a turtleneck pulled up to cover her face, her face curtained/veiled by her own soft, silken hair, or wrapped in a long, fluffy scarf. Better yet, layers - of veils, hoods, sweaters, scarves. Other passions of mine that dovetail quite naturally (and powerfully) with masking and veiling are bondage, Zentai, wool, fur and women with long hair.

**Q: You are attracted to both masked and veiled women and tend to use the term interchangeably: do you favour one (mask/veil) over the other and if so why?**

A: That's a difficult question to answer in a general sense. Each has its own particular appeal - very unique and powerful. It depends on the form of covering, the material worn as a mask, the circumstances and the attitude of the woman herself - real, or imagined by me.

**Q: Does this interest extend to women who wear veiling for religious or cultural reasons, or is it confined to women wearing them for play?**

A: My interest is in women covering their faces for their own pleasure and mine in terms of enjoyment, physical pleasure, and ways to intrigue and entice their partner - for play or for love. My interest is totally unrelated to religion, although I recognize the connection. I would however say that I am interested in cultures that may encourage masking and veiling. These could be occupational (medical professions), athletic (fencing) or certain communities (D/s), just to mention a few.

**Q: Do you wear masks yourself, or is the interest specifically on women having their faces masked?**

A: I do enjoy having my face covered - for sheer physical pleasure. I love the feeling of being softly wrapped in a soft material, the feeling of being nestled in a cocoon of softness, or even being very tightly wrapped, enough to make breathing difficult (but not impossible!) I find it is a physical turn-on when I am masked/veiled/wrapped and I almost always visualize and imagine being with a woman who is similarly masked or veiled and who has a similar passion and enjoyment of it.

**Q: Given this interest could be considered fairly non-confrontational (in comparison to others some might call fetishistic), does your wife a) know about your interest, and b) wear either masks or veils for you?**

A: My wife does know of this interest as well my others. I'm afraid that my efforts made many years ago to share these interests with her were met with revulsion, disgust, and anger at the fact that I could be interested in anything other than conventional, "normal" sexual relations.

**Q: For some women, the idea that a man would want her to hide her face could be construed as a specific form of objectification (e.g. not wanting to see her as a person); or even imply patriarchy (where power is held by adult men and in some cultures enforced by the masking of the female face). What are your thoughts in this regard?**

A: I don't generally make value judgements on the cultural or religious practices of others. However I do distinguish those I disagree with, and those which appeal and those which do not. I don't agree with beliefs or behaviours that involving force or coercion. I am not interested in forcing someone to do or not do something against her will or withholding choices from her. Having said that, there are those who enjoy being "forced" to do something - in a D/s relationship - for example, to be consensually bound or punished. But such relationships begin with choices, agreements, and negotiations. In person-to-person relations, choices must always be available. I believe that fundamentally, all human beings should have equal rights under the law. I abhor and repudiate any and all methods of oppression of any category of people, whether of a different race, creed, religion, gender, or sexual orientation.

I'm well aware of the various modes of oppression of women, compelling them to cover or seclude themselves; restricting their ability to travel, to work, to have an education, among others. I have occasionally seen women veiled in traditionally Middle Eastern ways, and while my impressions may include intrigue (who is it behind the veil; what's she thinking and feeling, etc.), my main reaction is revulsion towards the attitudes, laws, or rules of behaviour that compel her - or make her feel compelled - to keep herself hidden.

Sincere thanks to Mark (as always no real names were used), for providing us with this thought provoking interview, which I am sure will spark some debate amongst readers who are familiar with Jung and the theory of shadows. In regard to the image used for this article, as he indicated, Mark chose this beautiful painting by the Belgian artist Magritte entitled The Lovers as he felt it best encapsulated his feelings on veiled women,. This choice may also lead the reader to a further exploration of surrealism, the school of painting which chooses to delve into the subconscious of dreams and imaginings through imagery. Details on the artist and his intentions can be found on many internet sites, including (search for Magritte) and I would like to end with some brief of background material on Magritte's work from the www.moma.org website:

> Enshrouded faces were a common motif in Magritte's art. The artist was 14 when his mother committed suicide by drowning. He witnessed her body being fished from the water, her wet nightgown wrapped around her face. Some have speculated that this trauma inspired a series of works in which Magritte obscured his subjects' faces. Magritte disagreed with such interpretations, denying any relation between his paintings and his mother's death. "My painting is visible images which conceal nothing," he wrote, "they evoke mystery and, indeed, when one sees one of my pictures, one asks oneself this simple question, 'What does it mean?' It does not mean anything, because mystery means nothing either, it is unknowable."

# Resiliency and post-traumatic growth

By Paula Davis

The concepts of resiliency and posttraumatic growth are pertinent to the trauma survivors, especially those in East Africa. Recent civil wars in Uganda and Sudan, along with terror attacks on several East African countries are now a frequent phenomenon. Therefore, clinicians are increasingly interested in factors that foster resilience and lead to posttraumatic growth, especially as they apply to the growing number of East Africans seeking refuge in Australia. Although often used interchangeably, the concepts reflect subtle differences that are important for mental health and wellbeing that will be discussed in this article.

Research on resiliency and posttraumatic growth are discrete in the literature and crucial to understanding recovery for survivors of psychological trauma. Traditionally, the focus on individual conceptualisations of resiliency is beginning to shift towards interventions and training that is more contextual (Drozdek, 2013; O'Dougherty Wright, Masten, & Narayan, 2013). Wood and Tarrier's (2010) extensive review of the literature in the field of positive psychology found that the traditional focus on negative functioning and distress in the area of psychological health has largely ignored resiliency and posttraumatic outcomes. The welcome change of focus strives to integrate mental health issues with positive functioning and emotions, strengths as opposed to deficits, positive outcomes despite exposure to risks, and understanding the constituents of healthy development and wellbeing (Masten, 2001). Resiliency and posttraumatic growth will be discussed sequentially.

## Resiliency

Resiliency is defined as "the dynamic process of healthy response and coping in the face of adversity" (Hamaoka, Benendek, Grieger & Ursano, 2007). The majority of resilience research has focused on children and families. The concept of resilience first appeared in the research literature in relation to risk factors for chronic and acute illness in adults (Dawber, Meadors, & Moore, 1951) and risk and protective factors in children. Those children who thrive despite adversity were termed resilient (Werner & Smith, 1982). Early resiliency research was limited to individuals who did not develop problems (Garmezy, Masten, & Tellegen, 1984). At the time the research field was dominated by psychoanalytic theory. Research efforts were oriented towards a biomedical disease model and directed to pathology and deficits in order to predict later psychopathology or maladaptation, rather than strengths and preventative and positive outcomes (Masten, 1989; Masten & Coatsworth, 1998; O'Dougherty Wright, Masten, & Narayan, 2013). Nevertheless, longitudinal studies begun in the 1950's with continual publication into the 1970's (Zolkoski, & Bullock, 2012) identified a trend of positive adaptation among subsections of children who were considered "at risk" for developing psychopathology later in life ((Masten, 2001, 2004, 2013; Masten & Obradović, 2006; Masten & Reed, 2002; Wright & Masten, 2005). Thus, the capacity for resilience despite adverse circumstances was recognised.

Currently, resiliency refers to the "ability to recover readily from illness, depression, adversity or the like," the "ability to regain shape" and "resistance to adversity" (Tedeschi, 2012). The APA (2013) defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress — such as family and relationship problems, serious health problems or workplace and financial stressors. It means the propensity to bounce back from difficult experiences and sustain a healthy outcome following traumatic event/s (Alvord & Grados, 2005; Brooks, 2006; Cicchetti & Rogosch, 1997; Seery, Holman, Silver, & Cohen, 2010). There is considerable agreement in the field that two elements must be present in resiliency (Cicchetti, 2004; Luthar, Cicchetti, & Becker, 2000; Masten, 2001; Schilling, 2008): 1) Adversity related to negative life circumstances (that is, "high-risk" situations or threat); and, 2) Successful adaptation and proficiency on age-linked developmental tasks. These will be discussed in relation to East African resiliency factors.

## East African Resiliency Factors

An ethnic cultural group residing in northern Uganda have endured protracted political and war violence for close to twenty years. Yet they appear to contain a quality of collective resilience that supports the individual in the treatment of trauma. The collective includes family relationships where there is an expectation that members will remain together for life, serving as sources of belonging and support (Gashaw-Gant, 2004, p. 12). That sense of belonging and support extends to the community, as "Among East Africans families, neighbors and friends constitute the best support system for an individual who is suffering from physical or mental illness" (Gashaw-Gant, 2004, p. 12). This sense of familial and community support leads to a sense of belonging, worth and resiliency.

The literature assumes that resiliency requires certain processes to heal from psychological trauma. The association between resilience and various socio-contextual factors forms a growing body of research that indicates resiliency after traumatic events is more common than first thought (Bonanno, Galea, Bucciarelli, Vlahov, 2007). In a comprehensive review of empirical research on PTSD, Bovin and Marx (2011) found that a healthy outcome depends on an individual's appraisal of the event(s) and this is vital in shaping the significance and meaning of the event for future wellbeing. Inherent in resiliency is hope, for when hopes are shattered life loses its meaning and this can lead to isolation, hopelessness and despair (Boss, 2006).

PHOTO: 123RF.COM

Importantly, resiliency connotes more than trauma recovery and ideas surrounding resilience implicate a return to pre-trauma baseline levels of functioning (Bonnano et. al, 2007). Moreover, resiliency relates to the metaphor of an inoculation where individuals are more likely to experience a protective function when exposed to future adversity. Thus, how the Acholi ethnic group interpret the trauma of political and war violence has a significant effect on their capacity for resilience.

Additionally, resiliency is influenced by developmental factors. Undoubtedly, children are often victims of terror and civil warfare. Leading psychologists in the field of resiliency, Werner, Davis and Masten (as cited by Balswick King & Reimer, 2005), study risk and resiliency in children. They argue that risk includes, *"any factor in a child's world that jeopardises healthy development"* such as internal forces (attachment) or external forces (an unhealthy environment such as civil war or relationships) that might disrupt normal development (p. 155). However, resiliency represents *"any factor that promotes healthy development"* such as supportive relationships and children with a considerable number of resiliency factors are generally able to prevail in the midst of adversity and failure (Balswick King & Reimer, 2005, p. 155). Thus, supportive family and community relationships are vital to resiliency.

Moreover, research reveals that resiliency is determined by both pre-existing and protective factors. Pre-existing factors include temperament, age and stage of the developmental process, attachment history, the nature of the traumatic events, attributions held about the trauma, and level of anxiety (Apfel & Simon, 1996). Meyerson, Grant, Smith Carter and Kilmer (2011), in their systematic review of posttraumatic growth among children and adolescents, assert that protective factors that promote resilience especially in children, may include "individual traits, family qualities, and support (such as warmth, unity, and the presence of a caring adult in the absence of parents) and community support (including schools, religious affiliation) which may enable individuals to circumvent life stressors" (p. 636).

Similarly, a cross-cultural study of two collective-based cultures that continue to experience political and war violence found that children tend to be more resilient compared to adults (Harel-Fisch et al., 2010). Children appear to be impacted more by their parent's responses to traumatic stress demonstrating that parental support forms a mediator in the wellbeing and mental health outcomes of their offspring (Harel-Fisch et al., 2010). Therefore, targeting parental distress by fostering resilience is indicated alongside interventions aimed at improving protective factors and strengthening protective resources. This may result in a decrease in psychological symptoms of trauma in both adults and children.

Further, resilient individuals tend to share common factors. Studies by Brown (2010), drawing on other research (Agaibi & Wilson, 2005; Luther, Cicchetti & Becker, 2000; Ong, Bergeman, Bisconti & Wallace, 2006), discovered that the most common factors of resilient individuals could be reduced to five characteristics. Brown found that resilient people**:**

1. Are resourceful and have good problem-solving skills;
2. Are more likely to seek help;
3. Hold the belief that they can do something that will help them to manage their feelings and cope;
4. Have social support available to them; and,
5. Are connected with others, such as family or friends (p. 64).

Brown (2010) noticed that, "the very foundation of the "protective factors" – the things that made them bouncy – was their spirituality" and this spirituality consisted of "a shared and deeply held belief" (p. 65). Without exception she found that spirituality emerged as one of the important components of resilience. From this base Brown acquired three further components essential to resilience:

1. Cultivating hope;
2. Practicing critical awareness; and
3. Letting go of numbing and taking the edge off vulnerability, discomfort, and pain (p. 65).

It has been stated that hope is inherent in resilience. Snyder (2002) defines Brown's (2010) first component of resilience, *cultivating hope* as a cognitive mind-set. Brown suggests that cultivating hope includes a combination of the capacity to be goal-directed, for perseverance to achieve those goals, and believing in one's ability to attain them. Lack of hope leads to powerlessness and the "inability to effect change" produces feelings of desperation (p.65). Consequently, it is important to foster hope in traumatised East Africans by interventions designed to reconnect them to their spirituality.

Brown's second component of resiliency, *practicing critical awareness* involves "reality-checking" by assessing and challenging if necessary the messages being received from socio-cultural processes (p. 65). For example, in East African countries the male identity is related to the ability to discipline and contain his emotions (including anger) in order to gain the respect of the community. He should never engage in public displays of emotions. Crying in public is forbidden and believed to be a sign of weakness that leads to a nervous breakdown. As a result, men are constrained from seeking the support of other people. Consequently, they use common suppressants such as work, sex, alcohol and anger to assuage their grief.

Brown's third component involves, *letting go of numbing/taking the edge off vulnerability, discomfort, and pain* (p. 65). Numbing sabotages resilience. Brown (2010) believes that this style of coping actually dulls any good feelings such as the ability to experience joy. Emotions cannot

be selectively numbed. Hence, Brown's research offers a platform for reflecting on the components and protective factors that lead to resilience for traumatised East Africans.

Furthermore, researchers point to other common factors in resiliency. In their research with prisoners of war, natural disaster survivors and extreme abuse survivors, Southwick and Charney (2012) found ten factors that appeared to relate to resilience. They claimed that not everyone needs all of them. As individuals, different factors apply to each person but the central premise posited is that the self can be trained to become resilient. For example, three of the ten factors are:

1. Realistic positivity and acceptance – indicating first an acceptance of the event/s that may include appropriate mourning of incurred losses. Secondly, choosing to be positive and adopting an attitude of realistic optimism in the face of reality can facilitate resiliency;
2. Staying true to your morals – indicating that those who develop a set of robust morals are more resilient no matter how challenging the situation. A strong belief system such as a particular faith, an internal set of beliefs or a strong sense of morality means that there is an inner core that cannot be overcome or touched; and,
3. Support and nurture a social connection with others – indicating that those who seek out others who will offer them empathy and support feel less alone. Those who have suffered similar experiences have the potential to be primary support persons (p. 171).

Thus, East Africans can learn to be resilient.

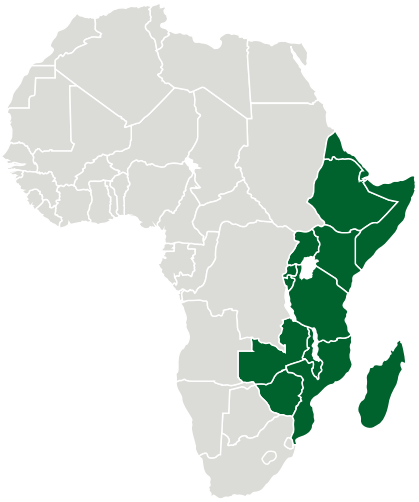
Notably, risk and protective factors are concepts used in resilience research that either promote or inhibit resiliency. Resilience necessitates both a risk factor and a contrasting or protective factor that reduces the negative influence and potential negative outcome of the risk factor (Luthar, Sawyer, & Brown, 2006). A risk factor is one that increases the likelihood of future harm or negative outcomes (DOCS, 2007). Protective factors consist of variables that mitigate the risk and lead to positive outcomes despite of the existence of adversity (Sandler, 2001). However, there is a significant scarcity of relevant literature on protective factors relating to culture (Luthar, 2006, Masten & Wright, 2010) and factors such as cultural traditions. Importantly, East Africa contains a collective-based value system where community support may provide a variety of protective functions for individuals, families and communities.

## Spirituality and Resiliency in East Africa

In East Africa, resiliency includes behaviours intended to manage adversity and promote spiritual wellness including storytelling, religious attendance, and purification rituals and ceremonies that promote healing and blessing. Examples are also found in tribal cultures such as East Africa and American Indian (Gone, 2009). East African cultures perform public and religious ceremonies associated with birth, planting and harvesting. Communal rituals and ceremonies can serve a protective function by offering "both a predictable structure that guides behavior and an emotional climate that supports early development" (Spagnola & Fiese, 2007). Thus, a significant relationship exists between resiliency and the constructive influence of spirituality in development across the lifespan (Crawford, O'Dougherty-Wright & Masten, 2006; O'Dougherty, Wright, Masten & Narayan, 2013).

Moreover, *spiritual wellness* is a term associated with resiliency where a religious belief system is not necessary (Briggs, Akos, Czyszczon, & Eldridge, 2011). Spirituality enhances wellness and "common dimensions to spiritual wellness include hope, meaning, purpose in life, connectedness, honest, compassion, forgiveness, rituals, recognition of what is held to be sacred, and transcendent beliefs/ experiences that may include a sense of a higher power" (Ingersoll, 2004 p. 302). Spirituality and religion offer universal and mythological themes that support and sustain people during and after times of adversity. For example, *The Heroes Journey*, by the American scholar, Joseph Campbell (1968), identifies an ancient wisdom narrative pattern where the hero or heroine embarks on an adventure and leaves the familiar realm, learns to navigate an unfamiliar and sometimes hostile environment, achieves great deeds on behalf of the group, tribe, or society, and returns to his/her familiar setting a changed person. Joseph Campbell (1968, as cited by Louie, 2007) portrays this journey as:

> The usual hero adventure begins with someone from whom something has been taken, or who feels there is something lacking in the normal experience available or permitted to the members of society. The person then takes off on a series of adventures beyond the ordinary, either to recover what has been lost or to discover some life-giving elixir. It's usually a cycle, a coming and a returning (p. 23).



*The Heroes Journey* and similar narratives resonate with universal ideals in the desire to impact one's inner and outer worlds, construct meaning from adverse circumstances and repair the world.

Storytelling in East Africa is a healing art and enables an individual to adopt the role of teacher in the healing and learning process (Drozdek, 2013). Hence, storytelling, song, dance and survival celebrations are ritually exercised by collective societies such as those in East Africa to reintegrate individuals, families and the group back into internal and external stability. Political and war violence shatters the fabric of social cohesion; therefore, healing may involve connecting communities to earlier behaviours that previously assisted them to manage adversity and promoted spiritual wellness. Further, Drozdek (2013) states that explanatory models and cognitions offered by religion are sometimes "closer" to someone than scientific thinking. They provide a protective function that may mediate resilience, for example, sharing of pain, forgiveness, life-long learning, and gratitude. Thus, the primary religious systems in East African culture may serve to counteract or ameliorate the impact of the devastating experiences of enduring civil war.

Notably, East Africans are inherently religious and each tribe has its own religious system with a specific set of beliefs and practices (Mbiti, 1969). The documentation of Africa's traditional

spiritual belief systems only began between 1912 and 1955 (Smith, 1998). However, it has mediated traumatic stress for millenniums (Gashaw-Gant, 2004). The dominant Christian belief system in Uganda views adversity in distinct ways, for example, "Christianity transmutes the tragedy of history into something that is not tragedy" (Niebuhr, 1937, p. 193). Further, "Try to exclude the possibility of suffering which the order of nature and the existence of free-wills involve, and you find that you have excluded life itself" (Lewis, 2009). Graham (1981, as cited by Tedeschi, & Calhoun, 1995) claims that:

> Suffering, on the other hand, tends to plow up the surface of our lives to uncover the depths that provide greater strength of purpose and accomplishment. Only deeply plowed earth can yield bountiful harvests (p. 7).

Additionally, elders play a spiritual role in suffering. Traditional East African families are hierarchical in structure governed by tribal elders who are revered as sources of spiritual wisdom. Thus, religion governs all aspects of life in East African culture including the provision of explanatory models for suffering and resilience (Gashaw-Gant, 2004, pp. 11-13). Thus, explanatory models and cognitions offered by religion are indeed, sometimes 'closer' to traumatised individuals and societies than scientific thinking and can offer meaning, hope and transcendence to experiences of adversity.

## Posttraumatic growth

Alternately, posttraumatic growth is a term that expands on the notion of resiliency to include a shift to "a new level of functioning and perspective" and "transformative responses to adversity" (Tedeschi, 2012). It includes positive change following the struggle with a traumatic event (Calhoun & Tedeschi, 1999). Whereas resiliency is about bouncing back from a traumatic experience, posttraumatic growth involves transformative growth (Tedeschi, et al., 2009). It is "positive change experienced as a result of the struggle with trauma" (Kilmer, 2006; Tedeschi, & Calhoun, 1996). Tedeschi (2012) believes that trauma constitutes a turning point in an individual's life narrative, "a watershed event… If an event divides life into "before and after" it may be traumatic, and also, growth-enhancing." Currently, a large body of research confirms that growth and positive change can occur after traumatic events (Helgeson, Reynolds & Tomich, 2006).

Furthermore, posttraumatic growth simultaneously involves both a process and an outcome (Tedeschi, Park & Calhoun (2009) and can be experienced collectively by communities and societies such as those in northern Uganda that have experienced profound trauma from political and war violence. The process includes components of resilience such as a positive cognitive mindset. However, confusion, grief and mourning are processes that precede rebuilding. The metaphor of physical rebuilding serves as a metaphor of an internal reality where the old structures must come down before new and stronger ones can be erected in their place (Tedeschi, et al., 2009). This new and stronger outcome results from experiencing positive changes arising from the struggle to find meaning in traumatic events (Tedeschi, 2012).

Moreover, posttraumatic growth appears to be a universal phenomenon and is reported across cultures including Israel, China, Turkey, Germany, Bosnia, Japan, Holland, Australia, Switzerland, and others (Tedeschi, 2012). Implications for counselling East Africans includes a focus on strengths, gifts, assets and the opportunity to reflect on spiritual themes both individually and collectively in a communal setting.

## Spirituality and Posttraumatic Growth in East Africa

Moreover, spiritual beliefs profoundly influence posttraumatic growth for East Africans. An example is found in Christians gaining strength and meaning from their faith in God. Also, African Tribal Religion (ATR) views mental health as dependent on harmonious interpersonal relationships with others and with ancestral beings (Bojuwoye & Edwards, 2011; Straker, 1994; Vontress, 1996). The departed are believed to live on in the spirit world and over time, eventually become gods of sorts possessing supernatural powers. They are revered for their ability to continue to play an active role in watching over the living by providing guidance and wisdom to families and the wider community. Elders are revered, both in life and after death for their experience and wisdom as witnesses to all that has preceded them. This social support of the living and the dead serves a protective and therapeutic function and may constitute an important factor in posttraumatic growth for East Africans. These powerful attachment figures can assist in the regulation of emotions that are problematic in PTSD (Nzimkulu, 2000, as cited by Bojuwoye & Edwards, 2011) and bestow meaning on traumatic events. Thus, ancestral beliefs explain the ability of East Africans to transform trauma into positive outcomes and transformational growth.

In addition, other components of posttraumatic growth include compassion, forgiveness and integrating traumatic events into a new reality. Kidnapping survivor Amanda Lindhout (2012) publicly shares her experience as a hostage in Somalia spending 460 days in captivity. She relates that she does not dwell on this:

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> …but relates moments where personal transformation occurred and she had the opportunity to turn suffering into growth. She explains how her journey through regret, anger and pain ultimately led her to discover that as long as she retained her ability to feel compassion, her humanity could never be taken from her. During her weakest moments, she found the ability to experience her greatest power: the power to forgive.

Linhout states that, "The process of forgiveness is not easy, but the decision to engage in it is the single most liberating experience a person can have."

Traditional religious instruction in East Africa focuses on mercy, guidance and compassion with caring support being both a "religious and moral obligation" (p. 12). Compassion and forgiveness are important values for East Africans. For example, a Ugandan ritual for cleansing and forgiveness involves stepping on a raw egg that is a symbol of innocent new life not yet been tainted. This ritual is performed to welcome child soldiers returning from the bush back into the community (Jacobs & Reyes, 2006). In fact, East Africans possess many rituals that, "are collective activities…which, within a culture, are considered as socially essential: they are therefore carried out for their own sake" (Hofstede (1991, p. 7).

In addition, several studies on the concepts of reconstructing or strengthening perceptions of self, others, and the meaning of traumatic events found that posttraumatic growth holds the idea of coming to terms with the personal meaning of traumatic experiences and the individual's place in the world (Tedeschi, et al., 2004a, 2004b, 2006). The studies maintain that growth does not occur from the traumatic events per se but the ensuing struggle to integrate the events and experiences into a new reality. Reports of posttraumatic growth indicate a new appreciation for life, a sense of the spiritual, changed priorities especially in regards to valuing intimate relationships, a sense of personal strength in surviving at great odds and the acceptance of the trauma accompanied by appropriate grief (Tedeschi, et al., 2004a, 2004b).

Africa has had a rich history and tradition of oral storytelling that may be utilised in counselling. Narrative therapy may assist East Africans to explore the constraining or restricting "dominant" life story they believe about their lives and relationships in the context of where they were formed (White, 2011). Interventions centre on assisting them to discover an alternate story by which they can create space for change and re-story their lives into more affirming and positive stories, beliefs and attitudes (Madigan, 2010; White, 2011).

Perhaps the final word goes to Rabbi Harold Kushner (1996, cited in Viorst, 1979) who laments the bitter sweetness of posttraumatic growth. He describes it in the following quote:

> I am a more sensitive person, a more effective pastor, a more sympathetic counselor because of Aaron's life and death than I would ever have been without it. And I would give up all those gains in a second if I could have my son back. If I could choose, I would forego all of the spiritual growth and depth which has come my way because of our experiences, and be what I was fifteen years ago, an average rabbi, an indifferent counselor, helping some people and unable to help others, and the father of a bright, happy boy. But I cannot choose (p. 295).

## Considerations for Counselling

There are several principles based on this review that should guide practitioners when working with East African people. Adopting these principles may promote resilience and posttraumatic growth by utilising cultural strengths and resources after a traumatic event. These principles are:

1. Assisting clients to connect or reconnect with familial and community support thereby increasing their sense of belonging, worth and resiliency;
2. Connecting clients to their spirituality and religious beliefs, thereby enabling them to gain strength and meaning;
3. Facilitating storytelling thereby assisting clients to re-story their lives into more affirming and positive stories, beliefs and attitudes; and,
4. Facilitating healing rituals of compassion, forgiveness thereby assisting clients to integrate traumatic events into a new reality.

These principles should not be seen as an independent treatment and should be integrated into accepted treatments that promote resiliency. Doing so may make interventions more culturally sensitive and increase the effectiveness of intervention with this group. Practitioners should be encouraged when working with trauma in an East African population as the case has been made that adversity does not necessarily lead to negative outcomes. Clinicians can actively include factors in therapy that foster resilience and lead to posttraumatic growth for the growing number of East Africans seeking refuge in Australia.

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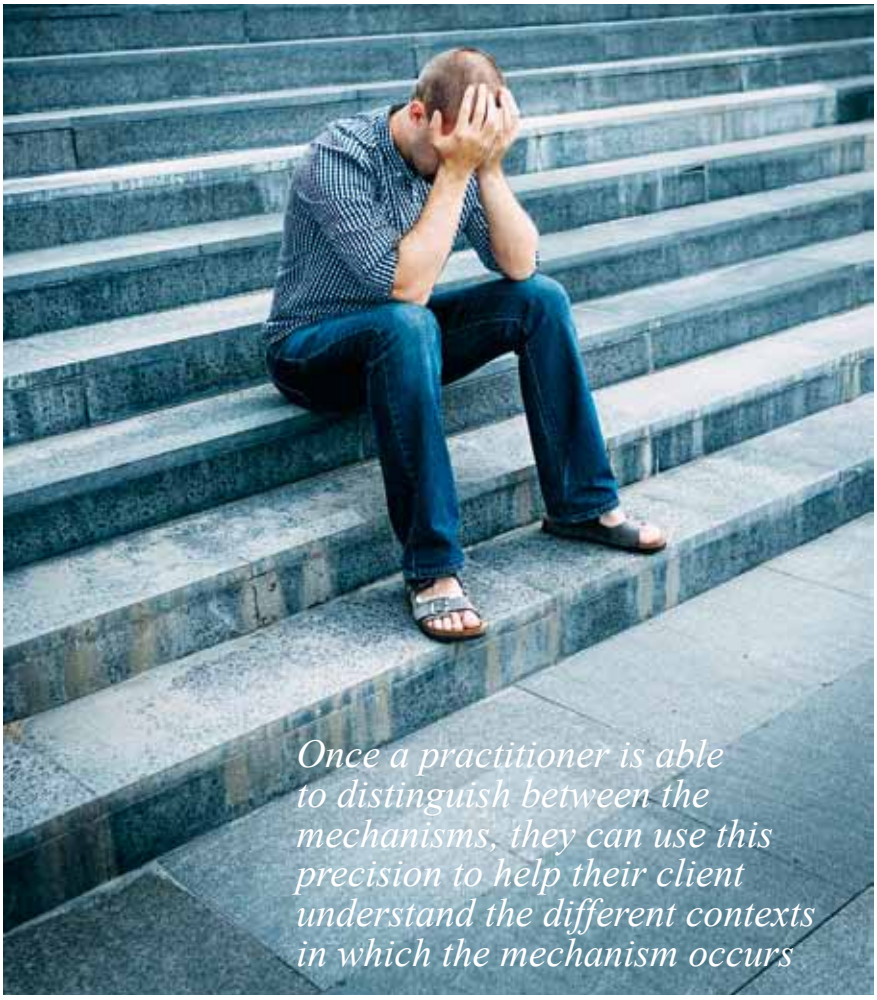
# Precision in Counselling Interventions - using Healing Inner Conflict (HIC) Principles

## By David 'Bhakti' Gotlieb

An article that explains the basics of 'Simple and Methodical Counselling Interventions using Healing Inner Conflict (HIC) Principles', a workshop presentation that will be part of the ACA Mini-Conference in Melbourne on 12/09/2015 by David 'Bhakti' Gotlieb

The ability to help a client understand their own disturbing behaviours and the context in which those behaviours actually make sense takes counselling interventions to a height of precision only dreamed about 20 years ago. Counselling, like Information Technology, is developing at an exponential rate and we either keep up or risk falling behind and disappointing many clients on the way.

HIC is not a panacea for all psychological ills, however, it does offer a precise underpinning that allows practitioners to diagnose (not in the medical sense of the word) the client's disturbing behaviours into Four Mechanisms. This comprehensive way of understanding behaviour adds a detailed clarity that complements almost all psycho-dynamic modalities. It is a holistic system that allows a client to bring understanding and compassion to their own inner landscape by developing a healthy relationship with their disparate parts or sub-personalities. This differs somewhat from the usual overriding that tends to pit one part against another due to the method it uses e.g. self-destructive. HIC helps the client make the distinction between the intent and the method that each part uses and brings healing to the context in which that behaviour was essential e.g. in early dependent stage childhood.



*Once a practitioner is able to distinguish between the mechanisms, they can use this precision to help their client understand the different contexts in which the mechanism occurs*

PHOTO: 123RF.COM

These Four Mechanisms can be categorised by their colloquial descriptors :

1. Inner Criticism
2. Acting Out
3. Passive Aggression
4. Addictiveness/Suicidality

I accidentally discovered these categories while working with clients dealing with extreme dissociation. Extreme abuse/trauma requires extreme dissociation and these clients were forced to autonomically compartmentalise their feelings and desires to minimise incoming abuse e.g. the abuse victim must become effective at NOT attempting to protect themselves from their abuser in order to minimise further harm.This ability to internally override their innate instinct to protect themselves is what all infants deal with in the dependant stage of childhood (inner criticism). When, eventually, they attempt to protect themselves (act out) it becomes clear that worse things befall them. Henceforth, a part overrides the desire to act out (passive aggression). Sometime later they will attempt to self-medicate in order to experience a moment of relief from the internal turmoil of trauma they are unable to have a healing relationship with due to the experience of

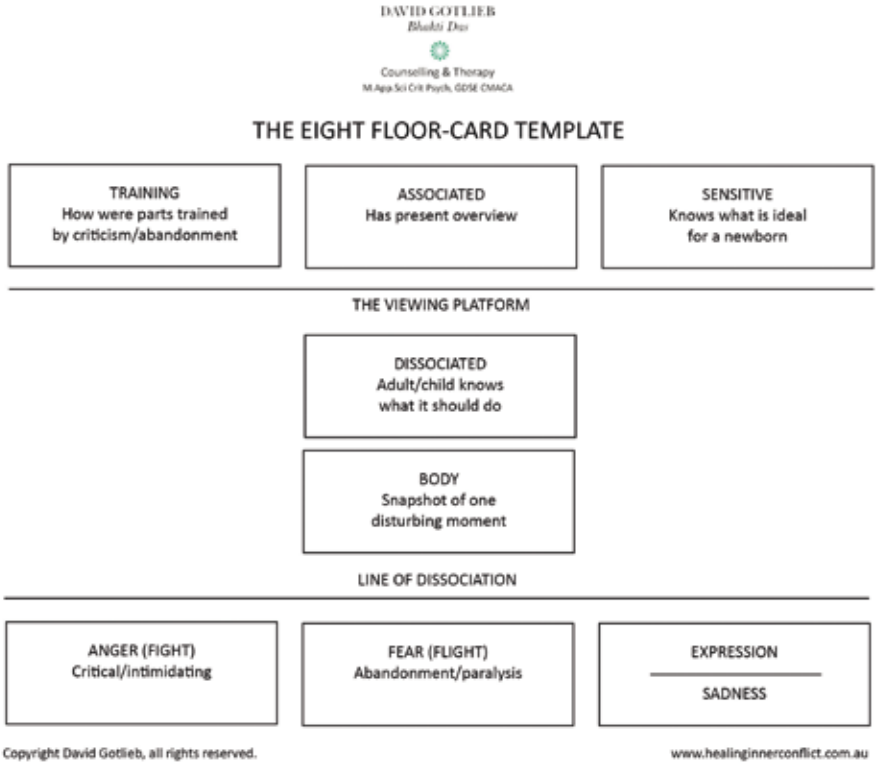
overwhelm associated it (addictiveness, and when that doesn't work, suicidality).

As I worked with these clients concurrently with, what I endearingly call, my 'normally neurotic' clients it became clear that the only difference between the two clinical populations was the level of trauma/abuse and therefore the level of need to dissociate. As Dr Arnold Mindel says," If you want to understand the norm, then explore the extremes." The Four Mechanisms were evident across both populations regardless, so I named them after the developmental stages where these internal and external behaviours are most likely to manifest themselves. However, there are many exceptions to this rule e.g. many people use an adolescent mechanism long before they begin physical adolescence.

Once a practitioner is able to distinguish between the mechanisms, they can use this precision to help their client understand the different contexts in which the mechanism occurs e.g. as a child it is essential to override expression in order to comply' This minimises incoming criticism/intimidation experienced by the child as potentially life-threatening and therefore counter to their survival instinct. When the child becomes an adolescent and notices they are not quite so dependent and are the same size as their parents or carers they act out in an attempt to override criticism externally because they can. When they reach the stage of adulthood where they are able to notice that acting out towards a boss or partner can have terrible consequences, an overriding of the acting out begins to manifest.

1. Child Mechanism - (Inner Critic) The criticism of the parent/carer is, by necessity, internalised by one part of the child in order to override the other part of the child that has a desire to express itself which will bring about more criticism/abandonment. Later in life, when the child has grown up and is no longer dependent on any one for their survival, these residual signals point to what HIC calls 'healing trying to happen' i.e. signals that don't make sense in present moment context other than to 'draw attention to that which requires healing', the emotional equivalent of physical pain proprioception.
2. Adolescent Mechanism – (Acting Out) The attempt to change the external relational situation. This is often noticed as external criticism sometimes with angry outbursts aimed at getting others to stop criticising or simply comply, sometimes with, and often without, great results due to the consequences of the outburst.
3. Adult Mechanism – (Passive Aggression) A more adult part has an ability to pit long term needs against the instant gratification of an insensitive outburst. This becomes an internal override of the Adolescent Mechanism aimed at not losing the job or marriage etc.
4. Self-Medication Mechanism – (Addiction/Suicidality) External use of pseudo-satisfiers (sex, drugs or any repeatable behaviour that distracts enough to be effective) in order to feel momentary relief, no matter how destructive the consequences in the long run. This gives a whole new perspective on the intent of most suicidality.

HIC uses an Eight Floor Card Template that acts as a simple guide to follow signals of disturbance to the exact place where internalised trauma and protective mechanisms play themselves out in the present moment. The client would describe these as internal conflict or experiences they do not understand.




## THE HIC EIGHT FLOOR CARD TEMPLATE

The experiential work in HIC offers the client a tangible experience of wellbeing predicated on the ability to bring effective adult strategies to where it's required internally and externally. This can sometimes be achieved in a matter of hours in as simple straightforward case and can take much longer where the dissociation is more extreme. The theory and practice behind the experiential part of HIC inner work including a comprehensive debunking of the myth of the 'resistant client' will be fully detailed in my next article.

Key HIC distinctions:

- Dissociation is a function...In childhood or situations beyond a person's control, dissociation becomes a survival mechanism.
- The triggered moment must be distinguished from the other moments when the client is NOT triggered. People act completely different when they are 'triggered' and are acting out of a sense of perceived threat. Erroneously explained as "I lost control", "I wasn't myself" or " I don't know what came over me". A more accurate explanation is that a part of themselves they are yet to understand has 'taken over control' for its own reasons, only understandable in a 'healing trying to happen' context.
- Anger, Fear and Sadness are the three subsets for all seemingly disturbing emotions, however Anger and Fear are in a distinct category as the motivational force behind the Fight/Flight mechanism in survival situations, including childhood

dependent stage. As explained in detail above, the internalization of criticism (anger) to override unique expression into paralysis (fear) in order to force out compliance and thus survive is essential in childhood and non-essential in most adult situations. HIC helps the client to bring their Adult self into a healing relationship with the Child parts and an awareness that the situation WAS a survival issue then, but that it IS NOT a survival issue now, even though it feels like one.

HIC owes much of its simplicity to the philosophies behind Dr Arnold Mindell's 'Process Oriented Psychology' and Dr John Briere's 'Self Trauma Model' and Dr Richard Schwartz's 'Internal Family Systems'. Through meeting and studying with Dr Richard Alpert (aka Ram Dass) author of 'Be Here Now' and 'Be Love Now', HIC has developed an ability to offer a practical method for maximising the ability to experience and offer unconditional love.

David (Bhakti) Gotlieb MAppSci Crit Psych, Grad Dip Social Ecology, ACA College of Supervision, is a supervisor, counsellor, and facilitator. He presents workshops at ACA and other conferences and in his private counselling and supervision practices in Crows Nest, Sydney and Bowral, NSW. He has trained with Dr Richard Alpert (Ram Dass) Dr Arnold Mindell (Process Oriented Psychology) Helena Cornelius (Conflict Resolution Network) and many others. He has written articles and an e-book on his modality 'Healing Inner Conflict (HIC) which are freely available at healinginnerconflict.com.au

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# Australian Counselling Association & National Disability Insurance Schemee

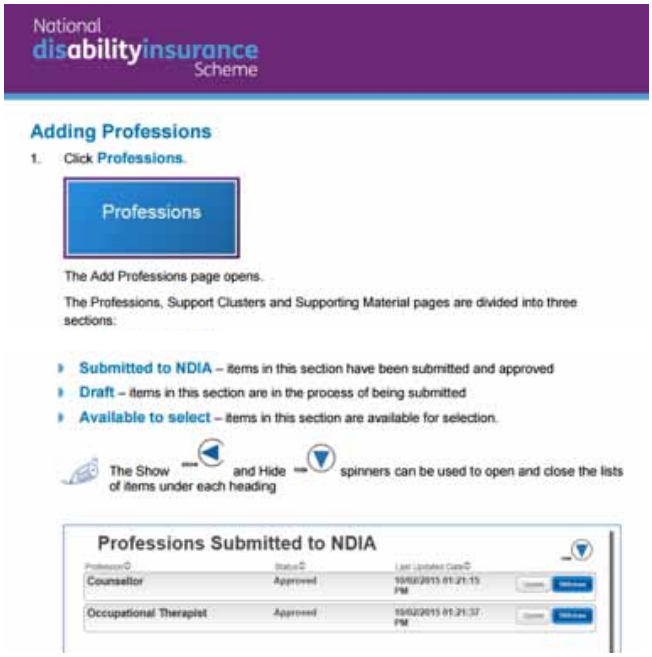
## By Thomas Parker

These are exciting times for registered counsellors and psychotherapists in Australia. At the moment, counselling is a recognized therapeutic support under the National Disability Insurance Scheme (NDIS). Thanks to the standards that ACA has put in practise, ACA registered counsellors can register to become providers with the National Disability Insurance Agency (the agency delivering the NDIS).

The agency has confirmed that the ACA policies and standards in place are acceptable when registering as a provider. This is news allows for an additional revenue stream in private practise. There are already two documents on the ACA website that explain the rules for registration in each state, and a breakdown of how to complete the application form. Because this is an area in which counsellors and psychotherapists can help grow their private practise ACA has rigorously follow up with the agency.

Counselling is well recognized within the NDIA, and the two below examples are taken directly from the NDIS Provider Support Page:

| Support Cluster | Professions | Evidence of experience | Capacity Requirements Evidence of: |
|---|---|---|---|
| **Provider Portal Name:**<br>Therapeutic supports<br><br>Therapeutic supports are provided to assist the participant to apply their functional skills to improve participation and independence in daily, practical activities in areas such as Language and communication, Personal care, Mobility and movement, Interpersonal interactions and Community living. | • Art Therapist<br>• Counsellor<br>• Music Therapist<br>• Registered Nurse<br>• Occupational Therapist<br>• Orthoptist<br>• Podiatrist<br>• Psychologist<br>• Physiotherapist<br>• Social Worker<br>• Speech and Language Pathologist | Provide details of ongoing professional / clinician supervision and development in place. | • Facilities and Equipment<br>• Specialist Disability Service State Approval<br>• National Police Check<br>• Working with Children / Vulnerable people check |




As you will note, the requirements for counselling within NDIS are already met by ACA requirements. All of which can be found on the ACA website. They will include the ACA supervision policy, code of ethical practise, and ongoing professional development policy.

For ACA members, being a registered provider allows for a new potential revenue stream and the ability to receive government funding for therapeutic supports. Your qualifications and efforts are worthwhile and it is beginning to be noticed. Please take advantage of this opportunity. We look forward to continue to represent you all in the future!

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This course will offer an introduction to the discipline of positive psychology and the concept of authentic happiness including the aetiology of happiness.

**Indigenous Counselling**

This course will offer an introduction on how to approach Indigenous clients from an understanding of their world view rather than from Western scientific worldviews.

**Responding to Suicide Risk**

This course provides a guide to best methods of response to suicide risk in clients while also providing an overview of potential risk factors.

**Working with Subpersonalities**

This course offers you information about subpersonalities: the theory behind the construct, the core understandings, and several exercises to guide your clients' work with them.

### WORKSHOP VIDEOS

**Crisis Counseling: The ABC Model**

Dr. Kristi Kanel (California State University) reviews the history of crisis counselling, provides a background of crisis theory and explores 2 case studies: the first client is a rape survivor, and the second is a war veteran.

**Crisis Stabilization for Children: Disaster Mental Health**

Dr. Jennifer Baggerly (University of South Florida) worked with children in Louisiana following Hurricane Katrina and with children in Sri Lanka after the tsunami. This live demonstration video presents the guiding principles for responding to children after a disaster.

**Therapies In-Action**

Presented in an authentic and flowing style, this video includes five role plays where counselling professionals apply five different therapeutic approaches with clients.

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## SPECIALTY COURSES (Continued.)

### Case Studies in Narcissism

Over this course you will have the opportunity to explore the NPD cases of a man, a woman, and a couple. You will be able to see the symptoms "in action" in the case study subjects' lives, and the huge impact the disorder has had on significant others in their lives.

### Fostering Resilience in Clients

The purpose of this course is to help you enhance the emotional resilience of your clients. To do that, you will want to understand what resilience is and which skills or responses to circumstances tend to increase it.

### Principles of Psychosynthesis

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

### Understanding Will

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

### Overview of the Principal Personality Tests

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

**Plus many, many more!**

## WORKSHOP VIDEOS (Continued.)

### Play Therapy: Basics for Beginning Students

This video is the place to begin instruction in play therapy – it is upbeat and entertaining with great visuals, but also includes the critical basics for students with many live demonstrations. The presenter uses puppets to help communicate the rationale, principles, and basic skills of play therapy. Each skill is demonstrated through video clips of play therapy sessions with culturally diverse children.

### Brief Counselling: The Basic Skills

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

### Attachment and the Therapeutic Relationship

When a child is referred for therapy it is common to discover that the child has experienced disruption to a significant attachment relationship which has impacted that child in serious ways. This presentation draws upon a number of actual cases, and shows experiential techniques to explore the topic.

### Using Undercover Teams to Re-story Bullying

This workshop uses real-life stories to describe how the school counsellor uses the Undercover Team Approach in a strategic way to disrupt a story of bullying relations in a secondary school classroom and rewrite an alternative story of support for the victim.

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PEER REVIEWED ARTICLE

# How do partners & families of sex addicts survive an addiction they struggle to even talk about?

By Sharalyn Drayton

**Paper Presented at the Australian & New Zealand Addiction Conference Gold Coast, 20-22 May 2015**

PHOTO: 123RF.COM

"Is it really an addiction or is it just an excuse for bad behaviour?" "How could you not know what he was up to?" "How could you stay with him after what he's done? You'll never be able to trust him again. If it was me I'd just walk away!"

These and so many more negative comments tend to be the primary responses on hearing the news that someone you know or love has been impacted by sex addiction. For the partner it is generally easier to just keep quiet and try and deal with this nightmare alone. Finding someone to confide the horrifying reality that your partner is acting out his sex addiction online, with prostitutes, through the use of pornography or by having affairs is almost impossible to deal with. How do you share the knowledge that your partner is a sex addict? The idea itself is so staggering and involves such a deep sense of betrayal that for some it seems even surviving the impact of this knowledge may be too much!

Sex addiction is a private addiction. It is unseen and its consequences are slow to reveal themselves. By the time someone comes for help it is generally not because they are an addict but because their primary relationship is falling apart. It tends to be the partners who drag their significant other along for couples therapy in a last ditch attempt to hold on to something that started out with such promise.

Partners of sex addicts generally know for a long time before they seek help that there is something very wrong. Just what that is can often remain something of a mystery but there is always anger, suspicion, self-doubt and despair. However there is also hope, both for the addict, their partners and also their families. In fact given the right information, motivation and support recovery is not only possible, but can be life changing. It is in fact possible to not only survive the discovery that your partner is a sex addict but rebuild a relationship which is stronger, more intimate and more resilient than anything that has gone before.

## Introduction

*Dear Sex Addiction,*

*You are a disgusting, deceitful liar and thief. You stole my partner's life and you nearly stole mine. You brought secrecy and shame into my life and into my home. You turned me into someone I didn't want to be, filled with self-loathing and fear. You stole any chance of real intimacy from my life and you made me feel responsible somehow for all the things that were wrong in my relationship. You are my worst enemy!*

*Sex Addiction you stretch your stealing, grasping fingers into the lives and hearts of so many. You promise something that you can't deliver and by the time people find out who you are you have destroyed part of their souls. You steal EVERYTHING.*

*You are a cheat, a disease, a heart breaker, a soul destroyer and you murder the hopes and dreams of couples. You creep into the lives of the unsuspecting and turn them into beings they never believed they could be. You bring out the absolute worst in people and you don't stop until you have destroyed everything in your path. You don't just destroy the addict, you destroy everyone who loves and cares for the addict. You destroy individuals, you destroy families, you destroy careers, you destroy homes, you destroy lives.*

*I wish I could destroy you and stop you from ruining so many lives. I wish I could teach people about real life – that is life without you. Life that is whole, joy-filled and real; life that lets people feel their real feelings and know they are loved even when it doesn't seem like it. Life that experiences real intimacy – not fancy dressed up bullshit which is just about sex, but real deep connection where it is safe to be vulnerable before one another and where sex is love, not lust. Where love is fulfilling and warms the soul, not hollow and empty leaving nothing but tears and bitterness.*

*BUT NO MORE. Sex Addiction I have had enough of you and your poison and the pain, shame and tears you bring. No longer will you have any power over me. No longer will you be able to twist my gut with your nasty suspicions and sneaky lies, or with doubt and shame. I choose honesty and to light my path with truth which you cant handle. I am breaking your hold on me and taking back my power. You will no longer create obsession and fear in my life. My life, from hence forth, is about what is best for me and YOU ARE NOT WELCOME. I will no longer allow you to control me, hurt me, confuse me.*

*This is my commitment to myself. Truth will be my guiding principal, secrets are henceforth banished. Secrets fester in darkness, which is the place you love. Truth brings a light too strong for your presence. Henceforth if the truth isn't present, I wont be either!*

*SEX ADDICTION I AM THROUGH WITH YOU.*

The letter you have just read was written by a women in one of the Partners Healing and Support groups I run in my

private practice (printed here with her permission). The experience of writing this letter was cathartic (to say the least) for the woman who wrote it and although it was difficult for the other women in the group to hear it was also helpful for them…..but more of that later!

Not so long ago sex addiction was something not many were familiar with. However thanks to the occasional celebrity, the Tiger Woods of the world, and increasing media interest in the impact of pornography, sex addiction is starting to be recognised in the wider community as a real issue (although there is still a lot of misinformation, misunderstanding and confusion along with some sniggering and "perhaps it's just an excuse for bad behaviour" attitude when sex addiction gets a mention). It is however an area which seems to be gaining momentum. With this increased interest we are finally starting to see journalists picking up the threads and seeking to explore this 'new' addiction. Hopefully this will assist in demystifying and normalising sex addiction, and help people to accept that it is as much a problem as other, better known addictions, such as drugs, alcohol and gambling which will help make it a topic easier to talk about.

I refer to sex addiction as "the Silent Addiction" largely because it is just that – silent! It is a private addiction that no one sees or hears and it is an addiction that is often misunderstand. Indeed many tend to lump sex addicts into the same category as sex offenders. Sexual Addiction or Hypersexual Behaviour Disorder or Compulsive Sexual Behaviour doesn't make it into the DSM 5 and I would have to agree with Alexandra Katehakis, the Founder and Clinical Director of the Centre for Healthy Sex in Los Angeles who says that

> "this completely disregards the pain, confusion, *trauma*, *fear* and hopelessness experienced by *sex* addicts and their families". Psychology Today (Dec 21, 2012). Post published by Alexandra Katehakis in *Sex, Lies & Trauma*.

So this paper looks a little at sex addiction and a lot at the impact that sex addiction has on the partners and family of the addict. It will look at trauma and shame (betrayal and infidelity as a violation of trust physically, emotionally and spiritually) and how the impact of trauma and shame work to silence the partners of sex addicts. It will also look at the importance of disclosure and how this is best handled to manage the trauma experienced by partners and the longer-term impact on the relationship; and the impact of loss and grief as experienced by the partners of sex addicts. Finally it will finish by looking at ways in which we can work with partners of sexual addicts to assist in their quest for healing and growth, the benefits of which effect not only them, but their partners and families also.

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

## Addiction

Addiction is a neurological disease that affects brain chemistry so that painful or negative feelings are medicated into something which feels more manageable. (Allen, J. The Secret Disease of Addiction, (2008) Introduction, & American Society for Addictive Medicine available at http://www.asam.org/for-the-public/definition-of-addiction)

Patrick Carnes in his ground breaking book "Out Of The Shadows – Understanding Sexual Addiction" (1983) explains sex addiction as a 'pathological relationship' with a mood altering experience. In his follow up book "Contrary to Love – Helping the Sexual Addict" (1989) he goes on to say that

> "sex addicts have lost control over their ability to say no; they have lost control over their ability to choose. Their sexual behaviour is part of a cycle of thinking, feeling, and acting which they cannot control.... the sex addict has learned to rely on sex for comfort from pain, nurturing, or relief from stress the way an alcoholic relies on alcohol, or a drug addict on drugs. ...The obsessional illness transforms into the primary relationship or need, for which all else may be sacrificed. As life unravels, the sex addict despairs, helplessly trapped in cycles of degradation, shame and danger. (p. 4, 5).

So imagine what life is like for the partner and family when the sex addict comes home!

Sometimes referred to as an 'intimacy disorder' addiction manifests in families as absence - not just physically, but emotionally and spiritually also. Even when physically present the addict is still absent. Addiction isolates the addict from others and keeps others away from the addict. The addict generally even has a sense of being in control of their addiction and this can feel less threatening than being vulnerable and 'exposed' to themselves and loved ones. This absence is particularly difficult for partners who are seeking connection at a deep personal level with the person they love, and it is confusing and painful to feel rejected by the one person who used to love them while that person is at the same time declaring that they still do and there is nothing wrong. However the relationship is under great stress, communication is a problem and mistrust and resentment is growing.

So clients present for couples counselling. She wants a relationship like they used to have (or at least one that isn't shrouded in lies and confusion) but if he hasn't been caught out yet he will have another agenda – one that doesn't include disclosure of his addiction! Assuming of course that he even recognises that he has an addiction. In some cases even if he has been caught out the level of denial and/or minimisation of the use of pornography or the infidelity can be incredibly persuasive for partners who at some level may know there is something going on. The desire to be convinced that he's telling the truth however can be so strong she may override her intuition and be persuaded that her thinking is flawed. Couples counselling can even feel like intimacy for some partners and can work to have a pacifying effect on the partner who may be lulled back in to thinking that perhaps she really was the one with the problem. So therapy is often doomed before it begins. However even if his infidelity has surfaced and all is apparently out in the open, when couples come for counselling the focus is generally on the one who has been unfaithful and addiction may not be diagnosed. Women in my support groups report being told that what they sense, suspect or have even observed is wrong! Partners often feel that they are invisible, not recognised and certainly not heard.

Although Sexual Addiction (or Hypersexual Disorder) didn't make it into the DMS 5, the criteria proposed for submission is as follows:

## DSM 5 PROPOSED DIAGNOSTIC CRITERIA FOR HYPERSEXUAL DISORDER

Over a period of at least 6 months, recurrent and intense sexual fantasies, sexual urges, or sexual behaviours in association with 3 or more of the following 5 criteria:

1. Time consumed by sexual fantasies, urges or behaviours repetitively interferes with other important (non-

sexual) goals, activities and obligations.
2. Repetitively engaging in sexual fantasies, urges or behaviours in response to dysphoric mood states (e.g., anxiety, depression, boredom, irritability).
3. Repetitively engaging in sexual fantasies, urges or behaviours in response to stressful life events.
4. Repetitive but unsuccessful efforts to control or significantly reduce these sexual fantasies, urges or behaviours.
5. Repetitively engaging in sexual behaviours while disregarding the risk for physical or emotional harm to self or others.

- Provided A: That there is clinically significant personal distress or impairment in social, occupational or other important areas of functioning associated with the frequency and intensity of these sexual fantasies, urges or behaviours.
- Provided B: That these sexual fantasies, urges or behaviours are not due to the direct physiological effect of an exogenous substance (e.g., a drug of abuse or a medication)
- Specify if: Masturbation, Pornography, Sexual Behaviour with Consenting Adults, Cybersex, Telephone Sex, Strip Clubs, Other

Kafka M.P. (2009)

While the purpose of this paper is not to debate whether Sexual Addiction should be in the DSM 5 or what the criteria for diagnosis should be, it would seem that this criteria is pretty realistic and that a lot of these behaviours would have been evident for longer than 6 months. Some partners in my groups report behaviours that may have surfaced years earlier and upon confrontation the addict is contrite and agrees to change or stop their behaviour. However rather than ceasing the behaviour (although they may have tried unsuccessfully) the addict essentially goes underground and continues to lie to hide his behaviour. It isn't until the behaviours surface again that partners finally seek help as they are no longer able, or willing, to try to deal with the lies, secrecy and betrayal.

Upon discovery of the addict's behaviour the partner is going to be traumatised by what they learn. In my groups I note that those with partners who act out with pornography are not always perceived to have been unfaithful in the same way that those who have used prostitutes and/or affairs to act out their addiction. If it is an addiction issue however there will have been longer term acting out, either with pornography and/or sex partners, and the trauma will be greater than if it is a 'one off' event or a casual fling.

Before couples can work on their relationship however, they need to understand the reality of their situation. They both need to understand addiction – what it is, how it manifests; and while he needs to identify his addiction, partners need to know that they are traumatised and how to manage that trauma. They will both need to understand their own family of origin stories which will ultimately help to make sense of behaviours which don't seem to make sense! Then there is the family unit. How to tell the children and the wider family? The discovery of sex addiction can be so overwhelming and shaming for partners that they seek desperately to hide this information from their family and friends. It is however important to disclose some information to children in an age appropriate way and at an appropriate time, as they are impacted significantly by what is happening in their family unit. Schneider points out that

> In the treatment of sexual addiction, the family unit is often neglected. Yet each family member is significantly affected by the compulsive sexual behaviour, and can benefit from treatment. Moreover, the family unit is the context in which the sexual addict continues to live, and the mental health of the partner has a tremendous impact on the sexual addict's recovery. Finally, treatment of children in such a family can help break the cycle of sexual addiction and prevent its perpetuation into the next generation
> Compulsive and Addictive Sexual Disorders and the Family
> Schneider, J.P. October, 2000:53-62

## Trauma, Grief & Loss

As you may have noted in the letter to Sex Addiction at the beginning of this paper, partners of sexual addicts experience an enormous sense of anger, grief and loss. Once the numbness of the initial trauma subsides, an overwhelming sense of loss is part of the experience of discovering that your partner is a sex addict. Nothing is as it was! Everything seems to have changed or been challenged - beliefs, dreams, goals, love, history…and what about the future? How does one move forward when the very platform on which one has built a life is shattered?

Many people have strong emotional or physical reactions following the experience of a traumatic event. The Australian Psychological Society say that the impact and time of recovery can be due to several factors such as the nature of the traumatic event, the level of available support, previous and current life stress, personality, and coping resources.

They describe the potential symptoms of psychological trauma as:

### Physical

- Excessive alertness, on the look-out for signs of danger
- Easily startled
- Fatigue/exhaustion
- Disturbed sleep
- General aches and pains
- Cognitive
- Intrusive thoughts and memories of the event
- Visual images of the event
- Nightmares
- Poor concentration and memory
- Disorientation
- Confusion
- Behavioural
- Avoidance of places or activities that are reminders of the event
- Social withdrawal and isolation
- Loss of interest in normal activities
- Emotional
- Fear
- Numbness and detachment
- Depression
- Guilt
- Anger and irritability
- Anxiety and panic

*'Understanding & Managing Psychological Trauma'* – Australian Psychological Society

They go on to say that

> "As long as they are not too severe or last for too long, the symptoms described above are normal reactions to trauma.… and that "they are part of the natural healing process of adjusting to a very powerful event, making some sense out of what happened, and putting it into perspective. With understanding and support from family, friends and colleagues the stress symptoms usually resolve more rapidly."

Partners of sex addicts experience all these symptoms of trauma with the discovery that their partner is, in the first instance:

- Unfaithful…
- They are further traumatised when they start to understand the nature of this infidelity….
- They are traumatised again when their partner starts to disclose the extent of the infidelity (and more traumatised

with each further disclosure)…

- Then again when the experience is internalised as (in most cases) there is no *"understanding and support from family, friends and colleagues"*!

> "If he had cancer it would be so much easier as then I'd get some support"
>
> "Who do I tell? I can't talk to my friends or my family because Im scared they will judge me. Its like I am somehow responsible for what he's done….maybe it is my fault"
>
> "How do I tell the kids? They know something's going on but Im terrified of how they'll respond. I want to protect them (and the wider family), but I feel angry because how come I have to protect everyone else when he's the one that's done all the damage?"
>
> "I wish he was dead…it would be so much easier…and I'd be able to let go and then I could expect my family to give me some support and this nightmare might actually end."

There's also financial trauma as the extent of the cost of the addiction comes to light.

Then there's the physical reaction to deal with as well. Chronic weight loss (or gain), inability to sleep, loss of concentration, unpredictable crying, depression, hyper-vigilance, reactions activated by triggers such as the places he may have been when he was acting out or, in some cases, seeing the people he was acting out with….which creates more stress, especially trying to keep this hidden from family and friends. Then there's the guilt - firstly for not telling family what's happened and for feeling responsible at some level; and then there's the anger because partners feel like even after all this, they are still keeping his secrets.

Post Traumatic Stress Disorder (PTSD), Complicated Grief (CG) and even Disorders of Extreme Stress Not Otherwise Specified (DESNOS) are all issues which may need to be addressed, particularly over the longer term. Many of the symptoms described in the proposed Diagnostic Criteria for Complicated Grief Disorder apply to partners of sex addicts which

> "includes symptoms of intense intrusive thoughts, pangs of severe emotion, distressing yearnings, feeling excessively alone and empty, excessively avoiding tasks reminiscent of the deceased (or, I would add here, sex addict), unusual sleep disturbances, and maladaptive levels of loss of interest in personal activities lasting longer than 12 months." 'Diagnostic Criteria for Complicated Grief Disorder' American Journal of Psychiatry 154:7,

The level of support partners receive, and how committed the addict is to his recovery and the relationship will influence the severity of the grief and trauma symptoms longer term. Understanding the partners background will help both the partner and the clinician understand her responses to the trauma of discovery, predict possible longer term issues and assist her to process this trauma, however if DESNOS is predicated "*...effective treatment needs to focus on self-regulatory deficits rather than [just] processing the trauma*". (van der Kolk (2013) p173). It would seem that enabling partners to manage 'self-regulatory deficits" would also be an effective treatment for partners relating to the experience of surviving their partner's addiction and the discovery of how it has manifested. Going forward partners need to be able to respond to memories and other triggers in a way that enables them to function appropriately in the family and in the wider community.

## DISCLOSURE

Having interviewed wives of male sex addicts…(Schneider) reported that nearly every women felt it should be her decision how much to be told; most did not ask for information that they were not ready to hear…"if a relationship is to survive the crisis of disclosure…a spirit of honesty and respect for each partner is essential… and should be guided by the spouse's desire to know…"

*Surviving Disclosure of Infidelity* Schneider, J.P., Corley, M.D., and Irons, R.R (1998). *Sexual Addiction & Compulsivity 5* (3): 189-218

There's no doubt that disclosure needs to be handled carefully. Disclosure can make or break the relationship. Some partners feel that they need to know everything….all the details, while others don't want to know any more than they absolutely have too. It is wise to encourage partners who want to know every little detail to look at why they need this information and what benefit it will be. In the long term too much information can have a more negative than positive impact. One thing is certain however, and that is that staggered, uncontained disclosure can be very destructive to the people involved and their relationship, and immensely traumatising to the partner. Partners can experience

> "depression…suicidal thoughts, fear of abandonment, loss of self esteem, decreased ability to concentrate…distrust of the addict and perhaps of everyone, anger…physical illness…."
> Schneider, *Sex, Lies & Forgiveness*. (2004) p104

It is recommended that disclosure contain the facts without all the details and Schneider's research shows that partners find it easier if the major issues are disclosed up front without the 'gory' details (*Surviving Disclosure of Infidelity*). This can pose problems for the addict as they are generally fearful that their partner will leave if they tell them too much. However Schneider's research suggests that threats to leave generally aren't carried out. At this point however partners generally feel that they will have to leave if they don't start getting the truth! Given that sexual addiction is all about secrecy and lies, by the time the addiction is out in the open partners are on the one hand relieved that what they suspected was actually true and on the other hand shocked and horrified by what they have uncovered. How disclosure is handled can determine the future of the relationship, and if the relationship is to be rebuilt it is going to require honest and open communication. Handled correctly the relationship can develop resilience and a level of honesty and intimacy not previously experienced.

## Healing & Growth

> "Owning our story can be hard, but not nearly as difficult as spending our lives running from it. Embracing our vulnerabilities is risky but not nearly as dangerous as giving up on love and belonging and joy—the experiences that make us the most vulnerable. Only when we are brave enough to explore the darkness will we discover the infinite power of our light."
> Brene Brown

So how do partners and families of sex addicts survive an addiction when it is so difficult to even talk about it? Not very well would have to be the answer to that question. However there is hope and in the Partners Healing Support Groups I run I have observed the following:

1. In the first instant it is important not to tell the partner of a sex addict that she is a co-addict, co-dependent or partly responsible for her partners addiction. Partners of sex addicts have experienced such a deep level

of betrayal that the brutality of this realisation, and all that is associated with it, can be almost unbearable. Partners need to be accepted with support and compassion and then treated for trauma before they will be in a position to start looking at their own story. Eventually partners will need to deal with the issues arising from their family of origin, particularly around issues of abandonment, self-esteem, abuse and dependence, but first they need a sense of safety and support to ensure that they are not further traumatised. Supporting and stabilising partners, and building a good therapeutic alliance, is at the heart of empowering partners to understand their situation and move toward healing and personal growth.

2. There can be a difference between women whose partner's sex addiction manifests as infidelity with other women (ie prostitutes/affairs) and those whose addiction is to pornography. The perception is often that this is not as bad and he hasn't really been unfaithful. How does this impact the partner in their recovery? In my groups I notice a difference in attitude as it is easier for these partners to minimise their experience. However although the sense of betrayal may be different the addiction is the same, as are the long-term consequences for both the addict, the partners and families. Sharing information with others who have similar experiences helps to avoid minimisation and empowers the partner to own her experience and its consequences on her and the family.
3. It is vital to have support and a safe environment to be able to discuss and explore freely the on going issues inherent in living with a sex addict. This sharing with others in similar situations normalises the experience and helps to reduce some of the shame associated with the experience. To be able to explore issues such as trust, telling the children and wider family, personal healing, dealing with sex and sexually transmitted diseases with others who have similar experiences is a gift beyond price.
4. Having a group of trusted others to help reflect on what has gone before - i.e. what life was really like before discovery of the sex addiction, helps to break through denial. This also helps to build understanding and lead to a curiosity about connecting with their own family stories, and eventually understanding of the role they have played in the relationship.
5. Discovering they are not alone, that they are not a failure who somehow mismanaged their relationship and destroyed the family, and they are also not solely responsible for fixing it, helps relieve some of the burden of doubt, shame and insecurity.
6. Learning about triggers (such as dates, certain people, events and locations) and setting boundaries around triggering events, is helpful in terms of partners knowing that they can keep their environment safe. This gives her permission to avoid those triggers (or at least seek support if a triggering event happens). Having boundaries around behaviour that is unacceptable in her partner and herself enables a sense of empowerment, and provides safety for the family.

I started this paper with a letter written to Sex Addiction because for people who can't speak writing is an obvious choice to externalise what is without doubt an incredibly painful and traumatising experience. The letter to Sex Addiction also helps to separate the person from the addiction. While partners need to have a voice and be able to acknowledge their experience in a supportive environment with a therapist who understands sex addiction and the unique issues faced by partners, recovery for both parties requires absolute commitment to the healing journey and starts with an understanding of the nature of addiction. With this commitment, time and help from appropriately trained therapists and other support and recovery groups, healing is not only possible but a relationship with real intimacy and connection is more than achievable.

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# My autistic awakening: Unlocking the potential for a life well lived.

## Written by Jude Boyland

**Master Education, Diploma Professional Counselling, PhD Candidate, Member College Clinical Counsellors (ACA Inc), Member College Professional Supervisors (ACA Inc)**

At the age of 37, Rachael Lee Harris was given a diagnosis of Asperger's Syndrome which, if we are to slot persons into little boxes, positions Rachael in the high functioning pigeon hole along the Autism Spectrum. However it is not about slotting into little boxes, it is about understanding that different persons process information in different ways and because of the differences in perceptions and understandings, expressed behaviours are also different and can often be confronting for both the person 'on the spectrum' and those who live with a loved one, 'on the spectrum'.

Rachael explains that she was self-motivated to seek the Asperger diagnosis and that once she was aware of that she, too, (as well as her son) was on the spectrum, she chose to seek diagnosis shortly afterwards.

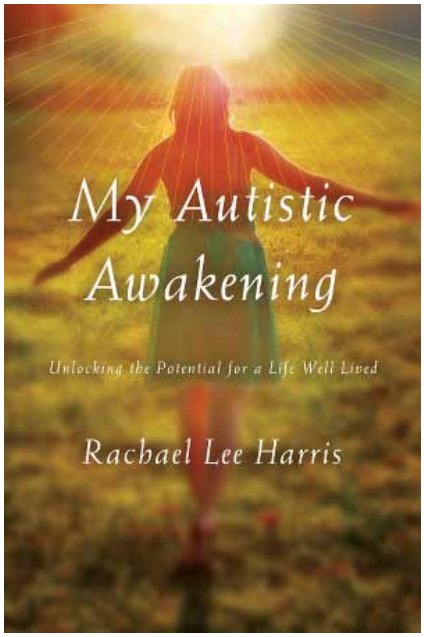
As Rachael reflects on her 'Brilliant Career' in Chapter 16 of *My Autistic Awakening*, she speaks with admiration of her colleague, Professor Tony Attwood, who is a world authority in the field of Autism Spectrum Conditions and who asked Rachael at an Autism Women's Conference in 2009, how it was that she had managed her life so well, both personally and professionally. Reflecting on the question, 'Why?' is what led Rachael to choose not to write a case study but to write a life story. She explains that although writing her story had been brewing at the back of her mind for some time, it was ultimately with the encouragement of her husband that she began to write about her life on the autism spectrum: actually starting the writing while overseas on honeymoon!

*My autistic awakening: Unlocking the potential for a life well lived*, has been described as 'a whimsical journey into one woman's search for her true self'. It has also been described as 'a beautiful and personal story to inspire and calm'. For Rachael, the most challenging part of writing this book was in choosing what parts of her history to present and what to prune. She states that in many ways, her autism autobiography is fairly unusual in that it was in no way 'cathartic'. For, by the time she wrote her story, Rachael explains that she felt she was writing from a 'redeemed perspective': all the events of the past, healed, so that the reader is left with an account that is moderate and positive in its telling.

For Rachael, her greatest reward is to use her history, her thoughts and her words to reach out to others, both on and off the spectrum and to show that, when all is said and done, we are not so very different in seeking our hopes and dreams. "In short", says Rachael, it is about "giving our humanity full expression".

I was drawn to purchase *My autistic awakening: Unlocking the potential for a life well lived*, from a threefold perspective – (1) to support a colleague in purchasing her publication, (2) professional curiosity and (3) a wanting to see if I could identify anything of Rachael's childhood reflections in my own grandson's expressions in relation to the world as he perceives it. I certainly got my money's worth! I laughed, I cried, I identified. And as, just for a moment, I walked in the footsteps of Rachael and Maxie, I learned, I imagined and I, too, was awakened to another level of appreciating the world through the diverse senses of difference.

For the clinician who works with persons on the spectrum, parents or siblings or partners of persons on the spectrum, persons who are themselves on the spectrum, research students compiling a qualitative literature review or those who are merely looking for a captivating read, written in the style of an engaging conversation, I whole heartedly recommend to you Rachael Lee Harris', *My autistic awakening: Unlocking the potential for a life well lived.*




*myautisticawakening.com*
*fb.com/MyAutisticAwakening*

**Harris, R. L. (2015). *My autistic awakening: Unlocking the potential for a life well lived.* Lanham, MARYLAND: The Rowman & Littlefield Publishing Group, Inc.**

# Special Ethical Considerations for Facially Distinctive Counsellors

## Note

For the benefit of this paper, the facially distinctive counsellor's name has been changed in order to protect their identity. From now on the counsellor will be named Justine.

## Scenario

Justine has an acquired facial disfigurement due to a motor vehicle accident when she was 12 days old. It is impossible to hide to those with whom she has face-to-face contact. The nerves were severed causing blindness and leaving the right lid partially to fully closed. Justine has no control over the eyelid. Justine finds that clients are "too shy" and do not know what to do thus feel "awkward". Some clients have told her she lost clientele because they are not comfortable with looking at her. She is considering her options such as:

1. Continue with her career in counselling or
2. Discontinue counselling and look else where, or
3. Disclose to clients what happened and answer any relevant questions pertaining to the accident that the clients have.

What is ethically appropriate here?

The two ethical issues that directly affect this counsellor are:

1. Discrimination towards Justine
2. Self-disclosure.

## Issue 1 – Discrimination towards Counsellor

Justine finds this applicable on a daily basis. It affects every part of daily living, whether it is gaining employment, meeting people, making friends, travelling, dining with friends in public, etc.

The hypothesises is that having a permanent facial disfigurement, "baring a miracle, which can happen" people discriminate more readily than if you have a physical disability. For example, wheelchair bound, or, if you are perceived as an able bodied person.

Instead of using the terminology 'facial disfigurement' it has been suggested to change the terminology to 'facially distinctive'. This terminology may encourage more positive connotations and more favourable first impressions (Stevenage & McKay, 1999). From this point forward the more favourable term facial distinctiveness will be used.

This issue impacts directly on the Justine's clients. Through her personal experience, even though a great deal of public awareness and training has taken place, people are still unsure what to do with people who have disabilities and tend to avoid interactions/confrontations.

It impacts Justine's clients first experiences with:

1. Not knowing where to look
2. Feeling uncomfortable with the way she looks
3. Not knowing whether or not it is rude to ask what happened
4. Client retention.

## Equal Opportunity Act & Code of Ethics

The Equal Opportunity Act of 2010 ("Equal Opportunity Act 2010 No. 16 of 2010 (version incorporating amendments as at 1 August 2012)," 2010)' states that discrimination in prohibited on the basis of impairment and physical features. It may be direct or indirect discrimination. The Equal Opportunity Act describes direct and indirect discrimination as follows…

*'**8. (1) Direct discrimination** occurs if a person treats, or proposes to treat, a person with an attribute unfavourably because of that attribute.*

*8. (2) In determining whether a person directly discriminates is irrelevant-*
*Whether or not that person is aware of the discrimination or considers the treatment less favourable;*
*Whether or not the attribute is the only or dominant reason for the treatment, as long as it is a substantial reason.*

***(1) Indirect discrimination** occurs if a person imposes, or proposes to impose, a requirement, condition or practice—*

*(a) that has, or is likely to have, the effect of disadvantaging persons with an attribute; and*

*(b) that is not reasonable.*

*(2) The person who imposes, or proposes to impose, the requirement, condition or practice has the burden of proving that the requirement, condition or practice is reasonable.*

*(3) Whether a requirement, condition or practice is reasonable depends on all the relevant circumstances of the case, including the following—*

*(a) the nature and extent of the disadvantage resulting from the imposition, or proposed imposition, of the requirement, condition or practice;*

*(b) whether the disadvantage is proportionate to the result sought by the person who imposes, or proposes to impose, the requirement, condition or practice;*

*(c) the cost of any alternative requirement, condition or practice;*

*(d) the financial circumstances of the person imposing, or proposing to impose, the requirement, condition or practice;*

*(e) whether reasonable adjustments or reasonable accommodation could be made to the requirement, condition or practice to reduce the disadvantage caused, including the availability of an alternative requirement, condition or practice that would achieve the result sought by the person imposing, or proposing to impose, the requirement, condition or practice but would result in less disadvantage.*

*(4) In determining whether a person indirectly discriminates it is irrelevant whether or not that person is aware of the discrimination. ("Equal Opportunity Act 2010 No. 16 of 2010 (version incorporating amendments as at 1 August 2012)," 2010).'*

PHOTO: 123RF.COM

From the information under the act, it is illegal to discriminate on physical attributes or impairments, however in 'reality' it occurs regularly and people often 'sweep it under the mat,' suggesting that people over exaggerate whilst the following studies put forward that people who are facially distinctive do not.

The Australian Psychological Society code of Ethics states that as counsellors, we are not to discriminate against people on the grounds of:

1. Age
2. Religion
3. Sexuality
4. Ethnicity
5. Gender
6. Disability or any other basis proscribed by law (APS, 2007).

**A.1.2.** Implies that counsellors need to demonstrate an understanding of the consequences for people who are discriminated against or stereotyped.
**A.1.3.** Expresses that counsellors need to address the unfair discrimination against the client… not against the client's discrimination towards the counsellor (APS, 2007).

The relevant area in which the link to discrimination against Justine is in regards to the general principle of integrity. Under this principle it is the counsellor needs to rectify any misconceptions/ misrepresentations that the client may have received or perceived. It states:

"**C.2.2.** Counsellors take reasonable steps to correct any misrepresentation made by them or about them in their professional capacity within a reasonable time after becoming aware of the misinterpretation.

*C.2.5. Counsellors take reasonable steps to correct any misconceptions held by client about the counsellor's professional competencies. (APS, 2007)."*

## Research into physical disability and the effects of being disabled

This is a limitation of both the Code of Ethics and the Equal Opportunity Act, neither take into consideration the individual cases and the context that surrounds the ethical debate on whether a person discriminates knowingly or unknowingly. Who will and can prosecute? How? Even though th e law clearly states that discrimination is wrong, who finds enough evidence to support this kind of discrimination in the court system?

In general people with physical and permanent facial distinctive disabilities have:

- Difficulty in forming relationships through people's lack of knowledge, fear, uncertainty of how to behave, and, attractive people form alliances with attractive people and avoid people with perceived unattractiveness (Thompson & Kent, 2001)
- Greater risk of developing body image dissatisfaction (Fauerbach, et al., 2000)
- Greater difficulty in finding and maintaining jobs. Stevenage & McKay (1999) conclude that the possession of a facial distinctive feature has a far greater negative impact on recruiters than having physical disability/ no disability. This is due to the disfigurement being on the face, the focal point for maintaining eye contact and following speech. This facial distinctiveness significantly reduces the likelihood of being hired. They also raise the issue that it might not be discrimination just in the recruitment process, it may however be more subtle and interpersonal… acceptance of and interaction with facially distinctive individuals in the workforce!
- Greater avoidance in public. Studies have proven that people with facial distinctiveness are being avoided to the extent that the general public stand twice as far away from them than they do from 'normal' people (Ramsey, Bull & Gahagan, 1982)
- Socially disadvantaged (Bull, 1990)
- Facially distinctive people asked to leave restaurants, swimming pools and other public places because of their appearance (Kent & Keohane, 2001).

Other studies have shown that people with facial distinctiveness who door knock for charity are given less money (Rumsey, et al., 1982). Another study has

demonstrated that if the interviewer is physically disabled than the interviewee terminated interaction sooner; expressed opinions which were less representative of their actual belief; smiled less; demonstrated less eye contact and admitted feeling less comfortable during the interaction than being interviewed by a physically normal person (Comer & Piliavin, 1972).

## Research on disabled counsellors with clients

There have been documented studies whereby effects of counsellor disability on clients have been researched. These studies were with the same person who appeared to be a physically disabled counsellor (wheelchair bound, with crutches, missing a limb, etc) not once did they act as a counsellor with a permanent facial distinctive feature. With this differentiation in mind, in relationship to counselling, disabled counsellor studies have shown that:

- Physically disabled counsellors had a greater rapport with disabled clients for personal problems (Brabham & Thoreson, 1973)
- Disabled clients point out that few able-bodied counsellors were knowledgeable about the issues faced by being disabled (Brabham & Thoreson 1973)
- Disabled counsellors were admired by able-bodied people because they had made it in spite of being disabled (Brabham & Thoreson, 1973)
- Disabled counsellors are perceived to be more aware and actively reach out to clients, hold clients in a positive light be more genuine and congruent (J. Mitchell & Allen, 1975)
- Disabled counsellors have an enhanced ability to understand and empathise (D.C. Mitchell & Frederickson, 1975).

## Research with a 'blind' counsellor

There has been one study found that included the disability of blindness (D.C. Mitchell & Frederickson, 1975). The confederate was an able-bodied person who was photographed as a 'blind person', the people in the study were asked hypothetical situations and were to record which counsellor they would go to for what issue. The study concluded the blind counsellor was the least preferred. This supports the hypothesis clients prefer:

1. Abled-bodied counsellors
2. Physically disabled counsellors and lastly
3. Counsellors with a facially distinctive feature such as Justine's.

The research clearly demonstrates that the general public discriminates both physically disabled people but more importantly discrimination is targeted towards facially distinctive persons. Generally the discrimination has been in a public setting whereby people can easily avoid or escape from the facially distinctive person without much hassle. However, take this knowledge into an intimate setting of a counselling session whereby the door is closed and the client is meeting the counsellor with whom they haven't met before… it is an entirely different situation.

Ethically and morally not to mention keeping Justine's business afloat, it is her responsibility as a counsellor to make sure her client feels relaxed and able to communicate. There is no legal action that can be taken towards clients who openly say that they don't like looking at her and terminate counselling because of such.

Is it being suggested that all clients discriminate… no. Is it being suggested that all clients will terminate future sessions due to Justine's facial distinctiveness… no. Is it being suggested all clients who terminate their sessions or don't come back will discriminate purely on looks… no. The suggestion is that unless there is a strategy found in which deals with this potential setback then Justine may continue to experience significantly fewer clients than other counsellors who do not have a facially distinctive feature.

Westin cited in Rumsey, et al., (1982) defines privacy as the 'right of an individual to decide *what information* about himself should be communicated to others and under *what conditions* such information exchange should occur' (emphasis added, mine). Facially disfigured people are clearly deprived of this right since they are unable to hide their abnormality from others (Rumsey, et al., 1982). This is why self-disclosure about facial distinctiveness is the only strategy in which to adopt to ensure that clients:

1. Know where to look
2. Feel comfortable with Justine's appearance
3. Know the facts about what happened
4. Client retention rate may significantly increase.

PHOTO: 123RF.COM

## Issue 2 – Self Disclosure

This is a vital area in which most counsellors do not have to face, unless therapeutically seen to be appropriate. As a teacher in her previous career, Justine spent anywhere between 15-20 mins discussing with the class the facts, their concerns, and turning it around to being incredibly empowering for them. Empowering in the knowledge of this information could be used to help other children who were injured in the schoolyard who needed to come to her for help. Armed with the truth, they confidently approached the child who required help and helped them receive assistance.

Without self-disclosure, children did not participate in lessons and their

behaviour towards Justine, on the whole, was one of fear and uncertainty, which studies have proven. Teaching became futile until she discussed about the accident. Justine couldn't continue the day without giving the children the opportunity to know the truth, get their questions out of the way and empower them. After explaining, the children were able to concentrate and feel 'at ease' the rest of the day.

Although Justine has the right to disclose or not to disclose information about herself, and, within the therapeutic environment self-disclosure should be kept to a minimum, Rumsey, et al., (1982), states a person with facial distinctiveness is deprived of this right because it is unable to be concealed.

## Code of Ethics & Conduct

In the Australian Psychological Society Code of Ethics (2007), it is suggested that self disclosure about facial distinctiveness could be placed in the area of:

> *'A.3.3. Psychologists ensure consent is informed by:*
>
> *(j) providing any other relevant information (APS, 2007).'*

Within the Australian Counselling Association Code of Conduct (2012), self-disclosure may fall into the following categories:

> *'Code of Ethics (a) ii. Establishment of helping relationship in order to maintain integrity and empowerment of the client without offering advice.*
>
> ***3.2 Client safety (a) i.** Counsellors must take all reasonable steps to ensure that the client does not suffer physical, emotional or psychological harm during counselling sessions.*
>
> ***3.9 Boundaries (a) i.** Counsellors are responsible for setting and monitoring boundaries throughout the counselling sessions and will make explicit to clients that counselling is a formal and contracted relationship and nothing else (ACA, 2012).'*

## Research into counsellor self disclosure

According to Goldstein (1994) self disclosure is defined as 'the therapist's conscious verbal or behavioural sharing of thoughts, feelings, attitudes, interests, tastes, experiences or factual information about themselves or about significant relationships or activities in the therapists life'.

Sweezy (2005) discusses that once Justine discloses information about herself either directly or indirectly that this is information is no longer hers to hold private. It appears what Justine may disclose isn't privy to confidentiality. This is unlike the code of ethics, which clearly states that what is said and discussed between client, and counsellor is strictly confidential (ACA, 2012; APS, 2007). Sweezy (2005) also makes a valid argument that withholding private information may help the client learn to be safe, protect personal limits, acknowledge rules and accept differences.

## Issues regards to self disclosure

Self-disclosure has very opposing viewpoints/research. One thought is that it is helpful and the other is that it should be avoided at all costs. The reasons why therapists should not disclose are:

- To control/manipulate clients (Henretty & Levitt, 2010)
- Gratify clients when therapeutically irrelevant (Henretty & Levitt, 2010)
- Disclosure can place unnecessary burdens upon the client (Peterson, 2002)
- Disclosure can produce feelings of disillusionment, disappointment or surprise (Peterson, 2002)
- Disclosure can make clients feel uncomfortable and potentially blur the lines between client/therapist (Peterson, 2002)
- Empathise dissimilarities between therapist and client unless therapeutically indicated (Henretty & Levitt, 2010)
- Satisfy therapist needs (Henretty & Levitt, 2010).

Satisfying therapist needs is called countertransference. Countertransference issues are often seen as a pitfall of self-disclosure. Examples of this is when the therapist requires the need for their clients:

- Applause
- Validation
- Affirmation
- Sense of closeness
- Sharing with a client (Goldstein, 1994).

Knox, Hess, Peterson & Hill (1997) produced a qualitative analysis of client perceptions of the effects of helpful therapist disclosure, and found that therapist disclosures were helpful when:

- Occurred whilst discussing important personal issues
- Perceived as being intended by the therapist to normalise or reassure clients
- Disclosures consisted of person non-immediate information about the therapist.

Henretty & Levitt (2010) have suggested guidelines to disclosure. Some of these guidelines are:

- Therapist should consider using self-disclosure with clients whom have a strong alliance/positive relationship (Audet & Everall, 2010; Henretty & Levitt, 2010)
- Disclosure is best avoided with clients with poor boundaries
- Therapists should consider disclosing:
  - Demographic information such as education, theoretical orientation and marital status
  - Feelings and thoughts about the client and or the therapeutic relationship
  - Therapy mistakes
  - Relevant past struggles that have been successfully resolved
  - Similarities between client and therapist
- Disclosure of values, especially when the therapist's and client's values are in conflict
- Disclosure in the early stages of therapy until therapeutic agreements are set, disclosure:
  - Builds alliance and rapport
  - Being courteous

During termination of therapy disclosure encourages separateness of therapist as a person (Henretty & Levitt, 2010).

Self-disclosure is also used to:

- Correct misconceptions (Henretty & Levitt, 2010)
- Equalise power (Henretty & Levitt, 2010)
- Normalise and promote feelings (Henretty & Levitt, 2010)
- Create a safe environment (Henretty & Levitt, 2010)
- Engage client in a meaningful working relationship (Audet & Everall, 2010)
- Offer alternative ways to think and act (Henretty & Levitt, 2010; Xu & Li, 2008)
- Counter internalised hate and shame (Henretty & Levitt, 2010)
- Viewed to be more credible source of help (Henretty & Levitt, 2010).

## Research into the use of self disclosure with disabled counsellors

There is little education about disabilities in counselling courses, Corsini & Wedding (2008) state that out of 618 internship sites only 81 listed that they have any disability training in their course structure. Is there any wonder there has been few research articles that have dealt or tried to explore self-disclosure with counsellors who have

disabilities or facial distinctiveness.

A research paper (Leirer, et al., 1998) attempts to explore the effects of counsellor disability status and reputation on perceptions of counsellor expertness and trustworthiness. Their conclusion suggests that when the counsellor self disclosed about their *physical disabilities* clients perceived them to:

1. Become more human
2. Share the universality of human struggle
3. Model effective behaviour.

## Research including visually impaired counsellor self disclosure

Mallinckrodt & Helms (1986) in their literature studies failed to find any studies that investigated the effects of self-disclosures by disabled counsellors. Their study used a male counsellor who was:

1. Able bodied
2. Obviously disabled (wheelchair bound)
3. Not obviously disabled, counsellor with a visual disability. (The disability was the counsellor wore contact lenses).

Mallinckrodt & Helms (1986) tested for counsellor:

- Expertness
- Trustworthiness
- Attractiveness.

In the tested counsellor attributes, the disabled counsellor using self-disclosure about his disability was more positively portrayed than if they had not disclosed. The findings for the visually impaired counsellor also found similar positive experiences on all attributes. The conclusion to this study was there seemed to be no negative effect on disclosing disabilities. They actually suggest that perhaps 'obvious and non-obviously disabled counsellors might be able to make productive use of self-involving self disclosures as a means to potentially enhance their therapeutic effectiveness.'

This was the only study found that incorporated any visual impairment… this shows the lack of research into counsellors who have a facially distinctive feature. The aforementioned study might be seen to those who have a facial distinctiveness as condescending in regards to whether or not self-disclosure could/should be utilised with such a 'normal' issue as wearing contact lenses! Though their conclusions perceived sound, found the research may offend a person such as Justine… because a person with facial distinctiveness is deprived of this right of non-disclosure because it is unable to be concealed (Rumsey, et al., 1982).

## Conclusion

Having read relevant literature on the issue of self-disclosure only reinforces the importance of self-disclosure. According to Justine, utilising the strategy of self-disclosure allows the client feel comfortable. This in turn should have a flow-on effect where clients feel the same way that studies have documented clients' responses towards counsellors with physical disabilities. These encouraging results are:

- Greater rapport with disabled clients for personal problems (Brabham & Thoreson, 1973)
- Disabled clients point out that few able-bodied counsellors were knowledgeable about the issues faced by being disabled (Brabham & Thoreson, 1973)
- Disabled counsellors were admired by able bodied people because they 'made it in spite of being disabled' (Brabham & Thoreson, 1973)
- Perceived to be more aware and actively reach out to clients, hold clients in a positive light and be more genuine and congruent (J. Mitchell & Allen, 1975)
- Enhanced ability to understand and empathise (D.C. Mitchell & Frederickson, 1975).

This is the research. It has not answered the questions what will be appropriate and inappropriate to self-disclose about the facial distinctive feature. It has raised what questions need to be answered and what would need to be disclosed on a client-by-client basis. What will cause greater rapport and establish therapeutic relationship and what will hinder and cause burden to the client will differ depending on the client. Firm boundaries and having decided what information to divulge and to who will model good boundary setting and establish a greater rapport thus eliminating the awkwardness often felt within the counselling room.

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# Men & Abortion Trauma Help Line Mental Health Grant

Abortion Grief Australia (AGA) has recently acquired a mental health grant through ConnectGroups in Western Australia to integrate the community in the healing, early intervention and prevention of abortion related mental illness.

A significant component of the grant is to consult with key players within the men's health community, to build up the Men & Abortion Trauma Helpline (MATH) and to facilitate training and a Men's Forum on the Impact of Abortion Trauma on Men in 2016.

Research on women is increasingly linking abortion to psychiatric illness, depression, substance abuse, suicide, relationship problems, anxiety and post-traumatic stress disorder (see abortiongrief.asn.au/research). Although there has been limited research on men, the data available suggests that men can experience similar reactions to abortion as women.

In 2011, Queensland researcher Kaeleen Dingle (whose research on women was published in the British Journal of Psychiatry[i]) reported that young men whose partners aborted, were twice as likely to abuse cannabis, hard drugs and suffer depression compared to men who had never fathered a pregnancy[ii].

Often presenting as a cocktail of self-destructive behaviours, relationship problems and replacement pregnancies, abortion trauma/grief can be a serious mental health issue that is exacerbated by the lack of acknowledgement and professional help available.

Typically, men and women do not connect their abortion exposure with how they are 'acting out'.

Additionally, while most women are unprepared for how deeply abortion can impact them, they usually have no concept that abortion might hurt men.

One tragic call to AGA's crisis line was from a young woman walking the streets in the early hours of the morning, hysterical and inconsolable. It should have been their wedding night. Her fiancé had taken his own life, the day after she told him she'd had an abortion. Concerned about the stability of their relationship and the pressure her unplanned pregnancy was creating on her fiancé, and without thinking to discuss it with him beforehand, she'd had an abortion.

Couples rarely work through their abortion grief in the same manner or time frame. For most, the topic is subsequently taboo. Sexual dysfunction, avoidance of intimacy, male insecurity and feelings of powerlessness, anger and isolation may manifest after an abortion and contribute to relationship instability.

Further, there can be a great deal of 'baggage' brought into new relationships. Men in particular may struggle to relate to small children or their pregnant spouse.

Abortion related mental illness is commonly associated with domestic violence. Irrespective of the role the male played in the abortion, women often feel abandoned and on an emotional level, blame the male for the abortion outcome. Thus the male, and men in general can become the object of their unexpressed self-hatred, anger and rage.

*Project Co-ordinator for Men & Abortion Trauma Helpline, volunteer Luke Bouwman*

Self-defeating, self-destructive and bizarre behaviours are a hallmark of unresolved abortion trauma/grief. With powerful feelings of self-hatred and anger, many women provoke conflicts in their interaction with others, particularly personal relationships. They may create or fuel emotional dramas that both serve as a distraction and as an opportunity to release pent up emotions.

The good news is that, when abortion trauma/grief is addressed appropriately the improvement in the lives of women and men affected, and that of their families, can be quite remarkable.

AGA's newly established MATH Steering Committee is working to provide training nationally in this area. The committee will also be creating the opportunity for the men's health community to participate in preparations for a Men Impacted by Abortion Trauma Forum to be held in Perth, August 2016.

## MORE INFORMATION

For further information contact:
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www.abortiongrief.asn.au
Men & Abortion Trauma Helpline: 1300 887 066

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# ACA COLLEGE OF SUPERVISORS (COS) REGISTER

| ACA SUPERVISOR COLLEGE LIST | | Medium key: FTF: Face to face \| PH: Phone \| GRP: Group \| WEB: Skype | | |
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| **Contact** | **Suburb** | **Phone Number** | **SUP PP Hourly** | **Medium** |
| **AUSTRALIAN CAPITAL TERRITORY** | | | | |
| Hun Kim | Downer | 02 6255 4597 | Upon Enquiry | FTF |
| Mijin Seo - Kim | Downer | 02 6255 4597 | Upon Enquiry | FTF |
| Karen Rendall | Barton | 0431 083 847 | Upon Enquiry | FTF |
| Brenda Searle | Canberra Region | 0406 376 302 | $100 to $130 | FTF/PH/GRP/WEB |
| **NEW SOUTH WALES** | | | | |
| Elizabeth Allmand | Queanbeyan | 0488 363 129 | $120 | FTF/WEB/PH |
| Penny Bell | Cumbi umbi | 0416 043 884 | Upon Enquiry | FTF/GRP/PH/WEB |
| Sandra Bowden | Bateau Bay/Central Coast | 0438 291 874 | $70 | FTF |
| Patriciah Catley | Narellan | 02 9606 4390 | Upon Enquiry | FTF |
| Patricia Cheetham | Kensington | 1300 552 659 | Upon Enquiry | FTF |
| Michael Morris Cohn | North bondi | 0413 947 582 | $120 | FTF/GRP/PH/WEB |
| Leon Cowen | Lindfield | 02 9415 6500 | Upon Enquiry | FTF/GRP/PH/WEB |
| Lorraine Dailey | Maroota | 0416 081 882 | Upon Enquiry | FTF/PH/GRP/WEB |
| Karen Daniel | Turramurra | 02 9449 7121<br>0403 773 757 | $125 1hr; $145 1.5hrs | FTF/WEB |
| Brian Edwards | Forresters beach | 0412 912 288 | Upon Enquiry | FTF |
| Aaron Elliott | Cardiff | 0408 615 155 | Upon Enquiry (flexible) | FTF/PH/WEB |
| Linda Elsey | Wyee | 02 4359 1976 | Upon Enquiry | FTF/GRP/PH/WEB |
| Wendy Gibson | Koolewong | 02 4342 6746<br>0422 374 906 | Upon Enquiry | FTF |
| David Gotlieb | Sydney/Bowral | 0421 762 236 | $40 Grp, $80 Indiv | FTF/PH/GRP/SKYPE |
| Kim Michelle Hansen | Putney | 02 9809 5989<br>0412 606 727 | Upon Enquiry | FTF |
| John Harradine | Cremone | 0419 953 389 | $160; GRP $120 | FTF/GRP/WEB |
| Margaret Hutchings | Yamba Grafton | 0417 046 562 | Upon Enquiry | FTF/PH/GRP/WEB |
| Vicki Johnston | Eastlakes | 02 9667 4664 | Upon Enquiry | FTF |
| Brian Lamb | Newcastle/<br>Lake Macquarie | 0412 736 240 | $120<br>(contact for sliding scales) | FTF/GRP/PH |
| Gwenyth Lavis | Albury | 0428 440 677 | Upon Enquiry | FTF/PH |
| Danny D. Lewis | Forresters Beach | 0412 468 867 | Upon Enquiry | FTF |
| Dr Dawn Macintyre | Clunes | 0417 633 977 | Upon Enquiry | FTF/PH/WEB |
| Moira McCabe | Hamilton | 0416 038 026 | Upon Enquiry | FTF |
| Rod McClure | Bondi Junction | 0412 777 303 | Upon Enquiry | FTF |
| Heide McConkey | Bondi Junction | 02 9386 5656 | Upon Enquiry | FTF |
| Karen Morris | Newcastle/Hunter Valley | 0417 233 752 | $100 | FTF/GRP/PH/WEB |
| Kathryn Jane Quayle | Hornsby | 0414 322 428 | $95 | FTF/WEB/PH |
| Leonie Frances Raffan | Hamilton | 0402 327 712 | 120 | FTF/PH/WEB |
| **NEW SOUTH WALES CONTINUED** | | | | |
| Judith Reader | Stockton | 02 4928 4880 | Upon Enquiry | FTF |
| Deborah Rollings | Sutherland | 0427 584 554 | Upon Enquiry | FTF/PH |
| Grahame Smith | Singleton | 0428 218 808 | $66 | FTF/GRP/PH/WEB |
| Kirilly Smitheram | Newtown | 0411 550 980 | Upon Enquiry | FTF |
| Carol Stuart | Bondi Junction | 0293 877 752 | $80 pp - % rate<br>$50 for early graduates | FTF/GRP/PH/WEB |

| ACA SUPERVISOR COLLEGE LIST | Medium key: FTF: Face to face \| PH: Phone \| GRP: Group \| WEB: Skype | | | |
|---|---|---|---|---|
| **Contact** | **Suburb** | **Phone Number** | **SUP PP Hourly** | **Medium** |
| David Edwin Warner | Peakhurst | 0418 283 519 | Upon Enquiry | FTF/PH/GRP |
| Michella Wherrett | Lake Macquarie/Newcastle | 0414 624 513 | $80 | FTF/PH |
| Jennifer Blundell | Austinmer | 0416 291 760 | Upon Enquiry | FTF/PH/GRP/WEB |
| Katrina Christou | Newtown | 0412 246 416 | Upon Enquiry | FTF |
| Lyndall Briggs | Kingsgrove | 02 9024 5182 | Upon Enquiry | FTF |
| Trudi Fehrenbach | East Ballina | 0427 678 275 | Upon Enquiry | FTF |
| Jacky Gerald | Potts Point | 0406 915 379 | Upon Enquiry | FTF |
| Matti Ngai Lee | Sydney | 0400 272 940 | Upon Enquiry | FTF |
| Hanna Salib | Luddenham | 0401 171 506 | Upon Enquiry | FTF |
| David Robert Watkins | Elanora Heights | 0404 084 706 | Upon Enquiry | FTF |
| **NORTHERN TERRITORY** | | | | |
| Margaret Lambert | Darwin | 08 8945 9588<br>0414 459 585 | Upon Enquiry | FTF/GRP/PH/WEB |
| Rian Rombouts | Millner | 0439 768 648 | Upon Enquiry | FTF |
| **QUEENSLAND** | | | | |
| Lynette Baird | Maroochydore/<br>Sunshine Coast | 07 5451 0555 | Grp $30 or Indiv $90 | FTF/GRP |
| Laura Banks | Broadbeach | 0431 713 732 | Upon Enquiry | FTF |
| Maartje (Boyo) Barter | Wakerley | 0421 575 446 | Upon Enquiry | FTF |
| Christine Boulter | Coolum Beach | 0417 602 448 | Upon Enquiry | FTF |
| Iain Bowman | Ashgrove | 0402 446 947 | Upon Enquiry | FTF/PH/GRP/WEB |
| Judy Boyland | Springwood | 0413 358 234 | $100 | FTF/GRP/PH/WEB |
| Rev. Dr. Apichart Branjerdporn | Kenmore | 0411 866 663 | GRP $100 Indv $80 | FTF/GRP/PH |
| Ronald Davis | Labrador | 0434 576 218 | Upon Enquiry | FTF |
| Erin Annie Delaney | Beenleigh | 0477 431 173 | Upon Enquiry | FTF |
| Catherine Dodemont | Grange | 0413 623 162 | $40 Grp; $100 indiv | FTF/GRP/PH/WEB |
| Heidi Edwards | Gympie | 0466 267 509 | $99 | FTF/WEB |
| Patricia Fernandes | Emerald/Sunshine Coast | 0421 545 994 | $30-$60 | FTF/PH |
| Aisling Fry | Lota | 0412 460 104 | N/A | FTF |
| Rev Peter Gee | Eastern Heights/Ipswich | 0403 563 467 | $65 | FTF/GRP/PH/WEB |
| Nancy Grand | Surfers Paradise | 0408 450 045 | Upon Enquiry | FTF |
| Valerie Holden | Peregian Springs | 0403 292 885 | Upon Enquiry | FTF |
| Anne-Marie Houston | Bundaberg | 0467 900 224 | Upon Enquiry | FTF |
| **QUEENSLAND CONTINUED** | | | | |
| Beverley Howarth | Paddington | 0420 403 102 | Upon Enquiry | FTF/PH/WEB |
| Kim King | Yeppoon | 0434 889 946 | Upon Enquiry | FTF |
| David Kliese | Sippy Downs/<br>Sunshine Coast | 07 5476 8122 | Indiv $80, Grp $40 (2 hours) | FTF/GRP/PH |
| Kaye Laemmle | Helensvale | 0410 618 330 | Upon Enquiry | FTF |
| Jodie Logovik | Hervey bay | 0434 060 877 | Upon Enquiry | FTF/PH |
| Sharron Mackison | Caboolture | 07 5497 4610 | Upon Enquiry | FTF/PH/GRP/WEB |
| Maggie Maylin | West End | 0434 575 610 | Upon Enquiry | FTF/PH/GRP/WEB |
| Neil Roger Mellor | Pelican Waters | 0409 338 427 | Upon Enquiry | FTF |
| Ann Moir-Bussy | Sippy Downs | 07 5476 9625<br>0400 474 425 | Upon Enquiry | FTF/GRP/PH/WEB |
| Judith Morgan | Toowoomba | 07 4635 1303<br>0412 372 431 | $100 | FTF/PH |
| Diane Newman | Bundaberg West | 0410 397 816 | Upon Enquiry | FTF/PH |

| ACA SUPERVISOR COLLEGE LIST | | Medium key: FTF: Face to face \| PH: Phone \| GRP: Group \| WEB: Skype | | |
|---|---|---|---|---|
| **Contact** | **Suburb** | **Phone Number** | **SUP PP Hourly** | **Medium** |
| Steven Josef Novak | Buderim | 0431 925 771 | N/A | FTF |
| Christine Perry | Bundaberg | 0412 604 701 | $70 | FTF/SKYPE |
| Penelope Richards | Corinda | 0409 284 904 | Upon Enquiry | FTF |
| Yildiz Sethi | Wakerley | 07 3390 8039 | Indiv $90, Grp $45 | FTF/GRP/PH/WEB |
| William James Sidney | Loganholme | 0411 821 755<br>07 3388 0197 | Upon Enquiry | FTF/PH/GRP |
| Deborah Stevens | Kingaroy | 0411 661 098 | Upon Enquiry | FTF |
| Frances Taylor | Redland Bay | 0415 959 267<br>07 3206 7855 | Upon Enquiry | FTF |
| Pamela Thiel-Paul | Bundall/Gold Coast | 0401 205 536 | $90 | FTF |
| David Hamilton | Beenleigh | 07 3807 7355<br>0430 512 060 | Indiv $80, Students $60 | FTF/PH/GRP/WEB |
| Stacey Lloyd | Mount Gravatt | 07 3420 4127 | Upon Enquiry | FTF |
| Tanya-Lee M Barich | Wondunna | 0458 567 861 | Upon Enquiry | FTF |
| Sherrie Brook | Murrumba Downs | 0476 268 165 | Upon Enquiry | FTF |
| Kirsten Greenwood | Mudgeeraba | 0421 904 340 | Upon Enquiry | FTF |
| Menny Monahan | Kippa-Ring | 0419 750 539 | Upon Enquiry | FTF |
| Gary Noble | Loganholme DC | 0439 909 434 | Upon Enquiry | FTF |
| Colin Palmer | Kallangur | 0423 928 955 | Upon Enquiry | FTF |
| Natalie Scott | Tarragindi | 0410 417 527 | Upon Enquiry | FTF |
| **SOUTH AUSTRALIA** | | | | |
| Leeanne D'arville | Salisbury Downs | 0404 476 530 | Upon Enquiry | FTF |
| Adrienne Jeffries | Stonyfell | 08 8332 5407 | Upon Enquiry | FTF/PH/WEB |
| Pamela Mitchell | Waterfall Gully | 0418 835 767 | Upon Enquiry | FTF |
| Carol Moore | Old Reynella | 08 8297 5111 bus<br>SMS 0419 859 844 | Grp $35, Indiv $99 | FTF/PH/GRP/WEB |
| Maxine Litchfield | Gawler West | 0438 500 307 | Upon Enquiry | FTF |
| Laura Wardleworth | Angaston | 0417 087 696 | Upon Enquiry | FTF |
| **TASMANIA** | | | | |
| Pauline Mary Enright | Sandy Bay | 0409 191 342 | 85 per session Group on App | Face to Face, Phone, Skype |
| David Hayden | Howrah North | 0417 581 699 | Upon Enquiry | FTF |
| Benjamin Donald Turale | Hobart | 0409 777 026 | Upon Enquiry | FTF/PH/WEB |
| **VICTORIA** | | | | |
| Joanne Ablett | Phillip Island/<br>Melbourne Metro | 0417 078 792 | $120 | FTF/GRP/PH/WEB |
| Danielle Aitken | Kilcunda/South Gippsland | 0409 332 052 | Grp $35, Indiv $70 | FTF/GRP/PH/WEB |
| Anna Atkin | Chetlenham | 0403 174 390 | Upon Enquiry | FTF |
| Nyrelle Bade | East Melbourne/<br>Point Cook | 0402 423 532 | Upon Enquiry | FTF/GRP/WEB |
| Marie Bajada | Ballarat | 0409 954 703 | Upon Enquiry | FTF |
| Judith Beaumont | Mornington | 0412 925 700 | Upon Enquiry | FTF/PH/GRP/WEB |
| Zohar Berchik | South yarra | 0425 851 188 | Upon Enquiry | FTF |
| Kathleen (Kathy) Brennan | Narre warren | 0417 038 983 | $35 Grp, $60 Indiv | FTF/GRP/PH/WEB |
| Zoe Broomhead | Ringwood | 0402 475 333 | Upon Enquiry | FTF |
| Sheryl Brosnan | Carlton North/Melbourne | 03 8319 0975<br>0419 884 793 | Upon Enquiry | FTF/GRP/PH/WEB |
| Sandra Brown | Frankston/Mount Eliza | 03 9787 5494<br>0414 545 218 | $90 | FTF/GRP/PH/WEB |
| Molly Carlile | Inverloch | 0419 579 960 | Upon Enquiry | FTF |

| ACA SUPERVISOR COLLEGE LIST | Medium key: FTF: Face to face \| PH: Phone \| GRP: Group \| WEB: Skype | | | |
|---|---|---|---|---|
| **Contact** | **Suburb** | **Phone Number** | **SUP PP Hourly** | **Medium** |
| Lehi Cerna | Hallam | 0423 557 478 | Upon Enquiry | FTF/PH/GRP/WEB |
| Tim Connelly | Healesville | 0418 336 522 | Upon Enquiry | FTF |
| Roselyn (Lyn) Ruth Crooks | Bendigo | 0406 500 410<br>03 4444 2511 | $60 | FTF |
| Debra Darbyshire | Berwick | 0437 735 807 | Upon Enquiry | FTF |
| Patricia Dawson | Carlton North | 0424 515 124 | Grp $60 1 1/2 to 2 hrs, Indiv $80 | FTF/GRP/PH/WEB |
| Lisa Derham | Camberwell | 0402 759 286 | Upon Enquiry | FTF/WEB |
| Sara Edwards | Dingley | 0407 774 663 | Upon Enquiry | FTF/WEB |
| Karen Efron | Northcote | 0432 391 887 | Upon Enquiry | FTF |
| Mihajlo Glamcevski | Ardeer | 0412 847 228 | Upon Enquiry | FTF |
| Batul Fatima Gulani | Melbourne | 0412 977 553 | Upon Enquiry | FTF |
| Melissa Harte | Pakenham/South Yarra | 0407 427 172 | $132 to $143 | FTF |
| Paul Huxford | Prahran | 0432 046 515 | $100 | FTF |
| Beverley Kuster | Narre Warren | 0488 477 566 | Upon Enquiry | FTF |
| Barbara Matheson | Melbourne | 03 9703 2920 | Upon Enquiry | FTF |
| Robert McInnes | Glen Waverley | 0408 579 312 | Indiv $70, Grp $40 (2 hours) | FTF |
| Marguerite Middling | North Balarat | 0438 744 217 | Upon Enquiry | FTF |
| Paul Montalto | Thornbury | 0415 315 431 | Upon Enquiry | FTF |
| Andrew Reay | Moorabbin | 0433 273 799 | Upon Enquiry | FTF |
| Patricia Reilly | Mount Martha/Gardenvale | 0401 963 099 | Upon Enquiry | FTF |
| **VICTORIA CONTINUED** | | | | |
| Graeme John Riley | Gladstone Park | 03 9338 6271<br>0423 194 985 | $85 | FTF/WEB |
| Lynne Rolfe | Berwick | 03 9768 9902 | Upon Enquiry | FTF |
| Claire Sargent | Canterbury | 0409 438 514 | Upon Enquiry | FTF |
| Kenneth Robert Scott | Bunyip | 03 5629 5775 | Upon Enquiry | FTF |
| Karen Seinor | Wodonga | 0409 777 116 | Upon Enquiry | FTF |
| Gabrielle Skelsey | Elsternwick | 03 9018 9356 | Upon Enquiry | FTF/PH/WEB |
| Cheryl Taylor | Port Melbourne | 0421 261 050 | Upon Enquiry | FTF |
| Suzanne Vidler | Newport | 0411 576 573 | $110 | FTF/PH |
| Helen Wayland | St kilda | 0412 443 899 | $75 Indiv | FTF/PH/GRP/WEB |
| Natalie Wild | Boronia | 0415 544 325 | Upon Enquiry | FTF |
| Cas Willow | Williamstown | 03 9397 0010<br>0428 655 270 | Upon Enquiry | FTF/PH/WEB/GRP |
| Rosslyn Wilson | Knoxfield | 03 9763 0772<br>03 9763 0033 | Grp $50 pr hr, Indiv $80 | FTF/GRP/PH/WEB |
| Jacquie Wise | Albert park | 03 9690 8159 | Upon Enquiry | FTF |
| Michael Woolsey | Seaford/frankston | 0419 545 260<br>03 9786 8006 | Upon Enquiry | FTF |
| Joan Wray | (Mobile service) | 0418 574 098 | Upon Enquiry | FTF |
| Maurice Grant-Drew | Elwood | 0412 331 301 | Upon Enquiry | FTF |
| John Dunn | Colac SW area/<br>Mt Gambier | 03 5232 2918 | By Negotiation | FTF/GRP/WEB |
| **WESTERN AUSTRALIA** | | | | |
| Sharon Vivian Blake | Fremantle | 0424 951 670 | Indiv $100, Grp $60 | FTF/PH/GRP/WEB |
| Marie-Josee Boulianne | Beaconsfield | 0407 315 240 | Upon Enquiry | FTF |
| Cindy Cranswick | Attadale | 0408 656 300 | Upon Enquiry | FTF |
| Alan Furlong | Winthrop | 0457 324 464 | Upon Enquiry | FTF |

| ACA SUPERVISOR COLLEGE LIST | | Medium key: FTF: Face to face \| PH: Phone \| GRP: Group \| WEB: Skype | | |
|---|---|---|---|---|
| **Contact** | **Suburb** | **Phone Number** | **SUP PP Hourly** | **Medium** |
| Merrilyn Hughes | Canning vale | 08 9256 3663 | Upon Enquiry | FTF/PH/GRP/WEB |
| Eva Lenz | South Fremantle/Coogee | 08 9418 1439<br>0409 405 585 | $85, concession $70 | FTF/PH/GRP/WEB |
| Salome Mbenjele | Tapping | 0450 103 282 | Upon Enquiry | FTF/PH/WEB |
| Carolyn Midwood | Duncraig | 08 9448 3210 | Indiv $110, Grp $55 | FTF/GRO/PH/WEB |
| Dr. Patricia Sherwood | Perth/Bunbury | 0417 977 085<br>08 9731 5022 | $120 | FTF/PH/WEB |
| Phillipa Spibey | Mundijong | 0419 040 350 | Upon Enquiry | FTF |
| David Peter Wall | Mundaring | 0417 939 784 | Upon Enquiry | FTF |
| Lillian Wolfinger | Yokine | 08 9345 0387<br>0401 555 140 | Upon Enquiry | FTF/PH/WEB |
| Genevieve Armson | Carlisle | 0412 292 999 | Upon Enquiry | FTF |
| Lynette Cannon | Carey Park | 0429 876 525 | Upon Enquiry | FTF |
| Karen Heather Civello | Bridgetown | 0419 493 649 | Upon Enquiry | FTF |
| **INTERNATIONAL** | | | | |
| Dina Chamberlain | | +852 6028 9303 | Upon Enquiry | FTF |
| Fiona Man Yan Chang | | +852 9198 4363 | Upon Enquiry | FTF |
| Pui Kuen Chang | | +852 9142 3543 | Upon Enquiry | FTF |
| Polina Cheng | | +852 9760 8132 | Upon Enquiry | FTF |
| Viviana Cheng | | +852 9156 1810 | Upon Enquiry | FTF |
| Eugnice Yiu Sum Chiu | | +852 2116 3733 | Upon Enquiry | FTF |
| Wing Wah Hui | | +852 6028 5833 | Upon Enquiry | FTF |
| Cary Hung | | +852 2176 1451 | Upon Enquiry | FTF |
| Giovanni Ka Wong Lam | | +852 9200 0075 | Upon Enquiry | FTF |
| Yuk King Lau | | N/A | Upon Enquiry | FTF |
| Winnie Wing Ying Lee | | N/A | Upon Enquiry | FTF |
| Frank King Wai Leung | | +852 3762 2255 | | |
| Mei Han Leung | | N/A | N/A | FTF |
| Lap Kwan Tse | | +852 9089 3089 | Upon Enquiry | FTF |
| Barbara Whitehead | | +852 2813 4540 | Upon Enquiry | FTF |
| Yat Chor Wun | | +852 264 35347 | Upon Enquiry | FTF |
| Deborah Cameron | | +65 9186 8952 | $100 | FTF/GRP/WEB |
| Eugene Chong | | +65 6397 1547 | Upon Enquiry | FTF |
| David Kan Kum Fatt | | +65 9770 3568 | Upon Enquiry | FTF |
| Gan Su Keng | | +65 6289 6679 | Upon Enquiry | FTF |
| Dan Ng | | N/A | Upon Enquiry | FTF |
| Jeffrey Gim Tee Po | | +65 9618 8153 | $100.00 | FTF/GRP/PH/WEB |
| Prem Kumar Shanmugam | | N/A | Upon Enquiry | FTF |
| Kwang Mong Sim | | N/A | Upon Enquiry | FTF |
| Saik Hoong Tham | | +65 8567 0508 | Upon Enquiry | FTF |

# 2015-2016 Trauma Education

Leah is a Sydney based doctoral-level clinical psychologist with 20 years of clinical and teaching expertise in CBT and traumatology

**presented by**
**Dr Leah Giarratano**

**REGISTER OR PLAN NOW TO SAVE ON THE FEE**

**Two highly regarded CPD activities for all mental health professionals: 14 hours for each activity**

**These workshops are endorsed by the, AASW, ACA and ACMHN**

## Clinical skills for treating posttraumatic stress disorder (Treating PTSD)

This two-day (8:30am-4:30pm) program presents a highly practical and interactive workshop (case-based) for treating traumatised clients; the content is applicable to both adult and adolescent populations. The techniques are cognitive behavioural, evidence-based, and will be immediately useful and effective for your clinical practice. The emphasis is upon imparting immediately practical skills and up-to-date research in this area.

| | | |
|---|---|---|
| **12-13 Nov 2015 , Melbourne CBD** | **2-3 June 2016, Cairns CBD** | **23-24 June 2016, Auckland CBD** |
| **19-20 Nov 2015, Sydney CBD** | **9-10 June 2016, Perth CBD** | **3-4 November 2016, Melbourne CBD** |
| **12-13 May 2016, Brisbane CBD** | **16-17 June 2016, Adelaide CBD** | **17-18 November 2016, Sydney CBD** |

## Clinical skills for treating complex traumatisation (Treating Complex Trauma)

This two-day (8:30am-4:30pm) program focuses upon phase-based treatment for adult survivors of child abuse and neglect. Participants must have first completed the 'Treating PTSD' program. This workshop completes Leah's four-day trauma-focused training. The content is applicable to both adult and adolescent populations. The program incorporates practical, current experiential techniques showing promising results with this population; techniques are drawn from EFTT, Metacognitive Therapy, Schema Therapy, attachment pathology treatment, ACT, CBT, and DBT.

| | | |
|---|---|---|
| **5-6 Nov 2015, Brisbane CBD** | **7-8 July 2016, Brisbane CBD** | **28-29 July 2016, Auckland CBD** |
| **26-27 Nov 2015, Sydney CBD** | **14-15 July 2016, Melbourne CBD** | **20-21 October 2016, Adelaide CBD** |
| **10-11 March 2016 Singapore CBD*** | **21-22 July 2016, Sydney CBD** | **27-28 October 2016, Perth CBD** |

**Program fee for each activity** (Please note that prices below only apply to 2015 offerings. Fees will increase in 2016)

* You need to be registered by 31/12/15 to attend Singapore otherwise it will be cancelled

**Early Bird $660** or $600 each if you register to both (or with a colleague) more than three months prior using this form

**Normal Fee $720** or $660 each if you register to both (or with a colleague) less than three months prior using this form

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

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

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

## 2015 Trauma Education Registration Form for ACA

Please circle the workshop/s you wish to attend above and return a copy of this completed page or register at our website

| | | | |
|---|---|---|---|
| Name: | | | |
| Address: | | | |
| Phone: | | Email (*essential*): | |
| Mobile: | | Special dietary requirements: | |
| Method of payment (circle one) | Visa | MasterCard | Electronic Funds Transfer (EFT) |
| Name of cardholder: | | | Expiry Date: |
| Card Number: | | | Card Verification Number: |
| Signature of card holder: | | | Debit amount: $ |

EFT or credit card payment is preferred. Simply complete the information above, scan and email this page mail@talominbooks.com

A receipt will be emailed to you upon processing. Note: Attendee withdrawals and transfers attract a processing fee of $55.

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


## WANT TO BE PUBLISHED?

# Submitting your articles to *Counselling Australia*

### About *Counselling Australia*

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

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

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

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

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

### Editorial policy

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

### Previously published articles

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

### Articles for peer review (refereed)

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

### Conditions

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

### Deadline

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

# Modern Hypnosis

## CERTIFICATION TRAINING

QUIT SMOKING | PERFORMANCE ENHANCEMENT | WEIGHT LOSS | STRESS REDUCTION

This accelerated 3 days training focuses on 4 of the most common reasons why someone will see a Hypnosis practitioner; quit smoking, performance enhancement, weight loss and stress reduction.

**You will be able to see clients at the completion of your training.**

**During the Training You'll Learn Effective Hypnosis Techniques:**

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- Create effective suggestions to use in Hypnosis
- Create powerful motivation for change
- Stop overeating
- Quit smoking
- Eliminate stress
- Self Hypnosis
- Use legally and ethically
- Getting insured to begin your practice

**Your Curriculum Includes:**

- Hands-on practice right from the start
- Learn by practice not from watching DVD's
- Supervision by an experienced Hypnotist & Certified Trainer
- Interviewing techniques to determine the suggestions necessary for best results
- Suggestibility testing
- Inductions and deepening techniques
- Post hypnotic suggestions
- Introduction to NLP
- Free lifetime support

Recognised Continuing Professional Development

ACA RECOGNISED PROFESSIONAL DEVELOPMENT

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**Brisbane:** Feb 12, 13 & 14 2016
**Sydney:** Feb 26, 27 & 28 2016

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AIPC

# Gain Entry Into An ACA Professional College

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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.

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

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