COUNSELLING AUSTRALIA

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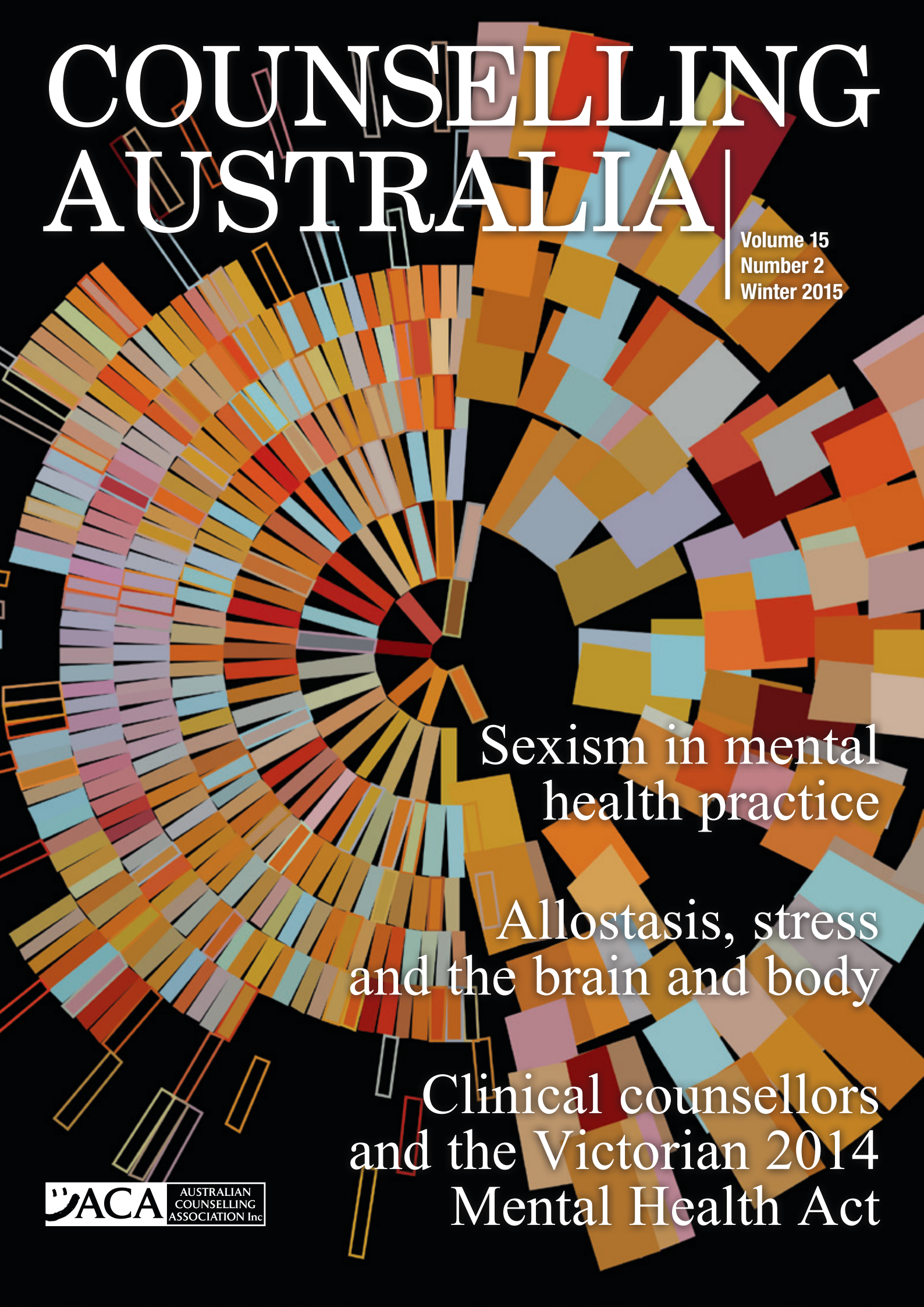

Sexism in mental health practice

Allostasis, stress and the brain and body

Clinical counsellors and the Victorian 2014 Mental Health Act

ACA AUSTRALIAN COUNSELLING ASSOCIATION Inc

Become A Self Employed Mental Health Social Support Trainer

As a licensed Mental Health Social Support Trainer you can earn very good money delivering MHSS programs. You have the freedom to advertise and schedule programs wherever, whenever and to whomever you want.

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Once you successfully complete your MHSS Trainer program you're issued with a Facilitator ID and secure access to the MHSS Trainer Portal. The MHSS Trainer Portal gives you access to:

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- Workbook order system.
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If you are **NOT YET MHSS Certified**, visit **www.mhss.net.au** and register now. Just after your registration has been completed, you will be invited to register for the MHSS Trainer program with a 63% discount ($1,000 savings).

If you are ALREADY MHSS Certified, visit **www.mhss.net.au/facilitator2** now to complete your MHSS Trainer program.

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

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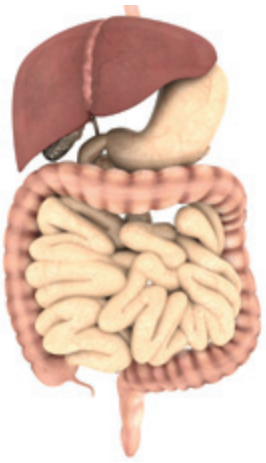

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See page 36 for peer-reviewed article submission guidelines.

www.aca.asn.au

EDITORIAL

By Philip Armstrong

NOTICE FOR ALL ACA MEMBERS:
ACA Annual General Meeting
Saturday
12 September 2015

It is my great pleasure to announce that *Counselling Australia*, Australia's only hard back peer reviewed counselling journal produced by a peak body, has a new co-editor Dr Matthew Bambling.

Dr Matthew Bambling is employed by the University Of Queensland School Of Medicine where he undertakes a variety of roles including coordinating the post graduate programs in mental health, teaching and research. He is internationally recognised for his early research work in the psychological treatment of depression and the outcomes of clinical supervision.

Most recently he has authored a chapter in the prestigious *International Handbook of Clinical Supervision* on the outcomes of supervision. In his work on the effectiveness of psychological treatments for depression Matthew was impacted by the positive results for the majority of depressed patients. However, he was also impacted by a sizable minority of patients who, regardless of receiving the best standard treatments or combination of psychological and medical treatments, would remain depressed. This led to the beginning of another research agenda which focuses on treatment resistant depression and various molecular pathways that may enhance treatment response.

Currently Matthew has been examining the role of a variety of nutraceutics as adjuvants to antidepressant medication and the human microbiome as an associated mechanism of response in resistant depression. Matthew is currently preparing a collaborative project to examine GIT dysfunction in treatment resistant depression.

I have known Dr Bambling for over 10 years and he has presented as a key note at several of ACA's conferences. He is well known throughout Australia and well respected as an author, researcher and lecturer. Dr Bambling may well be known to many of you for his articles in the now defunct *Psychotherapy in Australia*. Dr Bambling will bring a new dynamic to the journal adding another layer of quality to this high quality publication. A good example of this includes Matthew's contribution of a fascinating article in this edition of *Counselling Australia*: "The gastrointestinal tract, nutraceuticals and attenuation of resistant major depressive illness: A perspective." Matthew will also be joining our review panel.

ACA has raised a new position which has been filled by Thomas Parker, Tom is ACA's new Industry Liaison Officer (ILO). Tom will be visiting with training providers around Australia to build on ACA's current relationships with training providers from both the vocational and higher education sectors. Tom recently joined me for his first visit to a vocational training provider, Open Colleges, in Sydney. The ILO will also be responsible for continuing to build on ACA's relationships with employer groups, NGO's and government agencies. Tom will be responsible for raising the profile of ACA to students studying to become counsellors, working with employer groups to create more field placement positions for students in the industry and raising employer's knowledge of the benefits of employing counsellors. To help Tom in his position ACA has created the Careers Advisory Cell and will be developing an employment portal on the ACA website.

ACA is also at this moment conducting research on web development for private practitioners and experimenting on how to get the best results from a mixture of social marketing through Facebook personal and business sites. The current research project will take approximately three months. The purpose of this research is to be able to collect relevant data that will drive traffic to a counsellor's website that has specific embedded codes. At the conclusion of the research we will share the codes and our observations with members to help them improve the movement of traffic through their websites.

Notice: ACA would like to apologise to Bernard W S Fan for not including his name in his Peer Reviewed article titled 'Efficacy of gambling treatment program on incarcerated offenders in Western Australia Prisons" which was published in Counselling Australia in Vol. 14, No.3 2014

TOWARDS THE FUTURE

Conference

Joint ACA & Counsellors Victoria Inc Mini Conference

Saturday, 12 September 2015
Rydges, Melbourne 186 Exhibition Street VIC 3000

ACA will be partnering with our Victorian member association, Counsellors Victoria Inc, to host the 2015 1 x day Towards the Future mini Conference.

The conference venue will be Rydges Melbourne situated in the heart of the city's vibrant theatre district with Her Majesty's, Comedy Theatre, Princess, the Athenaeum and the Regent all within reach. All forms of public transport go almost to the door with a low cost public car park option also available.

The Towards the Future conference will explore what constitutes counselling in Australia and what it is about counselling that holds us together as an independent profession and how this will equate into the future. Conference speakers and subjects will reflect the diversity and richness of the profession.

• CALL FOR ABSTRACTS AND PAPERS
Deadline: 30 June 2015 | To submit a Paper for a 30 minute discussion or Abstract for a 90 minute workshop please supply the following: Name; Qualification/s; Paper/ abstract presentation title; Outline of presentation (no more than 600 words); Mobile; Email.

TECHNOLOGY UPDATE

With Technology Advisor Dr Angela Lewis

Dating Apps

This month we are taking a look at some of the most popular dating applications available for smart phones and other electronic device such as an iPad.

All dating apps works in essentially the way same way in that they match people based on initially on physical attraction followed closely by location and then other interests. The user decides whether or not they like the look of a person who pops up on their phone and if they do they can make contact and if they don't, nobody is any the wiser. All these listed can be used on iOS or Android devices, aside from Bumble which is iOS only. They can all be downloaded from either the Apple App Store or Google Play and are free to use.

Tinder

I am starting with Tinder as it is one of the most well-known and has been around for some time. Once downloaded specify the gender and age range of the people you'd like to meet, and how far you're prepared to travel to meet them, then it alerts you to other Tinder users who fall within your specified criteria. You'll also need a Facebook account to log in so that Tinder can attempt to match you with people with whom you have friends or interests in common and to use basic details from your Facebook profile such as your age and photos. This aspect of allowing Tinder to access Facebook data may not suit everyone (including me), so be aware you may end up sharing your Facebook data outside of your designated circle of friends.

When Tinder finds people who match your criteria it places cards on your screen showing a large photo of the person and tapping on this gives you a short description they've written of themselves. Tap the heart icon if you like them or tap the cross icon if you do not—or simply swipe the card to dismiss it and move on to the next. If you like someone who also likes you, Tinder will tell you that a match has been made and opens up a simple messaging function in which to chat and get to know each other.

Grindr

Grindr is a networking application geared towards gay, bisexual and bi-curious men. It is the largest and most popular gay mobile app in the world, available in 192 countries. It uses what's known as geo-location or positioning software to identify and locate other men in close proximity. Grindr's user interface displays a grid of representative pictures of men, arranged from nearest to farthest away and identifies them by a pin on a map. Tapping on a picture will display a brief profile for that user, as well as the option to chat, send pictures, and share one's location. It is said that at some gay social events, it's far more common to exchange Grindr usernames than Facebook or email addresses. Grindr does not require you to upload any information other than a profile name, an optional photo and answer a couple of optional questions.

Dattch

As Grindr is for men, Dattch is for lesbian, bi-sexual, and bi-curious women and operates in much the same way.

Bumble (iOS only)

Bumble, like Tinder, matches couples based on physical attraction, however it is set up so that women are the only ones who can start a conversation. Once the app is loaded a series of photos of potential matches appear and the user swipes to the right if interested and to the left if not. If a woman has liked someone who also likes them, she can then tap the speech bubble in the top right corner and has 24 hours to start up a conversation before the connection expires.

There are many more apps out there and all you need to do is perform a simple Google search to locate others. While dating/networking apps sound like fun and are easy to use, you still need to the same rules of safety and common sense to them as you would to any online dating site given that you'll never really know who you are agreeing to meet until you do so.

New Words in the Oxford Dictionary

As technology becomes more and more a part of people's everyday lives (think Facebook, Twitter, email, texting Google searching and Netflix watching); there has been a rapid change in language trends, prompting Britain's Oxford Dictionary to add some of these new words to their 2014 edition.

Bro hug: Another term for a man hug, two men hugging.
Clickbait: An eye-catching or provocative link on a website intended to encourage people to read on. Usually paid for by the advertiser.
Cray: Crazy (often said as cray-cray).
FOMO: Fear of missing out.
Flossing: Showing off online.
Doxing Researching and broadcasting personally identifiable information about an individual online.
E-cig Electronic cigarette.
Vape: To 'smoke' an electronic cigarette.
Humble-brag: Modest or self-deprecating statement intended to let others know how fantastic your life is while undercutting it with a bit of self-effacing humour.
Hench: Adjective for a well-built, strong or muscular male.
Hate-watch: Watching a TV show, movie, video, which you dislike so that you can mock or criticise it.
YOLO: You only live once.
Live Tweet: Tweeting while attending an event.
Listicle: An article or post online that is composed of a list (e.g. Top 10 Beaches).
Mansplain: When a man explains something to a woman in a condescending or overconfident manner.
Side eye: A sidelong glance expressing disapproval or contempt. Common saying on Twitter expressed as *side eye*.
Tech-savvy: Knowing a lot about modern technology, especially computer.

For more tips, hints and reference material on technology and social media, visit me at www.angelalewis.com.au

Children and screen time: how much is too much?

How much time does your child spend watching TV or movies, playing with a smartphone or computer, or enjoying video games?

Although some screen time can be educational, it's easy to go overboard. Consider this guide to children and TV, including what you can do to keep your child's screen time in check.

The American Academy of Pediatrics discourages media use by children younger than age two and recommends limiting older children's screen time to no more than one or two hours a day. Too much screen time can be linked to:

- **Obesity.** The more TV your child watches, the greater his or her risk is of becoming overweight. Having a TV in a child's bedroom increases this risk as well. Children can also develop an appetite for junk food promoted in TV ads, as well as overeat while watching TV.
- **Irregular sleep.** The more TV children watch, the more likely they are to have trouble falling asleep or to have an irregular sleep schedule. Sleep loss, in turn, can lead to fatigue and increased snacking.
- **Behavioral problems.** Elementary students who spend more than two hours a day watching TV or using a computer are more likely to have emotional, social and attention problems. Additionally, exposure to video games is linked with an increased possibility of attention problems in children.
- **Impaired academic performance.** Elementary students who have TVs in their bedrooms tend to perform worse on tests than do those who don't have TVs in their bedrooms.
- **Violence.** Too much exposure to violence through media — especially on TV — can desensitise children to violence. As a result, children might learn to accept violent behaviour as a normal way to solve problems.
- **Less time for play.** Excessive screen time leaves less time for active, creative play.

"Your child's total screen time might be greater than you realised," says Dennis C. Spano, M.D., Mayo Clinic Health System family physician. "Start monitoring it, and talk to your child about the importance of sitting less and moving more. Also, explain screen time rules — and the consequences of breaking them."

In the meantime, here are simple steps to reduce screen time:

- **Eliminate background TV.** If the TV is turned on — even if it's just in the background — it's likely to draw your child's attention. If you're not actively watching a show, turn it off.
- **Keep TVs and computers out of the bedroom.** Children who have TVs in their bedrooms watch more TV than children who don't

have TVs in their bedrooms. Monitor your child's screen time and the websites he or she is visiting by keeping TVs and computers in a common area in your house.
- **Don't eat in front of the TV.** Allowing your child to eat or snack in front of the TV increases his or her screen time. The habit also encourages mindless munching, which can lead to weight gain.

When your child has screen time, make it as engaging as possible:
- **Plan what your child views.** Instead of flipping through channels, seek quality videos or programming. Consider using parental control settings on your TV and computers. Preview video games and smartphone applications before allowing your child to play with them.
- **Watch with your child.** Whenever possible, watch programs together — and talk about what you see, such as family values, violence or drug abuse. If you see a junk food ad, explain that just because it's on TV doesn't mean it's good for you.
- **Record programs and watch them later.** This will allow you to fast-forward through commercials selling toys, junk food and other products. When watching live programs, use the mute button during commercials.
- **Encourage active screen time.** Have your child stretch or do yoga while watching a show. Challenge your family to see who can do the most jumping jacks during a commercial break. Choose video games that encourage physical activity.

"It can be difficult to start limiting your child's screen time. However, it's worth the effort," adds Dr. Spano. "By creating new household rules and steadily making small changes in your child's routine, you can curb screen time and its potential effects."

Mayo Clinic
www.healthcanal.com/child-health/62613-children-and-screen-time-how-much-is-too-much.html

Mindfulness as effective as drugs for treating depression, study finds

A form of mental training which helps people recognise the onset of depression, and control it, works as well as anti-depressants in preventing relapse, researchers say.

Mindfulness-Based Cognitive Therapy may offer a welcome alternative for people wishing to avoid long-term use of anti-depressants, which can have unpleasant side effects like insomnia, constipation and sexual problems, said a study in *The Lancet* medical journal.

In a two-year trial with 424 depression sufferers in England, researchers found that MBCT users faced a "similar" risk of relapse to those on anti-depressants. Mindfulness-Based Cognitive Therapy may offer a welcome alternative for people wishing to avoid long-term use of anti-depressants.

The method was not more effective than drugs, as many had hoped. But the findings nevertheless suggested "a new choice for the millions of people with recurrent depression on repeat prescriptions," said study leader Willem Kuyken, a professor of clinical psychology at the University of Oxford.

The study claims to be the first-ever, large-scale comparison between the efficacy of MBCT and anti-depressants.

Trial volunteers were randomly divided into two groups. Half continued taking their medication while the rest phased out the drugs in favour of MBCT.

The training involved eight group sessions of two hours and 15 minutes each, with daily home practice.

Participants were given the option of four follow-up sessions over the following 12 months. All 424 volunteers were assessed for a period of two years with a diagnostic tool called the "structured clinical interview", which measures mental state.

The MBCT group had a 44-per cent relapse rate, the researchers found, compared to 47 per cent in the group taking anti-depressants.

The Australian
http://www.theaustralian.com.au/life/health-wellbeing/mindfulness-as-effective-as-drugs-for-treating-depression-study-finds/story-fnr5f5xi-1227313155084

Low-serotonin depression theory challenged

A new paper challenges the prevailing opinion that depression is related to low levels of serotonin in the gaps between nerve cells in the brain.

This theory has predominated for nearly 50 years and has led to the development of the commonly prescribed anti-depressant medications called selective serotonin re-uptake inhibitors, or SSRIs. But it has never been proven.

The science behind many anti-depressant medications appears to be backwards, say the authors of a paper posted by the journal *Neuroscience & Biobehavioral Reviews*.

SSRIs keep the neurotransmitter's (serotonin) levels high by blocking its re-absorption into the cells that release it.

But those serotonin-boosting medications actually make it harder for patients to recover, especially in the short term, said lead author Paul Andrews, an assistant professor of psychology, neuroscience & behavior at McMaster University in Canada.

"It's time we rethink what we are doing," Andrews says. "We are taking people who are suffering from the most common forms of depression, and instead of helping them, it appears we are putting an obstacle in their path to recovery."

When depressed patients on SSRI medication do show improvement, it appears that their brains are actually overcoming the effects of antidepressant medications, rather than being assisted directly by them. Instead of helping, the medications appear to be interfering with the brain's own mechanisms of recovery.

"We've seen that people report feeling worse, not better, for their first two weeks on antidepressants," Andrews says. "This could explain why."

It is currently impossible to measure exactly how the brain is releasing and using serotonin, the researchers write, because there is no safe way to measure it in a living human brain.

Instead, scientists must rely on measuring evidence about levels of serotonin that the brain has already metabolised, and by extrapolating from studies using animals.

The best available evidence appears to show that there is more serotonin being released and used during depressive episodes, not less, the authors say.

The new paper suggests that serotonin helps the brain adapt to depression by re-allocating its resources, giving more to conscious thought and less to areas such as growth, development, reproduction, immune function, and the stress response.

Andrews, an evolutionary psychologist, has argued in previous research that antidepressants leave patients in worse shape after they stop using them, and that most forms of depression, though painful, are natural and beneficial adaptations to stress.

By Rick Nauert, Psych Central
http://psychcentral.com/news/2015/02/18/low-serotonin-depression-theory-challenged/81396.html

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 TO BOTH AND SAVE $120

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

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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
19-20 Nov 2015, Sydney CBD
5-6 May 2016, Brisbane CBD
9-10 June 2016, Perth CBD
16-17 June 2016, Adelaide CBD
23-24 June 2016, Auckland 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. The 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.

16-17 July 2015, Melbourne CBD
23-24 July 2015, Sydney CBD
30-31 July 2015, Auckland CBD
22-23 Oct 2015, Adelaide CBD
29-30 Oct 2015, Perth CBD
5-6 Nov 2015, Brisbane CBD
26-27 Nov 2015, Sydney CBD
10-11 March 2016 Singapore CBD

Program fee for each activity

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

Direct your enquiries to Joshua George on (02) 9823 3374 (phone/fax/voice) Email**: 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

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

Credit card payment is preferred. Simply complete the information above and fax this page to (61 2) 9823 3374.

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.

SEXISM IN MENTAL HEALTH PRACTICE

Misogyny continues in some current therapists' work

By Paula J. Caplan Ph.D.

Post published by Paula J. Caplan Ph.D. on Mar 19, 2015
in *Science Isn't Golden*

PEER REVIEWED ARTICLE

It should have been a sign that not all was what it seemed: During the middle of the 20th century, when the stay-at-home wife and mother was said to be serene and happy, some psychiatrists and other physicians prescribed for women vigorously – marketed tranquiliser pills in huge quantities. Unhappy women were more likely than unhappy men to be put on such pills, many of which can cause physiologically-based addiction within a very brief time and can be hell to withdraw from. Some doctors handed them out like candy to women who were bored, suppressed, or abused.

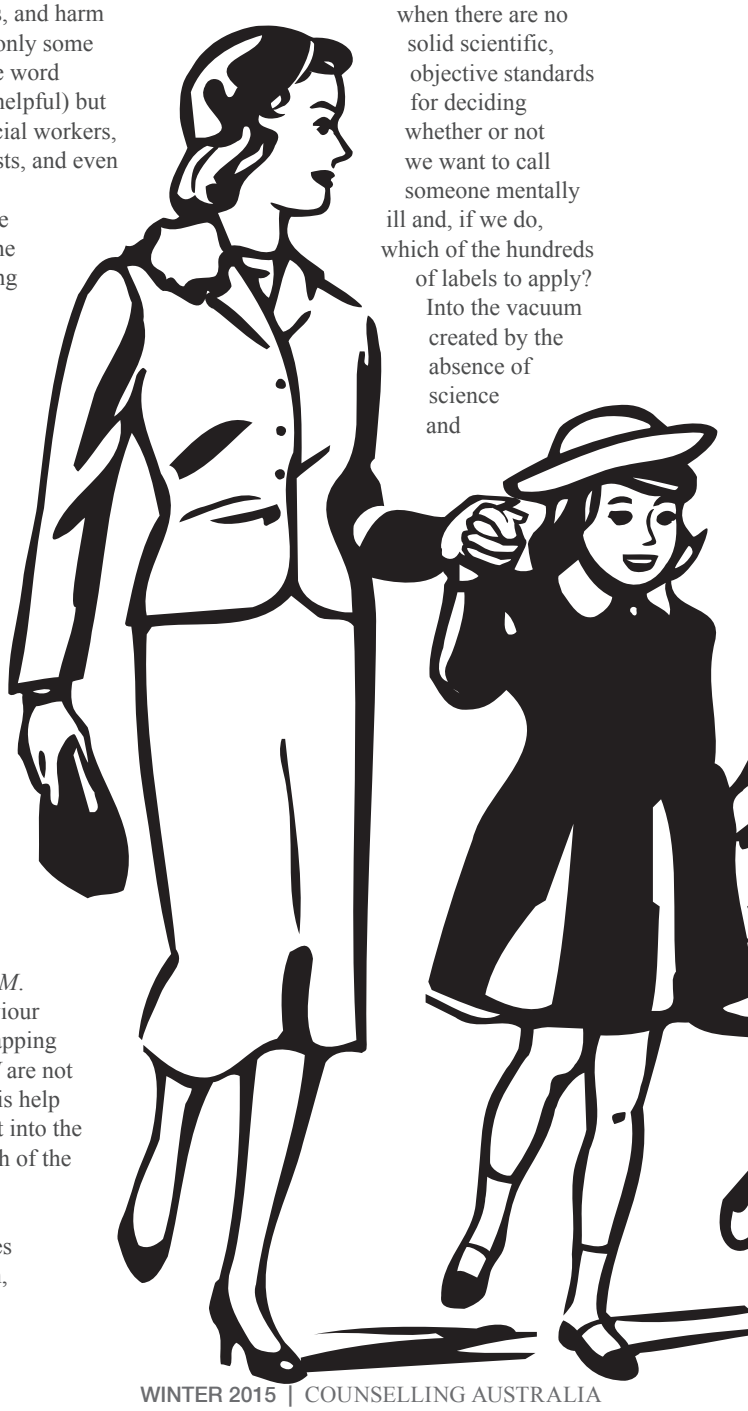
As decades passed, successive editions of the manual of psychiatric diagnosis ballooned in size, swollen as more and more unvalidated categories of alleged mental illness (Stuttering, Nicotine Dependence Disorder, Caffeine-Induced Sleep Disorder, Major Depressive Episode that applied on the first day of bereavement, etc.) were put into the manual that the American Psychiatric Association and its leaders touted as scientifically based (even while many simultaneously covered their bases by saying it was really only a common language). Increasingly, research revealed the sexism pervading so many of the categories – the way they were designed, the way they were assigned, or both. (See *Bias in Psychiatric Diagnosis* for many chapters about sexism in diagnosis, as well as some on racism, classism, ageism, and homophobia in diagnosis.)

Last Saturday on NPR I caught the last bit of an interview with Jeffery Lieberman, a past president of the American Psychiatric Association (publisher of the diagnostic manual, *DSM*). His new book, *Shrinks: The Untold Story of Psychiatry*, is apparently intended to elevate psychiatry to the level from which it has dropped in recent decades due to many discoveries about the mental health system's lack of science, influence of politics, and harm caused by – to be fair – not only some psychiatrists (please note the word "some," because others are helpful) but also some psychologists, social workers, marriage and family therapists, and even pastoral counsellors.

I want to address here one claim I heard him make in the NPR interview and, this being Women's History Month, to focus on how they relate to sexism in our field. This is not, of course, to say that some of the biases in mental health practices are not harmful to men, as well as the other forms of bias noted above are not also alarming.

Lieberman stated that psychiatry is a medical discipline just like other medical disciplines. In fact, as is often pointed out, despite some claims to the contrary, even the American Psychiatric Association has admitted that there is no laboratory test that reveals a brain defect that gives rise to any of the hundreds of alleged mental illnesses listed in *DSM*. Checklists of kinds of behaviour and feelings compiled by slapping together those listed in *DSM* are not helpful, because all they do is help the therapist who has bought into the DSM system to decide which of the hundreds of labels to apply. The symptom clusters that comprise the DSM categories are not, and never have been, scientifically based.

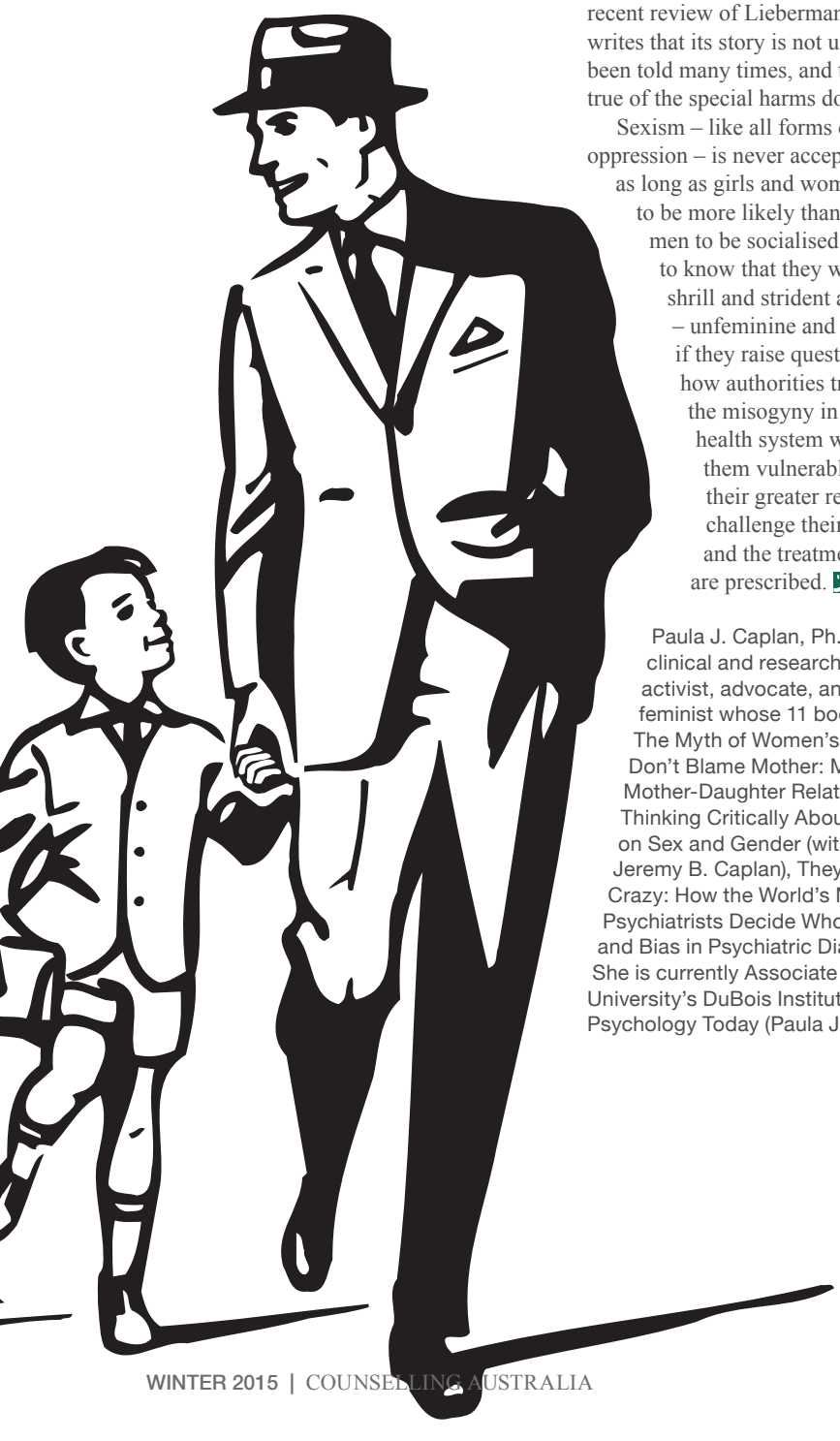
What happens when there are no solid scientific, objective standards for deciding whether or not we want to call someone mentally ill and, if we do, which of the hundreds of labels to apply? Into the vacuum created by the absence of science and



objectivity there swooshes every conceivable kind of bias. Thus, for instance, women who have been sexually assaulted are often labelled with "Bipolar Disorder" rather than told that of course they sometimes feel devastated – they have, after all, been raped. And often, mothers serving in the military whose jobs send them far from their children on deployments find that, when they go to see a military therapist because they miss their children and/or feel they are terrible mothers for being so far away, the therapist diagnoses them as mentally ill with Major Depressive Disorder or Generalized Anxiety Disorder (if not worse) rather than confirming that these are natural, understandable feelings. In these ways, women having deeply human reactions of distress now have the added burden, shame, and fear caused by being told, in essence, that there is something wrong with them, since they are not handling the situation "better." The *Bias in Psychiatric Diagnosis* book required a great many chapters about sexism in the field in order to document just a small fraction of its manifestations.

Psychologist Carol Tavris, author of the classic book *The Mismeasure of Woman*, has for decades been a perceptive analyst of sexism in the mental health field and psychological/psychiatric research. In her recent review of Lieberman's book, she writes that its story is not untold but has been told many times, and that is certainly true of the special harms done to women.

Sexism – like all forms of bias and oppression – is never acceptable. But as long as girls and women continue to be more likely than boys and men to be socialised to be nice, to know that they will be seen as shrill and strident and – horrors! – unfeminine and unattractive if they raise questions about how authorities treat them, the misogyny in the mental health system will render them vulnerable because of their greater reluctance to challenge their diagnoses and the treatments that are prescribed.



Paula J. Caplan, Ph.D., is a clinical and research psychologist, activist, advocate, and longtime feminist whose 11 books include The Myth of Women's Masochism, Don't Blame Mother: Mending the Mother-Daughter Relationship, Thinking Critically About Research on Sex and Gender (with her son, Jeremy B. Caplan), They Say You're Crazy: How the World's Most Powerful Psychiatrists Decide Who's Normal, and Bias in Psychiatric Diagnosis (ed.). She is currently Associate at Harvard University's DuBois Institute and blogs for Psychology Today (Paula Joan Caplan).

Useful links

Science isn't Golden:
https://www.psychologytoday.com/blog/science-isnt-golden

Prescribing tranquiliser pills:
http://whp-apsf.ca/pdf/coopProceedingsEN.pdf

Bias in Psychiatric Diagnosis:
http://www.amazon.com/Bias-Psychiatric-Diagnosis-Paula-Caplan/dp/0765700018

NPR
http://www.npr.org/blogs/health/2015/03/14/392798128/from-freud-to-possession-a-doctor-faces-psychiatrys-demons

The Mismeasure of Woman
http://www.amazon.com/The-Mismeasure-Woman-Carol-Tavris/dp/0671797492

Shrinks: The Untold Story of Psychiatry
http://www.wsj.com/articles/book-review-shrinks-by-jeffery-a-lieberman-with-ogi-ogas-1425942676

To see compelling 10-minute videos made by or about some of the many women who bravely filed with the American Psychiatric Association's ethics committee complaints about the harm done to them – or in one case to a brother – that began when they were classified under DSM labels, please have a look at:
http://psychdiagnosis.weebly.com/stories-of-harm.html

To read more about what happened with the complaints the women filed with the APA ... and then with the Office of Civil Rights of the Department of Health and Human Services, go to:

Caplan, Paula J. (2012). Will the APA listen to the voices of those harmed by psychiatric diagnosis? Mad in America: Science, Psychiatry, and Community. October 1.
http://www.madinamerica.com/2012/10/will-the-apa-listen-to-the-voices-of...

Caplan, Paula J. (2012). The APA refuses to listen to the voices of those harmed by diagnosis…and refuses and refuses. Mad in America: Science, Psychiatry, and Community. November 19.
http://www.madinamerica.com/2012/11/the-apa-refuses-to-listen-to-voices-...

ALLOSTASIS, STRESS AND THE BRAIN AND BODY

Counselling, the autonomic nervous system and the microbiota-gut-brain axis

By Dr Allen E. Ivey and Mary Bradford

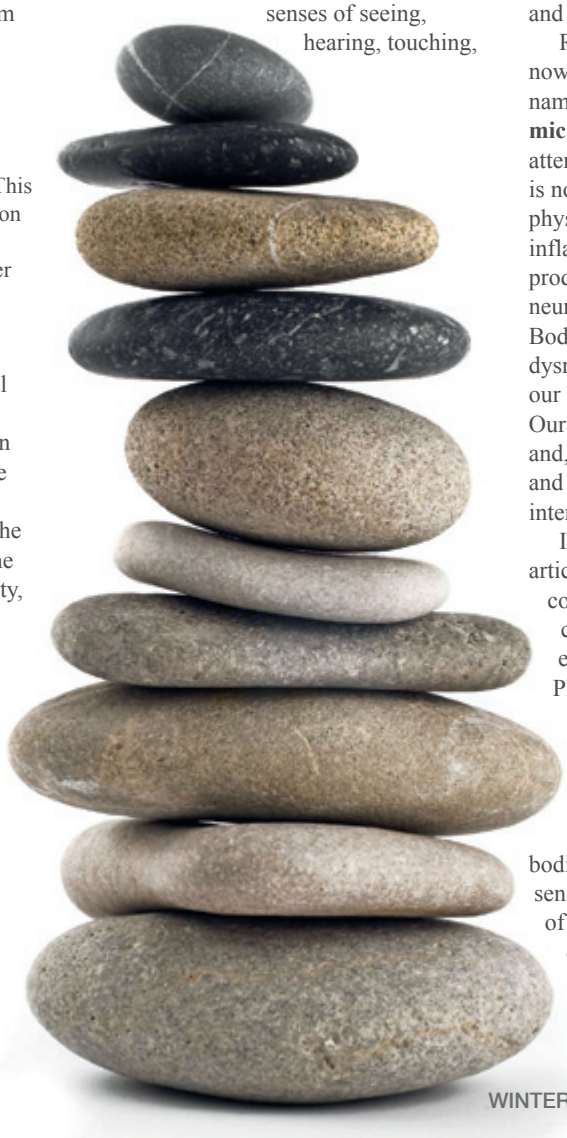
Stress underlies virtually every counselling issue we face ranging from the results of trauma, poverty, racism and abuse to decisional issues such as college choice, an argument with a loved one or career choice. At the same time, stress is necessary for learning and positive human development, both mentally and physically. Homeostasis has become a limited concept and leads us to think that we can find a perfect balance. What we all need is a more realistic term allostasis, as best defined by McEwen and Scott:

> **Allostasis** is the process of achieving stability, or homeostasis, through physiological or behavioural change. This can be carried out by means of alteration in HPA axis hormones, the autonomic nervous system, cytokines, or a number of other systems, and is generally adaptive in the short term.

Appropriate levels of stress, physical and mental, strengthen us and lead to resilience. Negative stress, however, can tear us apart and lead to reduction in the size of our hippocampus (memory) and increased size and negative activity in the amydala, which is the primary site of the emotions related to fear (sadness, anxiety, anger). We have made the error of only focusing on the results of being overly stressed. Allostasis can also be defined as a healthy balance of calming and activation or stimulation and quiet.

Counselling needs to focus on allostasis and an active, changing balance as a central goal of therapy. We help clients by building intentional self-regulation through improving cognitive, emotional, and behavioural skills. Vital in this process is increasing the strength of the prefrontal cortex for executive functioning and emotional regulation. Psychoeducation in the behavioural lifeskills is a vital supplement to traditional counselling.

We cannot learn, we cannot develop stronger muscles, we cannot strengthen our heart, we cannot climb a high mountain (intellectual or physical) without a degree of stress. Change in counselling, particularly through the supportive challenge known as confrontation, builds appropriate stress and motivation for change. When stimulated, our perceptual senses of seeing, hearing, touching, tasting, and smell are the basis of stress – necessary for the good things. But too much negative stimulation from trauma, poverty, abuse, bullying and harassment, plus repeated exposure to racism and other forms and oppression can lead to enduring brain change and dangerous bodily reactions. Social justice demands awareness, knowledge, skills, and action to meet the needs of those who encounter the multiple forms of oppression and trauma.



Recent thinking is leading to what is now called the **sixth sense**, sometimes named the **second brain**, the **gut-brain-microbe axis**, which gives special attention to **neuroinflammation**. Evidence is now clear that emotional as well as physical distress can cause damaging inflammation. We associate the brain with production of serotonin, but 95% of this neurotransmitter, is produced in the gut. Bodily stress from illness or other physical dysregulation has a profound impact on our brain, our thoughts and our emotions. Our total body reacts to external stressors and, at the same time, internal cognitions and "gut feelings" produce our own internal stress.

In our October 23rd *Counseling Today* article, we focused on the prefrontal cortex (PFC) as the seat of executive cognitive functioning, as well as emotional regulation. We noted that the PFC interacts with the more primitive amygdala, the "energizer bunny" which is key in our experience of all types of stress. The amygdala is activated by the events in the external world or from internal bodily stimulation and is particularly sensitive to stress. The hippocampus, one of our memory structures, stores and distribution information throughout the brain. One of the key objectives of counselling is positive memory

change with the possibility of brain "rewiring."

> "Depression is as real a disease as diabetes."

This statement by Stanford's famous Robert Sapolsky is based on considerable research showing that psychological depression has a deep impact on the body. In turn, dysfunction of the body through diet and obesity, infection/ inflammation, illness all lead to depression as well. Our cognitions, beliefs, emotions, and behaviour can build bodily health, or they can be as toxic as illness or environment pesticides. There is also a bi-directional feedback loop that can increase both depression and body reactions. However, additional research suggests that positive attitudes and beliefs, exercise and lifestyle affect the immune system in healthy ways. For a very clear and practical background about depression and the body, we suggest watching Robert Sapolsky's YouTube presentation at www.youtube.com/watch?v=NOAgplgTxfc.

What might this mean for your practice?

The implications of neurocounselling for short-term and long-term daily practice are:

1. Mental health and physical health are closely entwined. Mary and Allen recommend that you consider having a poster of the brain and body readily available for your clients. With some clients point out how the relationship and their ability/willingness to follow-up learning in the interview can change them in positive ways. This is for only clients who show interest. Within this, we are not physicians. Our work is counselling, prevention, education, and referral.
2. Search to build stress resilience and enable clients to balance inevitable and necessary reactions to stress with the ability to calm themselves and develop and learn new ways to cope with more demanding stressors.
3. Bi-directionality (also known as cross talk) is replacing linear thought in neuroscience/neurobiology and counselling. Allostasis reveals the bi-directionality of the interaction between the needed stress of stimulation and the need for calming. Too much emphasis in either direction can be problematic.

The autonomic nervous system connecting brain and body: key to stress resilience and allostasis

The Autonomic nervous system (ANS) regulates the body's unconscious actions of heart, esophagus, lungs, stomach and gastrointestinal system and consists of two divisions: the sympathetic, focused on response to stimuli and activation; and the parasympathetic, focused on calming and balance. The ANS is connected to the brain stem in a bi-directional pattern. What happens in the brain affects both sympathetic stimulation (e.g. stress) or parasympathetic calming. In turn, bi-directional crosstalk means that action in the ANS affects the brain. Note that another way to think about the stress as activation that can be strength building or destructive.

The "calming and activating" or "stop and go" actions of the ANS are repeated throughout the entire stress system from our neurotransmitters to every region and cell of our body. For example, the neurotransmitter glutamate activates and makes learning possible, while GABA is necessary for balanced calming. Hormones in the brain and body interact with cytokines in positive and negative ways. Even in our gastrointestional system, microbiota, interactive imbalance of highly diverse microorganisms can lead to poor mental and physical health, but a healthy gut through diet, exercise, and a positive attitude improve our mental well-being. Through our listening, we tend to calm clients. Through reframing and confrontation of discrepancies in their lives, we seek to activate change. Each of our counselling interventions impact the holistic body, as well as the mind.

The ANS is also basic to the evolutionary process and thus needs to be considered first as we consider stress. For example, view the embryos of fish, mammals, and humans. They all appear quite similar in the early stages of development. All have variations of the vagus nerve. Why? Heart function, eating, and lungs are basic to survival and future development. Alliostatic resilience, our counselling goal, ultimately impacts the ANS and the entire body, as well as the brain. The higher body processes of allostasis represent later stages in the evolutionary process.

Porges' Polyvagal Theory, was described by Chapin in the 2014 *Counselling Today* article "Strategies for self-regulation: rediscovering the physiological basis of behavior." He emphasizes the importance of sympathetic neural circuits of safety, danger, and life-threat (also central functions of the amygdala in the brain's limbic system). This is important for protection, but overstimulation can produce serious issues. Research has found that stimulating the parasympathetic vagal links to the amygdala not only calms, but also facilitates memory of emotional events, (www.apa.org/monitor/apr04/vagus.aspx). Do you agree with my use of parasympathetic here or would you suggest a rewording?

Polyvagal theory provides specific suggestions to help clients cope with flight and fight sympathetic overstimulation. In this body-aware framework we help clients become aware of the power of unconscious body processing and show them how they can calm the vagus nerve and themselves, through biofeedback and control of heart rate, breathing exercises and the relaxation response, as well as providing neurofeedback. Of course, our relationship and counselling with clients can be calming, but we seldom think of how our words and nonverbal behaviour are potentially therapeutic.

Porges stresses safety needs and emphasises social skills and engagement training as one key route to be comfortable in social relationships. This can be made more specific. For example with autistic children, working first just with gaze and eye contact is a beginning, but this is also true with some of our clients who lack social skills. Listening skills can be useful in calming. Further, his work turns out to be fully in tune with the general emphasis in our columns of what we call Therapeutic Lifestyle Changes, which emphasize the importance of diet, exercise, cognitive challenge, cultural health, and other healthy behaviours.

Illustrating the vagal and the microbiota-gut-brain axis

Figure 1 presents vagal connections from the brain's perceptions, cognitions, and emotions to our HPA hormone production of cortisol (hypothalamus, pituitary, adrenals). Cortisol in an allostatic balance facilitates learning, while overabundance can be seriously damaging to the brain and body. This same stimulation reaches down to the heart, lungs, and onward to the gut microbiota flora) with its 100 trillion microbes.

Grenham et al (2011) summarize:

> "A stable gut microbiota is essential for normal gut physiology and contributes to appropriate signaling along the brain–gut axis and to the healthy status of the individual as shown on the left hand side of the diagram. Conversely, as shown on the right hand side of the diagram, intestinal dysbiosis can adversely influence gut physiology leading to

inappropriate brain–gut axis signaling and associated consequences for CNS functions and disease states. Stress at the level of the CNS can also impact on gut function and lead to perturbations of the microbiota."

In summary thus far:

1. Counselling not only changes the brain, it also has a meaningful impact on the body and its functioning. Our present skills and theories remain relevant in the new neuroscience/ neurobiological world.
2. The National Institute of Mental Health is now giving major funding to a brain-based assessment AND treatment framework. Thus our attention to areas that our field has so far mostly ignored will be changing. Counsellor education and counselling and therapy practice will be changing and more scientifically based. Introduce yourself to this coming new world by exploring the links out of www.nimh.nih.gov/ research-priorities/rdoc/index.shtml
3. The material here is based on the most current research and we can only expect the connection between brain and body – and onward to key genetic factors will become increasingly central in the literature.

So far, we have presented allostasis and the building of stress resilience as central to the counselling profession. Allostasis was defined as a bi-directional balance between quiet and activation or stimulation and calming. As counsellors through listening and relationship we can build a calming presence, but at the same time we need to activate and stimulate our clients to action through new ways of thinking, feelings, and behaving. Mental health allostasis is a bi-directional balance. Stress management is another term for this, but the concept fails to recognise the complexity of our lives and the possibilities within.

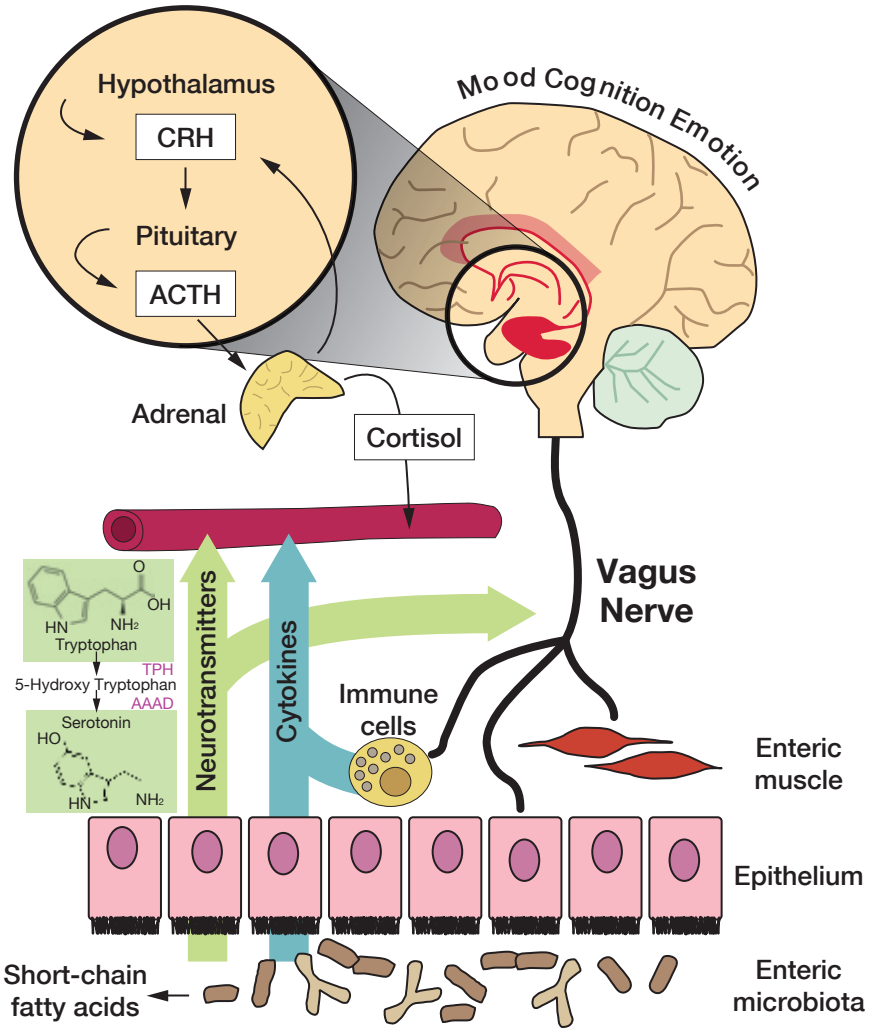
Let us now turn to the second brain, the gastrointestinal system—the microbiota-gut-brain axis. The axis is obviously disturbed by imbalances in the autonomic nervous system (ANS), the brain, the body, and by any external or internal stressor. Our stress system is holistic and the psychic distress reverberates throughout the body just as illness does the same to our body and brain.

In Figure 1we see the reciprocal bi-directional crosstalk interconnections of the brain, the gastrointestinal system, the immune system, all connected by the autonomic nervous system. These bi-directional interconnections are also labelled as "the brain to body and the body to brain" or "top down to bottom up". The HPA axis (hypothalamus, pituitary, adrenals) generates and passes on hormones throughout the body. Important here is the production of cortisol, necessary for learning, but is typically dysregulated in serious situations such as war trauma, rape, or the repeated traumas of bullying, poverty, or racism, and harassment. This disruption of cortisol can lead to damage to key brain structures, as well as increased heart rate, breathing rate change, and disturbances to the gut or gastrointestinal system (2015, www.medscape.com/viewarticle/704866_3).

Nearly every chemical that controls the brain is also located in the stomach region, including hormones and neurotransmitters such as serotonin, dopamine, glutamate, GABA and norepinephrine. The gut produces more of the neurotransmitter serotonin than the brain. No longer should we think of "gut feelings" as just a passing thought.

In turn, a recycling negative feedback loop can lead from the gut to the brain and to the immune system, with accompanying inflammation. Stress increases inflammation and it is been found that bodily inflammation accompanies depression and other psychological diagnoses. Interacting with the HPA are the cytokines, produced in both brain and gut. The cytokines are the proteins and chemicals that are most central in producing inflammation. Inflammation is a central issue to which counselling gives virtually no attention. Yet, depression and other distressing issues that we discuss with clients are often accompanied by inflammation, which can be dangerous to physical health over time.

FIGURE 1



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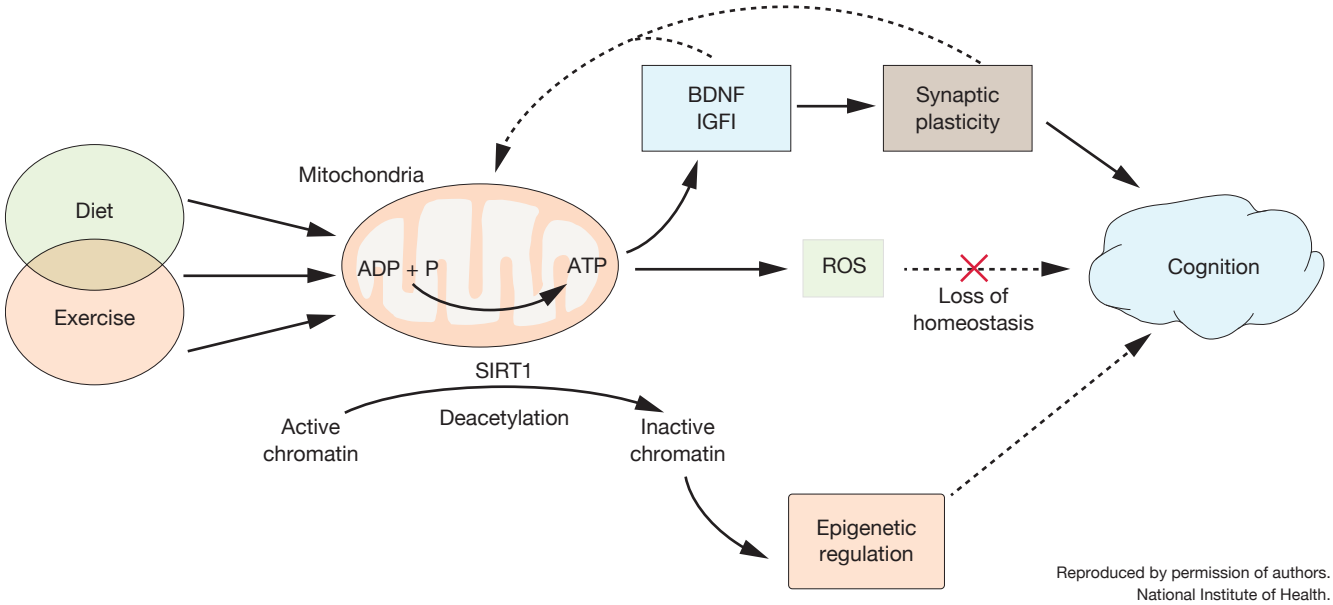
From Grenham, S., Clarke, G., Cryan, J., & Dinan, T. (2011) Brain–gut–microbe communication in health and disease. Front. Physiol., http://journal.frontiersin.org/article/10.3389/fphys.2011.00094/full

FIGURE 2



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National Institute of Health.

While stress (also known as oxidative stress) is often central in producing inflammation in brain and body, physical illness (cancer, diabetes, severe flu or cold) also is a cause. Chemicals, pesticides, gluten (for some), and other pathogens also produce inflammation. It is important to realise that oxidative stress also comes from interpersonal relations and self-talk. One's thoughts, beliefs produce inflammation in themselves.

Important in this process, and not receiving enough attention, is maintaining a balance of our trillions of gut microbiota. An imbalance of too many negative microbes can be the result of external stressors and emotional imbalance, a poor diet (particularly sugar), allergies, or environmental toxins, even genetically modified food for some. The imbalance is another route toward inflammation and has been proven to be an issue in depression and other diagnoses. The inflammatory actions are both caused and activated by cytokines. Diet, of course, is a central cause of body inflammation, which in turn can lead to psychic distress. Interestingly, research shows that a change in lifestyle can move the balance of microbes from negative to positive.

At this point, we also need to consider the mitochondria, found in large numbers within the cells, which produce the energy that move our brain and body. We now argue that it is basic for all counselors and therapists to be aware of the role of mitochondria in our lives. While mitochondria enable us to move our muscles and think clearly through the production of the fuel ATP, they also need strengthening themselves. ATP is the molecular unit that energizes our metabolism and enables our muscles to contracts and us to move and breathe. Among other things, it also is important in nervous system and cell signaling, as well as DNA synthesis. Therefore, we help our mitochrondria through exercise, diet, and positive health habits—the very same treatment methods we have emphasized throughout our columns—therapeutic lifestyle changes. Mitochondria are also in continuing bi-directional drama with cytokines as each can destroy or enhance the other.

Cytokines are small, vital proteins released from cells that affect communication among cells and their behaviour. There are over 30 and possibly they growing in numbers. They have been found to interact bi-directionally with multiple genes. For example, interferons are produced by T cells and regulate the immune system. Cytokines are closely related to depression. Research is underway progressing through examining cytokines in the blood of clients pre and post counselling. Another bi-directional aspect of cytokines is their relationship to hormones in the brain. Dysfunction here leads to inflammation in the brain, a factor that we have not yet considered in our practice.

Figure 2 is too detailed to discuss fully, but please note the nature of bi-directional crosstalk and how it relates to allostasis: 1) diet and exercise have a profound impact on the energy producing mitochondria; 2) mitochondria ATP energy produces BDNF (brain derived neurotrophic factor, "miracle grow" for the brain); 3) these lead to synaptic plasticity, brain growth and sharper cognition. Also key is ROS, reactive oxygen species that speak to oxidation in the body and brain. Illness or poor diet, lack of exercise, depression all can lead to oxidation, inflammation, apoptosis (death) of the mitochondria, oxidation and cognitive issues. In addition, throughout the process, epigenetic change to genes can be positive or negative (there actually should be a bi-directional arrow in the epigenetic/cognitive relationship, as cognitions can possibly impact epigenetics).

Mitochondria contain more DNA than the cells within which they live. It is at this foundational level, through epigenetics, counselling can even be part of enabling genes to turn on or off in ways that lead to more healthy living and even a longer life with better health. Similarly social oppression, trauma, negative experience, depression, illness can all lead to the death of mitochondria, and dangerous changes in DNA through epigenetics. A recent article carries this to a full cycle back to the CNS:

> Neuroinflammation and mitochondrial dysfunction are common features of chronic neurodegenerative diseases of the central nervous system. Both conditions can lead to increased oxidative stress by excessive release of harmful reactive oxygen and nitrogen species (ROS and RNS), which further promote neuronal damage and subsequent inflammation resulting in a feed-forward loop of neurodegeneration. (Fischer, R., & Maier, O. (2015) Interrelation of oxidative stress and inflammation in neurodegenerative disease. Oxidative Medicine and Cellular Longevity.)(http://dx.doi.org/10.1155/2015/610813)

The above discussion includes considerable data and some terms that may be unfamiliar at this point, but they will be central soon in counsellor education.

1. External psychological stressors or pathogens from the environment or internal physical stressors from illness or the nature of one's inherited genes can lead to:
2. the six senses perceiving stress threat or challenge impacting the autonomic nervous system, the vagus nerve, the flow of neurotransmitters and hormones through the HPA axis. Through this
3. proinflammatory or anti-inflammatory cytokines interact throughout the body at all levels from the HPA axis to the gut microbiota. Particularly important is the impact on the immune system and inflammation.

An optimistic view of our ability to build alliostasis and stress resilience

First, please review our three recommendations early in this article. We are effective in making a difference with our clients. Counselling changes the brain and can impact every one of the bodily systems we mention above. Of course, caution is central. We are not to healers of the body for that is the role of the physician. With each client we are honored to work with, we need to be alert as possible to the reality of unseen illness as it manifests itself and have referral sources available. For example, Sapolsky has stated that when we see depression and anxiety, we also need to think of the possibility of thyroid problems. Visit the popular site Everyday Health for a useful discussion of what we much of what we need to know. (everydayhealth.com/columns/therese-borchard-sanity-break/depression-bipolar-disorder-and-hypothyroidism/).

It is now virtually a truism – **relationship and the working alliance are 30% of effective counselling and therapy.** Carl Rogers lives! Now to repeat ourselves and our neurocounselling column colleagues, we highly recommend looking seriously at Therapeutic Lifestyle Changes as a proven way to improve mental and physical health. John Ratey of Harvard Medical School states that it is unethical for a physician not to prescribe appropriate exercise to all patients.

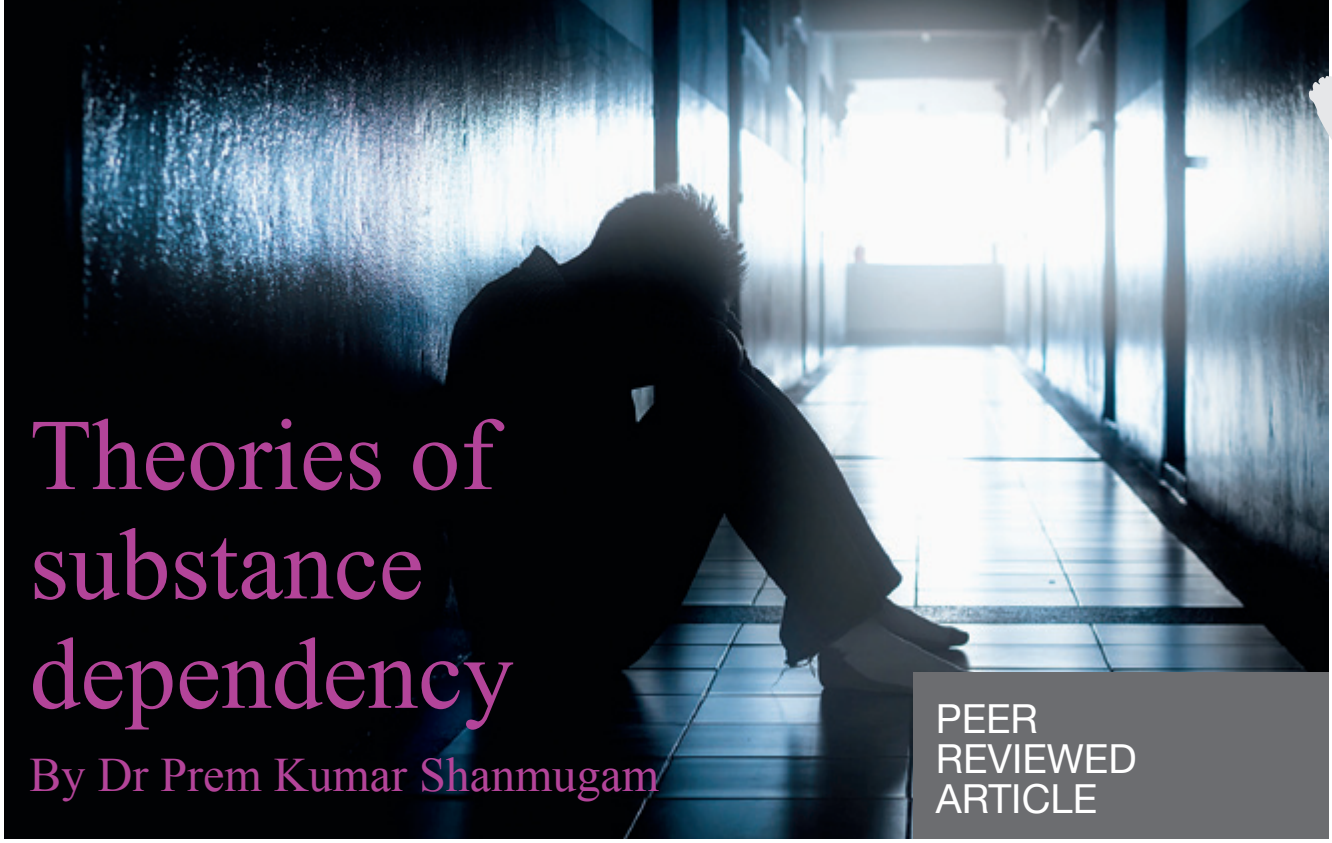
The same holds for us as counsellors. Are you also considering the importance of your client's diet, their sleep patterns, their willingness to take on cognitive challenge? We are rather good at helping clients with their social relations, so basic to calming or activating the autonomic nervous system. Cultural health and social justice action have positive mental and physical health benefits. Beyond these, other Therapeutic Lifestyle Changes, all based in some research in neuroscience and neurobiology, are well worth considering as adding to your present skills in CBT, REBT, narrative, psychodynamic, DBT, or other therapeutic system.

Dr Allen E. Ivey is a distinguished university professor (emeritus) at the University of Massachusetts, Amherst and professor of counseling at the University of South Florida, Tampa (courtesy appointment). He is president of Microtraining Associates, an educational publishing firm. Allen is a diplomate in counseling psychology and was honored as a Multicultural Elder at the National Multicultural Conference and Summit. He is author or co-author of more than 40 books and 200 articles and chapters, translated into 18 languages. He is the originator of the Microskills approach, basic to this book.

Mary Bradford Ivey is Vice President of Microtraining Associates and Courtesy Professor of Counseling, University of South Florida, Tampa. She is a former school counselor for the Amherst, Massachusetts, schools and has served as visiting professor at the University of Massachusetts, Amherst; University of Hawai'i, Manoa; and Flinders University, South Australia. Mary's undergraduate degree in social work and education is from Gustavus Adolphus College, and she has a master's degree in counseling from the University of Wisconsin. She earned her doctorate in organizational development at the University of Massachusetts, Amherst. Mary is the author or co-author of twelve books, translated into multiple languages, and several articles and chapters. She is a Nationally Certified Counselor (NCC) and a licensed mental health counselor (LMHC), and she has held a certificate in school counseling.

Allen and Mary Ivey are pleased to share their handout *Therapeutic Lifestyle Changes* to those who are interested. (allenivey@gmail.com, mary.b.ivey@gmail.com).

We thank Drs. Ted Chapin and Michael Hoffman for highly useful comments on this article.



Theories of substance dependency

By Dr Prem Kumar Shanmugam

PEER REVIEWED ARTICLE

The American Psychiatric Association describes addiction as a chronic relapsing disorder. There is a 50% to 70% possiblity of relapses occuring with people suffering from addictions. Over the years numerous theories have mushroomed around the globe to decscribe and make sense of this disorder while multiple models of treatment have been suggested based on these theories. A theory is applied to explain or predict the existence of a system whereas a model is a description or a representation of a system (West, 2006). In order for treatment of any illness to be optimised and outcomes enhanced, it is important to understand the rationale and logic for the theories.

Stepney (1996) argued that in daily use, substance dependency is very much concerned with moral and medical aspects of drug use, comparing it to either an infringement of moral values or utilisation for medicinal purposes. Tiffany (1990) describes drug use from a 'habit theory' point of view deriving his model from cognitive theories of automatic versus controlled information processing. He suggested that drug use is related to "cognitive, behavioural, motor and autonomic responses stored in long term memory as fully integrated semi automatic processes" (Newlin & Strubler, 2007, p. 509).

Ajzen and Fishbein (1980) on the other hand, formulated The Theory of Reasoned Action (TRA) to suggest that the best predictor of behaviour is intention, which is the cognitive representation of the willingness to act. An additional determinant of behaviour was added to the TRA model; Perceived Behavioural Control (PBC) and TRA was renamed the Theory of Planned Behaviour (TPB; Ajzen, 1991). PBC is described as '..an individual's perceptions of control over behavioural performance in the face of internal and external barriers' (Cooke & French, 2008). TRA has been applied to studies on the use of alcohol, tobacco and other drugs. TRA and TPB have been extensively applied to predict health behaviour (Cooke & French, 2008).

From a philosophical viewpoint, the concept of 'self' was introduced with 'addiction' as an ideology (Erickson, 2007). This concept claimed that addiction is an act of choice and the addict makes a voluntary decision to indulge in the habit.

The disease theories

In the 1960s, the American Medical Association declared alcoholism (which was the more popular substance dependency issue at that point of time) as a 'disease'. (Erickson, 2005). The disease model was used to explain why people addicted to one form of a substance may have histories of addiction to other forms of substances as well (Peele, 1985). This led to the understanding of narcotic addiction as caused by a predisposition to develop the dependency due to inbred endorphin deficiency in the substance abuser (Peele, 1985).

The social-psychological concept of substance dependency was explained with the neurological adaptation resulting from 'self-induced changes in neurotransmission' (Peele, 1985). Involuntary factors were noted with acts of volition with addiction, such as the fact that although initiation is voluntary, there is a predisposition to dependency caused by genetic factors (McLellan, Lewis, O'Brien, & Kleber, 2000). Leshner (1997) stated that there was enough scientific evidence gathered over 20 years to affirm addiction as a chronic, medical brain disease. Following this, scientists began to apply terms such as disorder, illness (Erickson, 2007; McLellan, et al., 2000) and syndrome based on consistent research and data gathered on addiction.

The behavioural theories

Addiction has also been conceptualised as progressing from impulsivity to compulsivity within the vicious cycle of dependency (Erickson, 2007; Koob, 2003). Addicts are impulsive by nature and tend to respond to triggers or cures by giving into the addiction. Over a prolonged period of time, this cycle turns impulsivity into a compulsive behavioru as a result of the conditioning nature of repeated use.

Conditioning theories express substance dependency as that of a highly rewarding behaviour. Reinforcement behaviour models have been extensively applied with behavioural addiction such as gambling, overeating and other forms of non- substance as well as psychoactive drugs (Peele, 1985). There is a strong 'motivational' feature of addiction where there is positive reinforcement due to pleasure or satisfaction experienced (Koob, 2003). Negative reinforcement caused by the negative experience of the dependent when the drug is removed or when he or she experiences uncomfortable emotions, such as anxiety, discomfort and irritability further reinforces the need for the drug (Erickson, 2007).

Addiction has been a battle field of various theories and models with regards to its origin, treatment and

goals (Mc Mahon, 2008). Much of the literature pertaining to substance abuse and dependency indicate that "…the etiology of drug abuse is multifactorial and complex. All the pharmacological and environmental, social and psychological factors play an important part in one way or another in the initiation of drug seeking behaviour" (Ong, 1989, p. 65). In order to achieve a proper model for treatment, it is crucial to blend the pharmacological, experiential, cultural, situational and personality components to best define and describe the motivation towards addiction (Peele, 1985). Reviews of studies on heroin addiction also shared similar opinions on the multiple causation to dependency model (Ong, 1989).

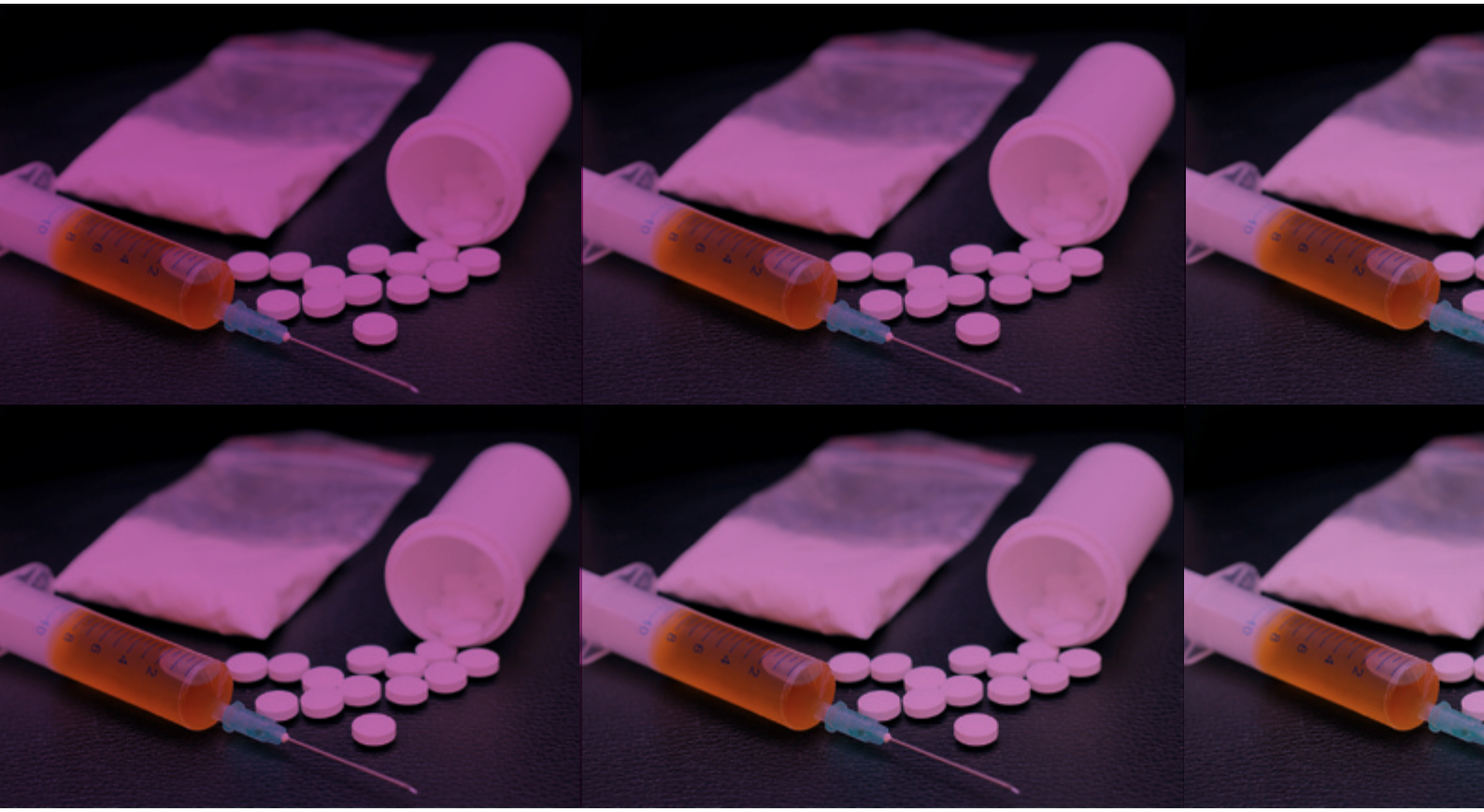
Though these models of addiction provided for an understanding of the onset of dependency, what they failed to show was the cause of the prevalence of the dependent behaviour despite serious adverse consequences. The argument that motivation and specific concepts of biological influences played an important role in the addictive cycle was explained through some of the models but it neglected to prove the combination of internal and external influences such as the biological, psychological and social factors. Engel (1977) introduced the biopsychosocial model which posits the influences of biological and psychological (referring to emotions and behaviours) along with social factors having a stronghold on diseases and illnesses. In order to explain and describe the ideology of a relapsing compulsive behaviour, such as substance dependency, this missing link of an integrated psychosocial model needs to be identified and addressed in order to obtain a successful treatment plan.

Theories in psychology were very much fulfilling the 'sensitising role' in generating ideas to help better understanding (West, 2006). It is arguable that theories are derived for the sake of trying to prove the point or a hypothesis of the researcher and may be conveniently structured or framed for this purpose. In time theories fade away and researchers accept the ideology of multiple theoretical approaches as acceptable and applicable (West, 2006).

Solace Prime is a treament programme developed for both substance as well as behavioural addiction. Multiple causations were considered when the theoretical models influencing addiction were taken into consideration to design Solace Prime. The biopsychosocial model influencing addictions was introduced by Engel (1977) while APA (2013) suggested another important component to this model, spirituality. Spirituality in this context is defined as moral values, self esteem, morale and belief in a Higher Power greater than self. During active addictions people tend to get very self absorbed and generally "selfish" in their needs. These are periods where values are lost and addiction takes over the individual's spirituality. This is sometimes known as becoming"spiritually bankrupt", therefore in treatment the concept of spirituality and gaining back the lost morality is crucial.

Solace Prime was developed based on the BioPsychoSocioSpiritual models. Treatment is targeted with each model employing various counselling techniques such as Cognitive Behavioural Therapy (CBT), Rational Emotive Behavioural Therapy (REBT), Solution Focused Behavioural Therapy (SFBT) and Mindfulness. It is important to appreciate the fact that there is no one technique that fits all and people respond differently. There are may claims that CBT is the best arppraoch to employ when working with addicts but the actual fact is that CBT is the most researched technique and therefore evidence points towards this form of counselling as being better.

In order to asertain that the treatment approach is customised to the needs of each guest, the Transtheoretical stages of change model (Prochaska & DiClementi, 1997) is used as the framework of the



treatment model. This helps to identify which stage of change each individual is at when coming into treatment. Finally, in order to achieve a holistic approach of treatment, physical activities complement the programme. Outdoor and indoor physical activities are introduced in order to help clients learn to feel rewarded by normal pleasure in life and not have the need to use chemical or behavioural stimulants to feel rewarded.

Dr Prem Kumar Shanmugam, Solace Sabah, Malaysia. www.solacesabah.com.

Dr Prem Kumar Shanmugam is Programme and Clinical Consultant with The Cabin Chiang Mai. He is one of the founding members and Regional Director of the Asia Pacific Certification Board (APCB). APCB is actively involved in credentialing addiction counsellors / therapists around the Asia Pacific Region. He also acts as the Vice President of the Psychotherapy and Counselling Association of Singapore while being one of the founding members as well.

Prem is an independent researcher, an active facilitator, trainer and an excellent presenter working with people with issues from all walks of life exposed to multicultural settings. He specialises in developing substance abuse treatment programmes and conducting group therapy. He is actively involved in lectures, research and programme evaluation on psychosocial treatment programmes for substance abusers. He brings with him vast experience in working with relationship issues, marital counselling, interpersonal issues and substance abuse counselling. He is a certified practitioner in Management of Family Violence Counselling (Ministry of Community Development Youth and Sports Singapore). Prem is a Certified Masters Addictions Therapist (APCB Singapore), a Certified Masters Psychotherapist (APACS Singapore) and an Accredited Clinical Supervisor (Australian Counselling Association and Association of Psychotherapists and Counsellors Singapore).

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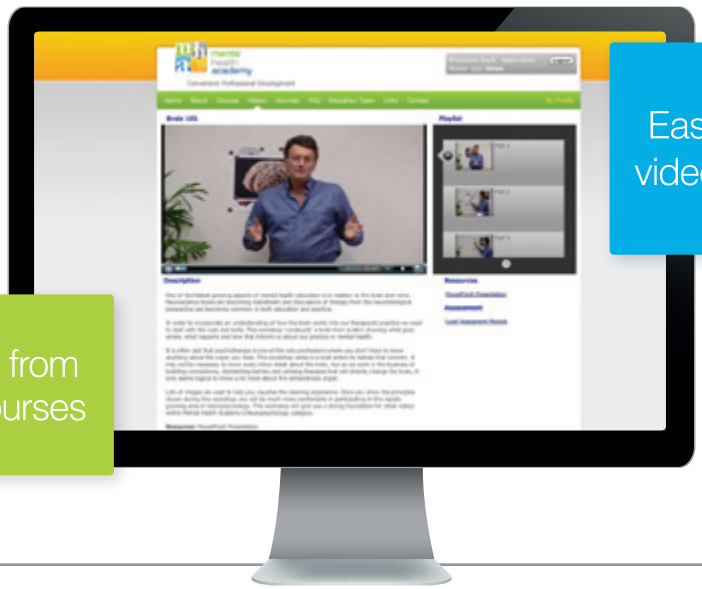

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Will is a central concept in the psychology of Psychosynthesis founder, Roberto Assagioli, who described will as operative on personal, transpersonal, and universal levels. This course is particularly oriented to those in the helping professions who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

Overview of the Principal Personality Tests

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

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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.

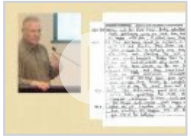
Brief Counseling: The Basic Skills

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

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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VICTORIAN 2014 MENTAL HEALTH ACT

Analysis of the legal context for clinical counsellors

By Mihajlo Glamcevski

PEER REVIEWED ARTICLE

This article will examine the *Mental Health Act 2014* of Victorian (Victoria State Government, 2014a) (from here on referred to as The Act), as it is one of the newest in the nation and considered progressive by many practitioners and policy makers. The article will look at the legal context of the Act, with reference to human rights and disability laws; how the Act manifests in social policy to improve well being of mental health populations with reference to recovery-oriented frameworks, minimising compulsory treatment, and increased safeguards to protect people's rights and dignity; and an overview of the core knowledge, skills and values Clinical Counsellors need to work effectively under the Act.

Legal context

For the profession of counselling, often the law directs public policy and provides guidelines on services provided to the public (Thompson, 2009). The Act influences and directs social policy and institution's activity, which in turn influences and guides actual practice for Clinical Counsellors. Therefore having a working knowledge of the legal context of the Act can be essential knowledge for Clinical Counsellors.

The Act is legislation that is forged in a legal context by many documents that guide, direct and influence. There are a range of legal and pseudo-legal documents that influence and direct the Act. For instance, The Roadmap for National Mental Health Reform 2012–2022 is produced by the Commonwealth (Council of Australian Governments, 2012) and is reviewed by the state governments who use it to produce detailed plan for the states. Another example is the *Federal Disability Discrimination Act* 1992, which provides protection people against discrimination. The definition of disability is broad and includes such impairments as physical, intellectual, psychiatric, sensory, and neurological (*Disability Discrimination Act* 1992), which have influence over defining the Act.

Implementing the mental health legislation requires that other legislation and these pseudo-legal documents are not violated, that human rights are maintained and discrimination is avoided. Clinical Counsellors, who provide service and in turn implement the Act need to have a good working knowledge of the Act. Importantly, the Act provides for the assessment, detention and compulsory treatment of people with severe mental illness (Victoria State Government, 2014a).

In the circumstances of compulsory treatment, Clinical Counsellors (and others) need to know legal application and least possible restrictive manner to protect vulnerable people and this includes limiting some of their rights (Victoria State Government, 2014a).

The former *Victorian Mental Health Act* (Victoria State Government, 1986) was almost 30 years old and not well aligned with contempory international and national laws (Rees, 2009). The Act attempts to reflect the advances in the area of mental health over this time and is primarily based on the National Mental Health standards (Victorian Government Department of Health, 2011). Notably it is consistent with the key legislation, documents and initiatives such as the Victorian Charter of Human Rights and Responsibilities Act, the United Nations Conventions on the rights of people with disabilities, current state and national recovery-oriented practice frameworks, and the rights of children (Victoria State Government, 2014b). A key feature of the Act is its intention to strengthen and support the human rights for people with mental illness.

Manifest in social policy

Social policy is defined by Jamrozik (2009) as actions and decisions of governmental bodies that that are geared towards improving the wellbeing of the population and individuals. It involves policy areas such as social security and welfare, disability, health, education, employment services, Indigenous peoples, community services and child protection.

In can be assumed or drawn from logic that when policy, organisational values and social work values align that 'best practice for the times' is achieved. Up until the 1950s in Australia, generally government funded institutions housed those with mental illness that were 'required' to be separated from the community for protective reasons (Thompson, 2009). From the 1970s Australia government policy began directing a move to de-institutionalisation (Thompson, 2009). However, there was lack of strong consistent government policy on mental health until the 1990s (Thompson, 2009; Rees, 2009). Thus social policy was 'honeycombed' and although there was clear direction for normalising and maintaining human rights for people with mental illness, it often lacked traction (Rees, 2009).

The Act manifested in social policy by outlining reforms from the old 1986 *Mental Health Act,* by incorporating a range of legal and pseudo-legal documents' recommendations that influence and directs how to improve the wellbeing of the population and individuals affected by mental health issues, while in the care of mental health providers.

The key reforms of the Act, that have had significant impact on social policy are a recovery-oriented framework for treatment including: built into the system (framework) new options for consumers aimed to engage in supported decision making (Victorian Government Dept. of Health 2014); a very strong focus on limiting (where appropriate) compulsory treatment, and when it is used, that it is for the minimal duration, theleast restrictive and least intrusive manner possible; a range of new and improved safeguards to protect people's rights and dignit such as the establishment of an independent Mental Health Tribunal, limitations on restrictive interventions and so on; and, in addition, enhanced oversight and service improvement such as Mental Health Complaints Commissioner and appointment of a Chief Psychiatrist.

How this legislative manifests in social policy is imperative to the profession of Clinical Counsellors to comprehend. The reasoning is captured eloquently in points from the Australian Association of Social Workers (2013):

- •understanding of the impact of socio-political, economic and environmental factors on individuals, communities and groups;
- understanding of the impact of inequality, disadvantage and discrimination;
- knowledge of the micro and macro levels of policy and social systems and their impacts; and
- knowledge and understanding of the legislative context of their practice.

Knowledge, skills and values

Policy and legislation provides the framework in which practice actions and judgements can be made and evaluated. The Act provides this framework for Clinical Counsellors (and other professionals) within the mental health realm. Thompson (2009) points out the study of law and policy is a key component to effective mental health practice because it influences, directs judgements and service delivery to the community and individuals. Therefore, it seem imperative that Clinical Counsellors need a well developed knowledge of the Act. This assists them to direct/guide skills and evaluate values for servicing mental health populations.

In reviewing the knowledge and skills required for a Clinical Counsellor to work effectively and appropriately under the Act, the core values of the Act need to be reflected at the practice level. Clinical Counsellors employing the Act need to: have well developed assessment skills for those with severe mental illness i.e. an excellent knowledge of DSM, as this is what the Act was developed to deal with; understand the application of the least restrictive manner to protect vulnerable people i.e. behavioural management, behavioural support skills, de-escalation and negotiation skills, as well as being able to determine when these skills are not applicable; and be conversant with

laws, rights, and process for detention and compulsory treatment of people with severe mental illness. In accordance with the Act Clinical Counsellors will require well developed skills in recovery-oriented frameworks and apply options for consumers to engage in supported decision-making.

Generally the Clinical Counsellors need to evaluate the situation according to the cultural context, inappropriateness, values of the individual and system as well as risk of harm. The Act attempts to help guide social policy which in turns helps Clinical Counsellors determine limits and application in the field. For example, is a person hearing voices, psychotic in nature, and homeless and dishevelled in Melbourne in middle of winter, in need of treatment? However, an assessment for severe mental health issues is required and consumer participation is one of the highest priorities for treatment. The Act helps regulate and provide guidance. In this, it is considered progressive and in accordance with current ideologies.

Conclusion

The Act can be seen as four decades of continual progression for rights of those with mental illness. It is based on the main ideologies that permeate mental health services. Nevertheless, there was other infrastructure and pseudo-legal documents to support its development.

The Act has had clear impacts on social policy especially in regards to a recovery-oriented framework, options for consumers to engage in supported decision making, and limiting compulsory treatment in accordance with the least restrictive and least intrusive manner possible. It has provided for a range of new and improved safeguards to protect people's rights and dignity and enhanced oversight and service improvement.

Clinical Counsellors need to understand the application and limits of the Act and social policy to deliver services. This also includes understanding the social political climate, the intent, process and limitations (fund/resources) of the Act as a regulatory and supportive framework.

Mihajlo T Glamcevski II G.Dip.PSY, G.Dip. Appl.Sc (Counselling).

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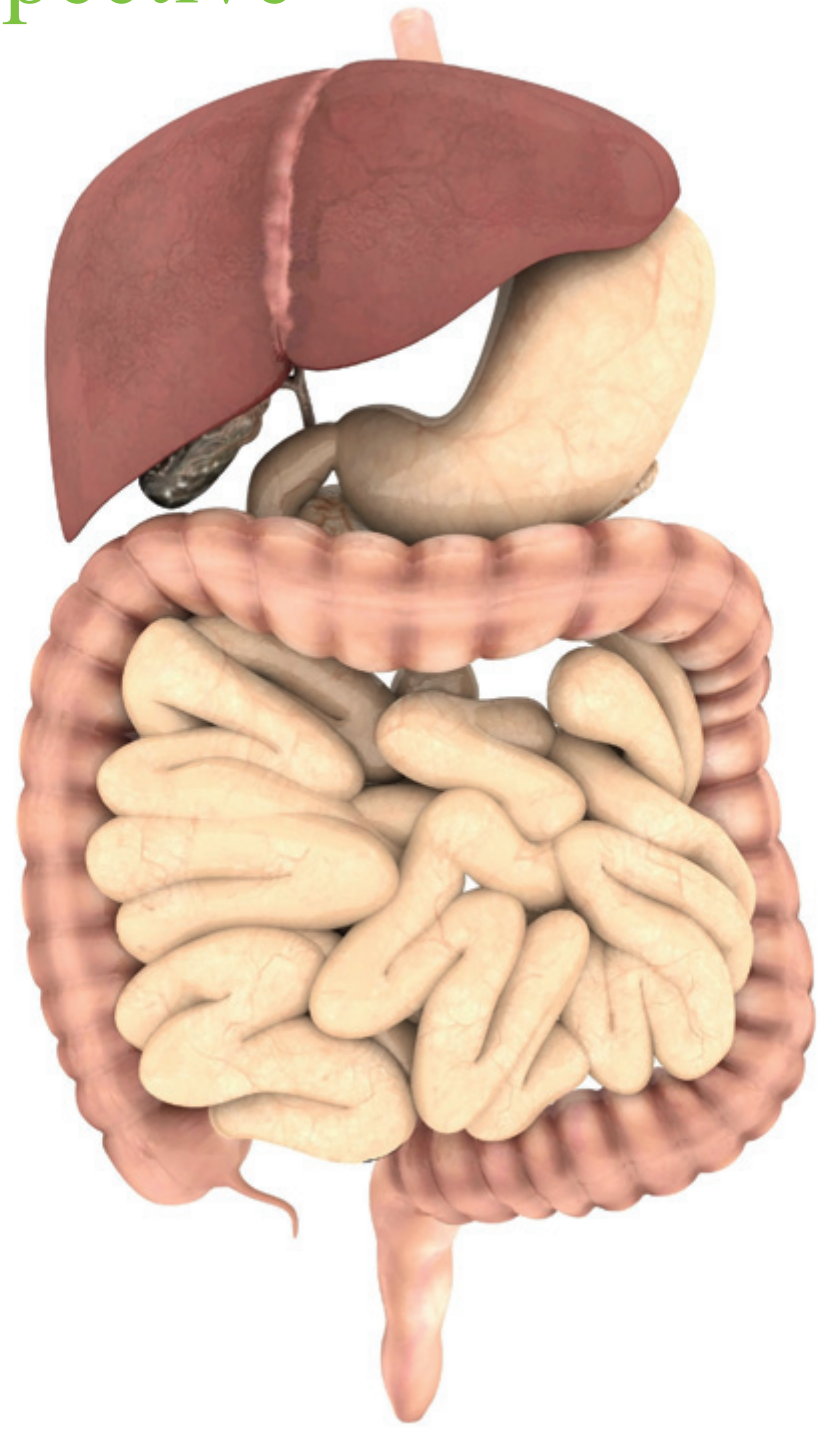
The gastrointestinal tract, nutraceuticals and attenuation of resistant major depressive illness: A perspective

By Dr Matthew Bambling
and Professor Luis Vitetta

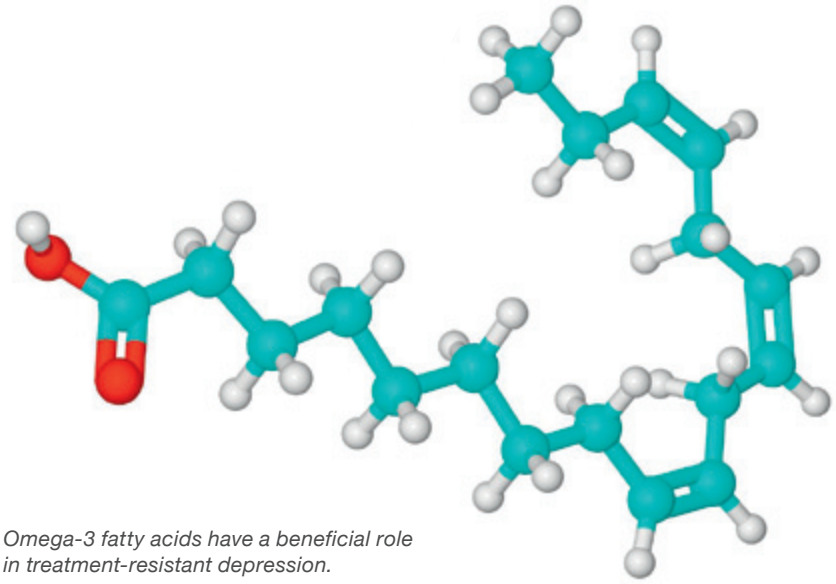


Mental health is closely linked to physical health and depression is highly prevalent worldwide and a major cause of disability. In a sub-group with treatment–resistant depression standard pharmacotherapy interventions provide small if any incremental improvement in patient outcomes and may also require the application of an alternate approach. Therefore in addition to the standard pharmacotherapies prescribed, patients will also be advised on the benefits of psychological counselling, and increasing physical activity and reducing harmful substance consumption. Certain nutraceuticals have a beneficial role in treatment-resistant depression and include, herbal medicines of which *Hypericum perforatum* is the best studied, omega–3 fatty acid preparations, various mineral formulations (e.g., magnesium), folate (B group vitamins) are prescribed to a lesser extent.

However, treatment-resistant depression has a sub-optimal response to efficacious alternative approaches. A novel approach is to combine select nutraceuticals such as S–Adenosyl–L–Methionine (SAMe) or Orotic Acid and antidepressant medication. Some of our published data on the administration of (SAMe) and Orotic Acid as an adjuvant to SSRI medication is discussed. Furthermore, a largely neglected area of research activity has been the role of dysbiosis (a gut barrier–associated abnormality) in the gastrointestinal tract (GIT) and targeting its repair with live probiotic cultures with or without prebiotics. We progress a hypothesis that implicates the microbiome as an important target for the adjuvant treatment of resistant depression.

Depression is a highly prevalent mental health problem, with the burden of care second only to heart disease. At least 350 million people worldwide live with depression and it is now the leading global cause of disability irrespective of gender and age.[1] Lifetime prevalence rates for depression in the Australian community have been estimated at 25 % for females and 12 % for males.[2] Antidepressant medication treatment assists with acute episodes; however, its efficacy is relatively poor for chronic depressive illness, with 40 % relapsing within 15 weeks.[3,4,5] Many patients experience multiple depressive episodes of increasing frequency and duration and are considered to have a sub-optimal response to current pharmacological treatments. Studies of 15-year follow-up have found that one-fifth of depressed patients remain incapacitated or commit suicide.[6,7] Suicide, for which depression is the highest risk factor of morbidity, is an outcome that highlights the lack of effective treatment.[8,9,10]

The clinical response to antidepressant medication is complex. Pharmacotherapy achieves acceptable results for about 30 % of patients, mixed results for 40 % and poor results for 30 % of patients.[11] It has been reported that when the mixed medication response group is taken into account the majority of depressed patients will not experience clinical remission for their depression.[12] Sub-optimal responders often have a complex psychiatric and physical presentation which may be better thought of as an imbalance in neurophysiology and associated comorbid physical health problems. Most antidepressants act upon monoamines (primarily norepinephrine [NE] and serotonin [5HT]) and much of the research has focused upon interactions between these neurotransmitters and their reuptake and receptor proteins. Response to antidepressant medication is slow, often requiring weeks to months before any symptom response despite immediate effects on brain monoamine transmission. The variable response to medication suggests that the monoamine augment is insufficient and other mechanisms may be involved in symptom remission.[13,12] More recently, there has been an acknowledgement of the importance of intracellular mechanisms involved with response to antidepressant treatments. Alterations of brain phospholipid composition and membrane fluidity can affect extracellular processes such as neurotransmitter–receptor binding, intracellular processes such as signal transduction and mitochondrial function, as well as eicosanoid-mediated processes, which may underlie mood disorders.[13,12]

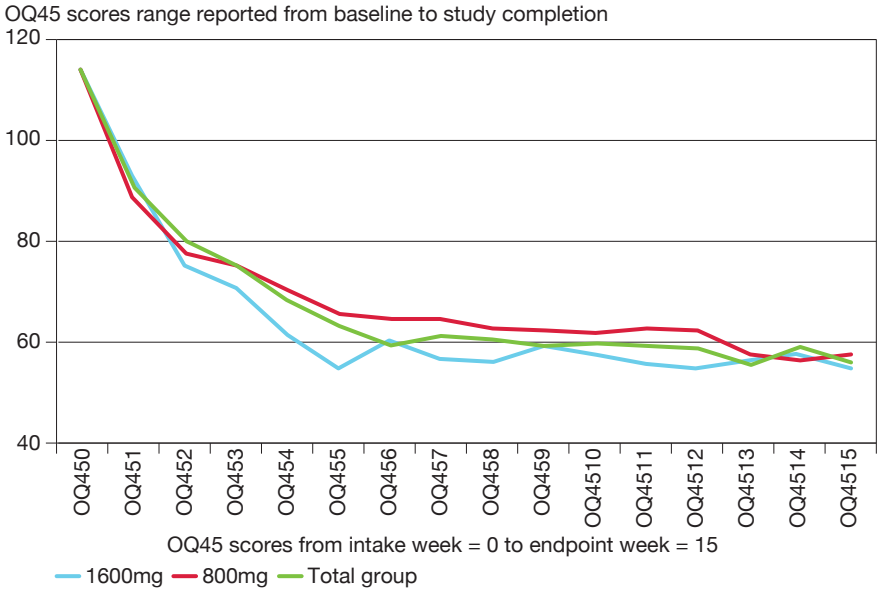


Omega-3 fatty acids have a beneficial role in treatment-resistant depression.

Of interest is that sub-optimal treatment response is often accompanied by systemic inflammatory states that are reported to originate from GIT inflammation or break down of the GIT barrier known as dysbiosis.[14] Dysfunction of the GIT microbiome is likely involved in depression and impaired immunomodulation. However, this is a contentious issue because of the indirect measurements that have been reported.14-18 Depression has been reported as accompanied by activation of immune–inflammatory pathways, and increased IgM/IgA responses to LPS of gram-negative commensal bacteria, and autoimmune reactions directed against O and NS-modified neopepitopes. As the peripheral nervous system (PNS) and central nervous system (CNS) have a bi-directional relationship there is also an effect on neuronal intracellular metabolism generating inflammatory states as indicated by impaired hippocampal protein synthesis in dysbiosed animal models. This indicates that depression may be at least in part created by bacterial translocation.[15]

GIT bacteria manufacture and secrete a range of neurochemicals. A non-

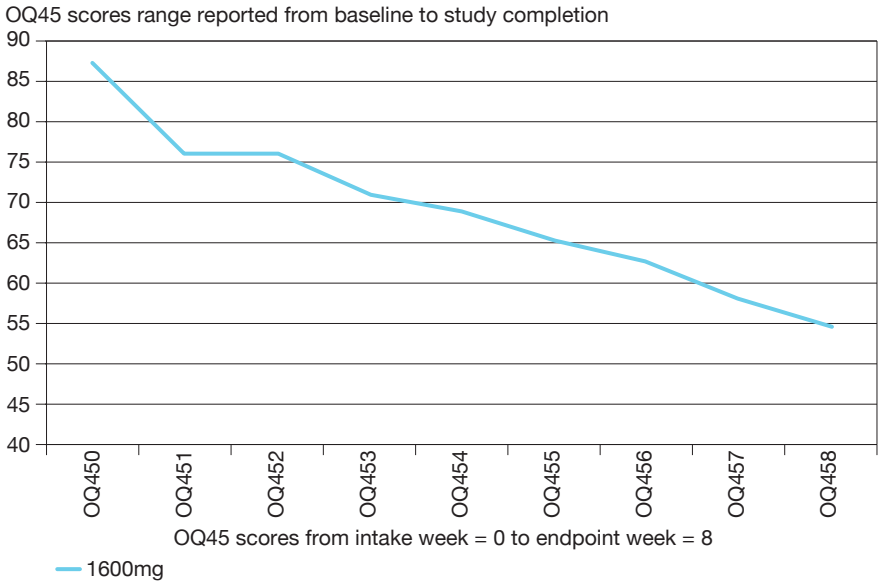
FIGURE 1 SAMe weekly interval symptom response scores on the outcome questionnaire (OQ45) clinical cut off = 63 and scores over 80 indicate significant symptom distress.



exhaustive list includes certain strains of Lactobacilli and Bifidobacteria that secrete gammaaminobutyric acid (GABA)[16] which is an inhibitory neurotransmitter and when under expressed is implicated in anxiety and depression.[19] Known subspecies of Lactobacilli produce the essential neurotransmitter acetylcholine, which is implicated in memory, concentration, learning, and mood.[20] Serotonin (5-HT) is a metabolite of tryptophan and is implicated as a central mood regulating neurotransmitter.[21] Candida, Streptococcus, Escherichia, and Enterococcus produce serotonin, while Bacillus and Serratia have the potential to produce dopamine, which is involved in a host of cognitive and mood functions.[22]

The stability and relationship between these classes of bacteria is relatively fragile and imbalance can lead to dysbiosis. Dysbiosis has been associated with higher anxiety and mood problems in animal models and reduced hippocampal protein synthesis which returns to normal with the correction of dysbiosis. Likewise, chronic stress that is often involved with the onset of depression can cause bacterial translocation and dysbiosis, which corrects with the removal or adaption to stressors. Therefore the microbiome is sensitive not just to environment but also to the host emotional state and behaviour.

FIGURE 2 Magnesium Orotate weekly interval symptom response scores OQ45 clinical cut off = 63 and scores over 80 indicate significant symptom distress.



A healthy microbiome and GIT is also important for optimal absorption of therapeutic compounds and the production of metabolites and it is plausible that metabolites of many therapeutic agents may be important to effectiveness. It is likely that the microbiome has a complex relationship with PNS and CNS feedback, as well as metabolilsation and absorption of compounds that may improve mood. Therefore, an impaired microbiome function may have an independent role in the development of depression and response to treatment.

In our previous pilot research[23] (n=36) we attempted to influence neurotransmitter synthesis and receptor signalling using SAMe. SAMe is a common co-substrate

Certain nutraceuticals have a beneficial role in treatment-resistant depression and include herbal medicines of which Hypericum perforatum (St John's Wort) is the best studied.

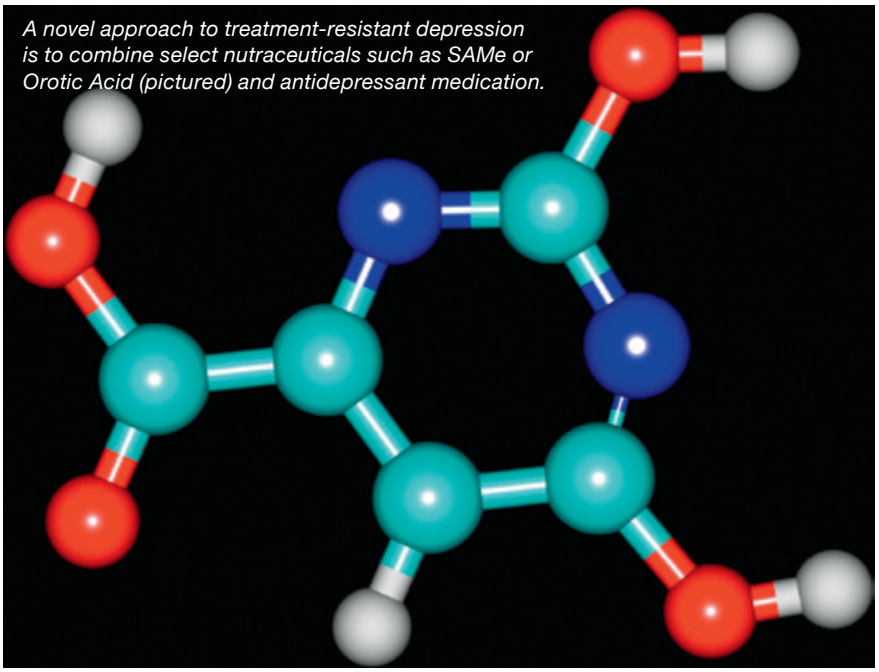
TABLE 1[26] DEVELOPED BY VITETTA 2014.

Studies implicating specific probiotic strains in correcting or enhancing mood and/or markers of cognitive function

Participant type	Study type (number of patients)	Treatment	Duration results (weekly)	References
Anxiety-depressive symptoms	PCT (123)	10^8 CFU/capsule *L. casei*/65 mL/i.o.d.	Improvement in mood scores	Benton et al. (2007)
Chronic fatigue syndrome	PCT (39)	8 x 10^7 CFU/sachet *L. casei* strain Shirota/t.i.d.	↑ Fecal total Bifidobacteria and Lactobacillus ↓ Anxiety symptoms	Rao et al. (2009)
Healthy adults	DBPCT (25)	3 x 10^9 CFU/sachet *L. helveticus* R0052/ 3 x 10^9CFU/cap *B. longum* R0175/i.o.d.	↓ Behaviours indicative of anxiety	Messaoudi et al. (2011)
Traumatic brain injury	SBCT (52)	0.5 x 10^8CFU/sachet *B. longum*/ 0.5 x 10^7 CFU/sachet *L. bulgaricus* 0.5 x 10^7 CFU/cap *S. thermophiles*/ t.i.d.	Adjustment of the Th1/Th2 imbalance ↓ Infection rate ↓ Use of antibiotics ↓ Level of IL-12	Tan et al. (2011)
Healthy women with no gastrointestinal psychiatric symptoms	DBPCT (36)	1.2 x10^9 CFU/cup *S. thermophiles* *L. bulgaricus*/b.i.d.	↓ Task-related response of a distributed functional	Tillisch et al. (2013)

involved in methyl group transfers and works at least as well as antidepressant medication for treatment responders and we co-administered it with SSRI medication due to its different mechanisms of action. When delivered with SSRIs in the range of 800–1600 mg per day to sub-optimal treatment responders there was a 36 % remission rate with good symptom maintenance at 15 weeks.[23,24]

We then trialled 1600mg daily of magnesium Orotate with those patients that did not respond to SAMe + SSRI (n=8) for a 2 month period. Orotic acid is available as a salt complexed with magnesium, calcium, potassium or zinc ions. It is safe and inexpensive and rapidly increases uridine synthesis in a dose dependent manner. Uridine has proven antidepressant effects in analogue animal models and show efficacy for children with bipolar disorder in the depressive phase. Orotate phosphoribosyl transferase and orotidine-5'-decarboxylase are enzymes responsible for catalysing the formation of uridine monophosphate (UMP). Orotic acid is nearly structurally identical to uracil is taken up efficiently by cells via the uracil transporter. In addition to uridine synthesis, Orotic acid participates in numerous cellular metabolic activities such as participating in RNA and DNA synthesis and altering cell metabolism i.e. increasing carnosine levels, mediating inflammatory processes, and increasing cerebral blood flow, however the implications for depression is unknown. Magnesium facilitates the absorption and conversion of orotate and represents a cost effective and readily available standardized product that is suitable for research use to modulate uridine metabolism. Results of our Mg Orotate trial were symptom remission for 50% of the group and significant improvement of mood for 40% of the group.[23]



A novel approach to treatment-resistant depression is to combine select nutraceuticals such as SAMe or Orotic Acid (pictured) and antidepressant medication.

We consider that both treatment response and non-response implicates dysbiosis due to prevalence inflammatory-based co-morbid health problems reported in our cohort and the anti-inflammatory actions of SAMe and Orotic acid. SAMe is made in small amount by the microbiome (certain sub-species) and has potent anti-inflammatory effects and may have GIT specific actions in addition to a system wide reduction of inflammatory mediators by several mechanisms including down regulating pro-inflammatory bacteria or by-products in the GIT, increasing

levels of glutathione and direct or indirect signalling of growth factors.[25] Orotic acid is made in large amounts in the microbiome and has a known role in neuro and endocrine receptor modulation which is likely impaired by dysbiosis. Likewise, SAMe and its metabolites may modulate neuro and endocrine receptors in the GIT and have an anti-inflammatory action directly impacting some classes of pro-inflammatory bacteria or blocking at the action of by-products and favorably modulate hypothalamic-pituitary-adrenal (HPA) functioning via the GIT independent of effects once absorbed. In this way, SAMe and Orotic acid may modestly reduce GIT inflammation, improve GIT integrity and treatment response in resistant cases. Therefore, an impaired GIT may be involved in sub-optimal response to oral treatments due to inflammation, impaired absorption and impaired receptor signalling.[23]

Correcting dysbiosis

Correcting dysbiosis in people with depression may not be as simple as a general probiotic treatment such as eating yogurt. It should be noted that probiotic bacteria encompass examples from different genera (e.g., Bifidobacteria, Lactobacilli, Escherichia Streptococcus or Saccharomyces (a yeast) recognising that there exists a variety of different species of each genera (e.g., Lactobacillus acidophilus; Lactobacillus bulgaricus, Lactobacillus rhamnosus); and as such, lead to different strains within a species (e.g., L. acidophilus La-1, L. acidophilus NCFM). This taxonomic differentiation critically emphasizes that different strains from the same bacterial species may exhibit different metabolic activities and therefore may elaborate different physiological functions within the GIT whilst expressing overlapping or specific therapeutic actions to different organ systems.[26] The emerging evidence proposes that there are more genes encoding regulatory RNAs in the microbiome than those that encode proteins in them human genome.[27] In bacteria, it is well known that RNA molecules serve a wide range of regulatory functions and can modulate almost every facet of cellular metabolic function.[28] RNA regulators have been reported to participate in numerous cellular physiological actions and defence mechanisms. Research is required to better understand the mechanisms of actions in relation to mood, as well as optimal forms of probiotics/prebiotics and the delivery methods administered to ensure beneficial effects on the gastrointestinal tract.

Some strains that will correct dysbiosis and have a positive impact on mood and anxiety are Lactobacilli which in dysbiosed rat model, increased GABA which influenced signalling via the vagus nerve normalizing behaviour and immune activity.[18] In this study, probiotic treated anxious dysbiosed mice showed lower levels of anxiety, fear, and decreased stress hormones. While there is a lack of human studies, it is plausible that probiotics may improve symptoms of depression[29] through anti-inflammatory actions and an ensuring reduction in hypothalamic-pituitary adrenal axis activity. There are only a few clinical trials that have investigated the administration of live bacterial cultures on brain functionality (Table 1). Three studies investigated mood and behavioral changes with probiotics[30,31,32] and two other studies reported the use of probiotics in subjects diagnosed with chronic fatigue[33] and head injuries. The three human studies reported beneficial psychological effects. These studies add weight to the hypothesis that the health of the GIT microbiota is important for mental health and that there is scope for its beneficial modulation. See Table 1 for probiotic strains that may improve mood and anxiety.

Conclusion

Patients who have a suboptimal response to medications experience a high degree of chronicity and impaired function in life for which there are limited tolerable effective treatment options. Efforts to identify key mechanisms in the etiology of this chronic disorder are needed. Identifying effective and safe treatments for people with depression who do not respond to standard treatments have great value to assist people to remain independent, employed and to maintain their significant relationships. SAMe and Orotic Acid represents a potential step forward in the treatment of resistant depression and more research is required with larger clinical trials to examine issues such as dosage and long term efficacy. The increased awareness of the microbiome as a determinant of healthy nervous system functioning represents a largely un-explored avenue for influencing mental health. However, we consider gut dysbiosis as an important causal mechanism in resistant depression and may help to explain treatment

non-response, and probiotics represent an important potential adjuvant pre-treatment for a variety of biological or psychological treatments.

The genomic pool provided by the eukaryotic human nuclear genome in addition to the human microbiota together harbour more than nine million specific genes that control a multitude of metabolic functions. The sheer volume of genetic information provides endless possibilities for microbiome and human nuclear genome interaction. There is little doubt that GIT microbiome acts as an important biosensor for the production of numerous critical metabolites influencing homeostatic control and therefore the efficacy of therapeutic compounds in mood disturbances. An enhanced understanding of the mechanisms of actions in relation to mood will depend on the optimal forms of probiotics administered and the delivery methods employed to ensure beneficial effects on the gastrointestinal tract that may then translate to a positive effect on mood in extra–intestinal organ such as the brain.

Dr Matthew Bambling is employed by the University of Queensland School of Medicine where he undertakes a variety of roles including coordinating the post graduate programs in mental health, teaching and research. He is internationally recognised for his early research work in the psychological treatment of depression and the outcomes of clinical supervision.

Professor Luis Vitetta The University of Sydney, Sydney Medical School, Sydney, Australia & Medlab Clinical Ltd, Sydney, Australia

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Mijin Seo - Kim	Downer	02 6255 4597	Upon Enquiry	FTF
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Brenda Searle	Canberra Region	0406 376 302	$100 to $130	FTF/PH/GRP/WEB
NEW SOUTH WALES				
Yvonne Aldred	Albury	0439 820 945	Upon Enquiry	FTF
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Sandra Bowden	Bateau Bay/Central Coast	0438 291 874	$70	FTF
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Lorraine Dailey	Maroota	0416 081 882	Upon Enquiry	FTF/PH/GRP/WEB
Karen Daniel	Turramurra	02 9449 7121 or 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 or 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 or 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/Lake Macquarie	0412 736 240	$120 (contact for sliding scales)	FTF/GRP/PH
Anne Larcombe	Wagga Wagga	02 6921 22 95 or 0448 212 295	Upon Enquiry	FTF/GRP/PH/WEB
Gwenyth Lavis	Albury	0428 440 677	Upon Enquiry	FTF/PH

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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
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
Rhondda Stewart	Leichhardt	0419 698 650	Upon Enquiry	FTF
Carol Stuart	Bondi Junction	0293 877 752	$80 pp - % rate $ 50 for early graduates	FTF/GRP/PH/WEB
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
NORTHERN TERRITORY				
Margaret Lambert	Darwin	08 8945 9588 or 0414 459 585	Upon Enquiry	FTF/GRP/PH/WEB
Rian Rombouts	Millner	0439 768 648	Upon Enquiry	FTF
QUEENSLAND				
Lynette Baird	Maroochydore/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
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
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

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Beverley Howarth	Paddington	0420 403 102	Upon Enquiry	FTF/PH/WEB
Kim King	Yeppoon	0434 889 946	Upon Enquiry	FTF
David Kliese	Sippy Downs/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 or 0400 474 425	Upon Enquiry	FTF/GRP/PH/WEB
Judith Morgan	Toowoomba	07 4635 1303 or 0412 372 431	$100	FTF/PH
Diane Newman	Bundaberg West	0410 397 816	Upon Enquiry	FTF/PH
Christine Perry	Bundaberg	0412 604 701	$70	FTF/SKYPE
Penelope Richards	Corinda	0409 284 904	Upon Enquiry	FTF
Veronica Sandall	Cairns	0420 436 460	Upon Enquiry	FTF/PH/GRP/WEB
Yildiz Sethi	Wakerley	07 3390 8039	Indiv $90, Grp $45	FTF/GRP/PH/WEB
William James Sidney	Loganholme	0411 821 755 or 07 3388 0197	Upon Enquiry	FTF/PH/GRP
Deborah Stevens	Kingaroy	0411 661 098	Upon Enquiry	FTF
Frances Taylor	Redland Bay	0415 959 267 or 07 3206 7855	Upon Enquiry	FTF
Pamela Thiel-Paul	Bundall/Gold Coast	0401 205 536	$90	FTF
David Hamilton	Beenleigh	07 3807 7355 or 0430 512 060	Indiv $80, Students $60	FTF/PH/GRP/WEB
Stacey Lloyd	Mount Gravatt	07 3420 4127	Upon Enquiry	FTF
Aisling Fry	Lota	0412 460 104	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 or SMS 0419 859 844	Grp $35, Indiv $99	FTF/PH/GRP/WEB
Laura Wardleworth	Angaston	0417 087 696	Upon Enquiry	FTF
TASMANIA				
David Hayden	Howrah North	0417 581 699	Upon Enquiry	FTF
Benjamin Donald Turale	Hobart	0409 777 026	Upon Enquiry	FTF/PH/WEB

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Joanne Ablett	Phillip Island/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/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
Sheryl Brosnan	Carlton North/Melbourne	03 8319 0975 or 0419 884 793	Upon Enquiry	FTF/GRP/PH/WEB
Sandra Brown	Frankston/Mount Eliza	03 9787 5494 or 0414 545 218	$90	FTF/GRP/PH/WEB
Molly Carlile	Inverloch	0419 579 960	Upon Enquiry	FTF
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 or 03 4444 2511	$60	FTF
Debra Darbyshire	Berwick	0437 735 807	Upon Enquiry	FTF
Linda Davis	Leongatha/Gippsland	0432 448 503	Upon Enquiry	FTF/PH/GRP/WEB
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
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
Kaye Allison Jones	Camberwell	0417 387 500	Upon Enquiry	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	0115 315 431	Upon Enquiry	FTF
Patricia Reilly	Mount Martha/Gardenvale	0401 963 099	Upon Enquiry	FTF
Graeme John Riley	Gladstone Park	03 9338 6271 or 0423 194 985	$85	FTF/WEB
Lynne Rolfe	Berwick	03 9768 9902	Upon Enquiry	FTF
Claire Sargent	Canterbury	0409 438 514	Upon Enquiry	FTF

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Kenneth Robert Scott	Bunyip	03 5629 5775	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 or 0428 655 270	Upon Enquiry	FTF/PH/WEB/GRP
Rosslyn Wilson	Knoxfield	03 9763 0772 or 03 9763 0033	Grp $50 pr hr, Indiv $80	FTF/GRP/PH/WEB
Michael Woolsey	Seaford/Frankston	0419 545 260 or 03 9786 8006	Upon Enquiry	FTF
Joan Wray	(Mobile Service)	0418 574 098	Upon Enquiry	FTF
Mihajlo Glamcevski	Ardeer	0412 847 228	Upon Enquiry	FTF
Andrew Reay	Moorabbin	0433 273 799	Upon Enquiry	FTF
Karen Seinor	Wodonga	0409 777 116	Upon Enquiry	FTF
John Dunn	Colac Sw Area/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
Merrilyn Hughes	Canning Vale	08 9256 3663	Upon Enquiry	FTF/PH/GRP/WEB
Eva Lenz	South Fremantle/Coogee	08 9418 1439 or 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 or 08 9731 5022	$120	FTF/PH/WEB
Lillian Wolfinger	Yokine	08 9345 0387 or 0401 555 140	Upon Enquiry	FTF/PH/WEB
Alan Furlong	Winthrop	0457 324 464	Upon Enquiry	FTF
Phillipa Spibey	Mundijong	0419 040 350	Upon Enquiry	FTF
David Peter Wall	Mundaring	0417 939 784	Upon Enquiry	FTF
INTERNATIONAL				
Natalie Chantagul		N/A	Upon Enquiry	FTF
Karen Heather Civello		N/A	Upon Enquiry	FTF
Dina Chamberlain		+852 6028 9303	Upon Enquiry	FTF
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ACA SUPERVISOR COLLEGE LIST		Medium key: FTF: Face to face | PH: Phone | GRP: Group | WEB: Skype		
Contact	**Suburb**	**Phone Number**	**SUP PP Hourly**	**Medium**
INTERNATIONAL CONTINUED				
Eugnice Yiu Sum Chiu		+852 2116 3733	Upon Enquiry	FTF
Wing Wah Hui		+852 6028 5833	Upon Enquiry	FTF
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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
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Mei Han Leung		N/A	Upon Enquiry	FTF
Lap Kwan Tse		+852 9089 3089	Upon Enquiry	FTF
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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
Abigail Lee		N/A	Upon Enquiry	FTF
Ellis Lee		N/A	Upon Enquiry	FTF
Dan Ng		N/A	Upon Enquiry	FTF
Jeffrey Gim Tee Po		+65 9618 8153	$100.00	FTF/GRP/PH/WEB
Nadia Rahimtoola		+65 9647 1864	Upon Enquiry	FTF
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

SUBMISSION GUIDELINES

WANT TO BE PUBLISHED?

Submitting your articles to *Counselling Australia*

About *Counselling Australia*

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

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

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

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

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

Editorial policy

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

Previously published articles

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

Articles for peer review (refereed)

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

Conditions

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

Deadline

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

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Regional NSW	|	1800 625 329
Regional QLD	|	1800 359 565
Gold Coast	|	1800 625 329
NT/Tasmania	|	1800 353 643

Australian Institute of Professional Counsellors – www.aipc.edu.au/degree

AIPC

Gain Entry Into An ACA Professional College

With An ACA Accredited Specialty Vocational Graduate Diploma

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

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

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

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

Flexible And Cost Effective

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

- Demonstrate your specialty expertise through ACA College Membership.
- Develop a deeper understanding of your area of interest and achieve more optimal outcomes with your clients.
- A graduate qualification will assist you move up the corporate ladder from practitioner to manager/ supervisor.
- Make the shift from being a generalist practitioner to a specialist.
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