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COUNSELLING AUSTRALIA

Australian Counselling Association Journal
ACA AUSTRALIAN COUNSELLING ASSOCIATION

Counselling Australia's Contributor's Guide for 2002

Counselling Australia is now calling for articles and papers for publication in 2002. Counselling Australia is a peer-reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285). Counselling Australia is designed to inform and to discuss relevant industry issues for practising counsellors, students, and members of the Australian Counselling Association.

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

Counselling Australia has an editorial board of experienced practitioners, trainers and specialists. Articles can be peer-reviewed and refereed, upon the author's request, or simply assessed for appropriateness for publishing by the editor. Non-editorial staff may assess articles if the subject is of such a nature as to require a specialist's opinion.

EDITORIAL POLICY

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

ARTICLES FOR PEER REVIEW (REFEREED).

- Articles are to be submitted with a covering page requesting a peer review;
- The body of the paper must not identify the author;
- Two assessors will read refereed articles and advise the editor on the articles' appropriateness for publication;
- Articles may be returned for rewording, clarification or correction prior to being accepted;
- Attach a separate page, noting your name, experience, qualifications and contact details;
- Articles are to be between 1500 and 4000 words in length;
- Articles are to be submitted in MS Word format via email or floppy disk;
- Articles are to be single-spaced, with minimal formatting.

CONDITIONS

- References are required to support argument and should be listed alphabetically;
- Case studies must include a signed agreement from the client, providing permission for publication. This is to be attached to the article. 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

The 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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Editorial

I hope I find all of our readers safe and looking forward to the challenges of 2002. As we move forward and further away from the last century we face new issues and hopefully resolve old ones.

The primary objective of ACA this year is to initiate or to continue talking to other industries such as the compensation sector and private health funds. We will be informing them of the proven positive effects of counselling and the standards ACA has initiated in the industry. We will be putting forward arguments to convince these industries that it is in their own best interests to provide counsellors with provider numbers and access to rebates. Another objective is to become more involved as a reference and consultation authority for government and non-government bodies involved in the mental health industry. I believe ACA, being the only national professional body of counsellors in Australia with full time management and administration, needs to take on even more of a representative role.

One old issue that has risen again is that of legislation to register/regulate counsellors. Unsubstantiated rumours of counselling in Australia being regulated through legislation still abound. Counselling in Australia is presently a self-regulating industry and according to the government **is not** being reviewed for legislation now nor in the near future. In this issue we look at the other side of the regulation debate, through the work of Richard Mowbray. We have reprinted Mowbray's "Professionalization of therapy by registration is unnecessary, ill advised and damaging", in which he makes a strong argument against registration.

I believe ACA, being the only national professional body of counsellors in Australia with full time management and administration, needs to take on even more of a representative role.

When discussing registration/regulation in this issue we are not talking about a register of qualified members such as ACA has. The discussion relates to setting up a national register that is controlled or regulated by a mandated body and whose membership can become exclusive through their authority to set standards for inclusion on the register. This has the hidden advantage of controlling the market in the provision of training. For example, if the governing body were to be overly represented by counsellors with a vested interest in training, there could exist a strong urge to regulate the profession by setting standards that meet the level of training offered by members of the registration board and thus control the market in the provision of training. This could see the demise of the private provider, TAFE courses and many small private practitioners. A cynic could see this as manipulating market forces to control an industry and even possibly to cull competition.

Many people argue the case for registration without much thought about the possible repercussions. Richard Mowbray will challenge the basis of your ideas. Mowbray is not arguing that the profession be opened up so anyone can practise without appropriate training. What he is arguing is that any attempt to regulate the industry through legislation and thereby setting up one body as the authority (monopoly) can have a detrimental effect on the industry and how we train counsellors. Counsellors in Australia are currently represented by several professional bodies, which in itself acts as a check and balance for the industry. Richard Mowbray challenges us to ask the question "What is wrong with the system we currently have and if we change it is it really for the benefit of the practitioner and public?" ACA

Philip Armstrong

STOP PRESS

PRIVATE HEALTH FUND REBATES FOR ACA COUNSELLORS IN WEST AUSTRALIA

I mentioned last year that I was in communication with some private health providers to have rebates made available to ACA members. Well it is my pleasure to inform you that we have made our first inroads into this issue. It is now **a fact** that health rebates are available for counselling by counsellors as opposed to psychologists. ACA has once again led the industry by not accepting that it could not be done. This is the direct repercussion of ACA's insisting that a profession cannot be represented appropriately without full-time professional management. I hope in the near future to be able to report more funds making rebates available for our members. These rebates are not available for non-ACA members.

ACA has just successfully finished negotiating with the Health Insurance Fund of West Australia. We have successfully negotiated the following:

- The Health Insurance Fund of WA (HIF) will offer a rebate for Relationship Counselling for services on or after the 1st April 2002.
- The Fund is predominately in WA but does have a few hundred members throughout other states of Australia.
- A benefit of $30.00 per hour or part thereof will be payable to eligible members of their two top ancillary covers, ie Premium Options and Super Options.
- The annual limit, per person is: Premium Options $1,000.00 and Super Options, $740.00. This limit is a combined limit and includes Psychological consultations.
- Providers must be registered with HIF for their patients to receive a rebate. Registration is available to Professional and Clinical members of the Australian Counselling Association.
- To apply for registration, please contact HIF for a registration form. Contact details are: HIF Provider Liaison, PO Box X2221 Perth WA 6847. Phone 1300 13 40 60. Facsimile 08 9328 3345. email info@hif.com.au.

This is great news! (Who said it couldn't be done? Probably someone not in ACA). This is the first of what we hope will be many funds that realise the significance of counselling as a health benefit. ACA is currently in contact with other state and national funds and we hope we will be able to make rebates available to all our members sometime in the future. Please ring Philip at the National Office, on (07) 3857 8288, if you have any questions in relation to this rebate. I like to think this success exemplifies our commitment to our members that they belong to an association that leads not follows.

Philip Armstrong *National Manager*

Professionalization of therapy by registration is unnecessary, ill advised and damaging

By Richard Mowbray

*In **The Case Against Psychotherapy Registration** I concluded that*

> the case against statutory psychotherapy registration is, firstly, that the case for it is so poor. 'The case for' fails to stand up to close scrutiny….Secondly, the case against psychotherapy registration is that the effects of it would, on balance, actually be negative and represent a deterioration of the existing situation. This 'treatment' would be worse than the 'disease'. (Mowbray, 1995: 213, original emphasis)

In this chapter, I will summarize the reasons for this assessment.

Statutory registration, also known as licensing, especially in North America, refers to the legal protection of an occupational title (Title Act) or practice (Practice Act) and is the crowning event in the formation of an established profession. This 'legally enshrined closure' (Saks, 1995: 73) confers state-endorsed monopoly powers with all the economic and status advantages that bring for the recipients.

Where I use the term 'registration', I will be referring to statutory registration unless the term is otherwise qualified. However, the arguments that follow are relevant to both statutory and voluntary registers in so far as the latter are intended as preludes to the former or may become *de facto* equivalents.

The arguments are also as relevant to 'counselling', 'personal growth work' and 'psychology' as to 'psychotherapy', since the use of terminology in this area is highly ambiguous and there are no clear or agreed boundaries between these activities. For example, psychotherapy is regarded as a form of psychology in many countries and title usage or practice restricted to licensed psychologists (and medical practitioners).

The assumptive nature of the 'case for'

Whilst bearing a seductive plausibility, arguments in favour of registration in this field frequently amount to little more than taken-for-granted assumptions that the registration of psychotherapists is *necessary, beneficial, preferable* (to any other means of regulation available) and in any case probably *inevitable*.

The purported benefits of licensing and their means of achievement

Statutory registration is invariably argued for on the grounds that such legislation is necessary to protect the public from harm resulting from the practice of the occupation in question. This protection is supposed to be achieved first through a process of accreditation which establishes restrictive entry requirements for practice or title usage. This represents a form of what is known in economics as the 'input regulation' of a market for goods or services. It is a form of regulation which is particularly prevalent in professional markets in which the costs of incompetent supply for the consumer or third parties are particularly high and yet the consumer cannot reasonably be expected to make an informed choice as to who is competent. This is because competence to practise such occupations depends upon the mastery of a body of professional knowledge which is not readily open to lay understanding and which can be acquired only by long and arduous training (Trebilcock, 1982).

In addition to screening out the incompetent at the entry stage, codes of ethics and practice are promulgated and complaints and disciplinary procedures established in order to provide a means of deterring and addressing subsequent 'malpractice' or 'unprofessional conduct' by licensed practitioners.

Finally, under a system of statutory registration, unlicensed practice or title usage becomes a crime, and prosecutions, when they occur, will usually be initiated by the regulatory authority.

Failure to deliver the benefits

However, the claimed benefit of enhanced public protection through statutory registration 'has not been a proven consequence of such laws' (Alberding et al., 1993: 34). Why not?

As with psychotherapy in the UK, it is usually the occupation itself which is the main source of pressure for professionalization and statutory recognition, often in competition with or emulation of other occupations. Whilst claims of client protection are invariably the rallying cry for this, there are sound reasons for doubting that such altruism is the primary motivation (Mowbray, 1995: 28-34; Saks, 1995).

Once established, the profession typically dominates, either directly or indirectly, both the accreditation system and the disciplinary system. This ensures that when the system does work, it tends to do so more for the profession's benefit than for that of the public.

With regard to accreditation, professions in general have been inclined to raise the barriers to entry under the banner of 'raising standards' by the promotion of compulsory prerequisites for practice which enhance professional 'closure' but not necessarily client safety.

With regard to disciplinary procedures, these tend to be more concerned with preserving the public image and status of the profession than the ethical significance of the offence. Thus the extent to which violations receive publicity or notoriety that would negatively impact on the public image of the profession tends to be the determining factor in the responsiveness of the procedures (Hogan, 1979a; Mowbray, 1995, 1997b).

As to the prevention of unlicensed practice or title usage, when enforcement of legislative powers occurs, 'it is frequently aimed at curbing economic competition, not dangerous practices' (Hogan, 1979b: 2).

Both the Foster and Sieghart reports (which were early inspirations for movement towards psychotherapy registration in the UK) made claims for statutory registration as this 'well-tried method' (Sieghart, 1978: 5) which has 'worked excellently in the past' (Foster, 1971: 178). These enthusiastic claims were not, however, substantiated in those reports and appear to have been unsound. As the

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Professionalization of therapy by registration is unnecessary, ill advised and damaging – (Continued)

conclusions of Pfeffer indicate, the prevalence of licensing systems is not a testament to their publicly beneficial nature:

> It must be concluded that the outcomes of regulation and licensing are frequently not in the interests of the consumers or the general public. It is difficult to find a single empirical study of regulatory effects that does not arrive at essentially this conclusion.
>
> . . . There is evidence that administrative regulation and licensing has actually operated against the public interest: and that rather than protecting the public from the industry, regulation has frequently operated to protect and economically enhance the industry or occupation. . . Even if quality differences are observed, the question remains as to whether they are worth the cost. (Pfeffer, 1974: 474, 478)

The harmful side-effects of statutory registration

Not only does statutory regulation often fail to deliver the purported benefits of public protection, it is also likely to be detrimental as well. The potential liabilities of legislated regulation are 'facts of life to political scientists, economists, and sociologists' (Alberding et al., 1993: 37). Licensing tends to have the following negative side-effects:

(a) unnecessarily restricting the supply of practitioners by introducing monopolistic factors into the market such as higher than necessary and irrelevant entry requirements;

(b) decreasing the geographic mobility of practitioners;

(c) inflating the cost of services;

(d) making it difficult for paraprofessionals to perform effectively;

(e) stifling innovations in the education and training of practitioners and in the organization and utilizing of services through accreditation systems, disciplinary provisions and ethical standards based on what is currently acceptable by the majority of practitioners rather than empirical evidence of effectiveness;

(f) discriminating against minorities, women, the poor and the aged by raising entry requirement in terms of time, cost and academic prerequisites;

(g) promoting unnecessary and harmful consumer dependence and hence vulnerability (Hogan, 1979a: Vol. 1, 238-9; 1979b: 2; Mowbray, 1995: 86-8).

In sum, '(The) weaknesses of an occupational licensing system are formidable' (Trebilcock and Shaul, 1982: 99).

Preconditions for licensing: valid criteria for the establishment of a statutory profession

The deleterious public impact of these unintended side-effects of licensing must be compared with the *actual* rather than claimed benefits in order to establish the overall balance of risk and benefit that the licensing of a particular occupation would produce: 'the preferred policy is to protect the public from harm in general, whether or not incurred by a practitioner' (Hogan, 1979a: vol.1, 239).

How do psychotherapy, counselling, psychology and associated activities measure up in the face of these preconditions? These occupations certainly have a significant degree of public impact but fail to fulfil any of the other preconditions.

As a basis for assessing this balance, Hogan offers the following *pre-conditions for licensing* – criteria which need to be met if the overall impact of statutory registration is to be beneficial rather than detrimental:

(1) The profession or occupation being regulated must be mature and well established.

(2) The profession being regulated must have a clearly defined field of practice adequately differentiated from other professions.

(3) The profession must have a significant degree of public impact.

(4) The benefits of licensing must outweigh the negative side-effects cited above.

(5) Simpler and less restrictive methods that would accomplish the same purposes must be unavailable (for example, education measures or the application of existing laws).

(6) The potential for significant harm from incompetent or unethical practitioners must exist and must be extremely well documented.

(7) Practitioner incompetence must be shown to be the source of harm.

(8) The purpose of licensing laws must be the prevention of harm.

(9) Adequate enforcement mechanisms for disciplining those who violate the law must exist.

(10) Adequate financial resources must be committed to ensure proper administration and enforcement of the licensing laws (Hogan, 1979a: Vol. 1, 365-8).

Applying the preconditions for licensing to psychotherapy, counselling and psychology

How do psychotherapy, counselling, psychology and associated activities measure up in the face of these preconditions? These occupations certainly have a significant degree of public impact but fail to fulfil any of the other preconditions. They are neither mature nor clearly differentiated from each other or from other occupations (Mowbray, 1995: 92-9; Howard, 1996: 30-5). Whilst a degree of risk is involved in their practice, this risk is neither very large, nor unequivocally attributable to practitioner actions. Nor can this risk be readily influenced by those factors which a licensing system can address (Mowbray, 1995: 100-14). It can, however, be ameliorated by other means (Mowbray, 1995: 203-12).

Entry requirements (preconditions [4] *and* [8]) The requirements being established for entry to the so-called 'voluntary' registers intended as precursors for statutory registers are those which would be appropriate to the establishment of a postgraduate profession. The training standards espoused require or favour graduate entry, substantial academic content and extended duration (three or four, going on five, years). Training courses are increasingly run under the auspices of academic institutions, and the pursuit of the status of a postgraduate profession for psychotherapy in the UK is occurring at both national and European levels.

Psychotherapy does 'work' (Smith et al., 1980); however, surveys of outcome research in psychotherapy reveal that the factors being given such prominence as part of the drive towards a professional status are of minor relevance to competence as a

practitioner (Russell, 1981/1993; Mowbray, 1995). The theoretical knowledge and technical considerations that psychotherapy trainees will usually required to spend much of their time learning and addressing, including the acquisition of a specialized professional language, account for only 15 per cent of the variation in psychotherapy outcome.

The practitioner's contribution to outcome has mainly to do with the ability to relate to a range of people on a deep level, including those who have difficulty with relating itself. This depends upon personal qualities such as empathy, genuineness, integrity, autonomy and respectfulness, as well as idiosyncratic factors (Mowbray, 1995: 118-19, 132-5). These cannot be acquired from a study of theory and technique. Nor are they likely to be found in greatest profusion amongst university graduates.

Appropriate training for practitioners would emphasize the maximum emergence of those personal qualities which are known to be crucial (Mowbray, 1995). Not surprisingly, however, in view of the irrelevance of much of what passes for psychotherapy training, a growing body of literature shows *at best* only a very modest relationship between professional training and therapeutic effectiveness, whilst academic qualifications correlate with effectiveness hardly at all (see Russell, 1981/1993; Dawes, 1994: Mowbray, 1995, 115-19: Bohart and Tallman, 1996: 12-16: Roth and Fonagry, 1996: 346, 355: House, 1997a; Miller et al., 1997). Thus, in the occupations in question, the 'unqualified' are those who lack the appropriate personal qualities – however many hours of training they may have undergone and however many certificates they may have acquired.

In view of the negative side-effects discussed above, the legal establishment of occupational entry requirements of minor relevance to the fundamentals of competent practice would be harmful to the public interest rather than protective of clients, as usually claimed.

The risks of psychotherapy (*preconditions* (6), (7) *and* (8)) The prevalent pre-occupation with the dangers posed by psychotherapists is a natural counterpart to the common erroneous amplification of the practitioner's potency to effect change in the client.

Congruent with their statutory aspirations, registration protagonists are inclined to foster as image of the practitioner's activities as the primary agent of change in the client, and hence, by the same token, the main source of potential danger for the client, who is usually also characterized as 'too vulnerable to choose' (Mowbray, 1997a). This scenario does not, however, accurately reflect the available empirical evidence:

> [M]uch of the writing and thinking about psychotherapy places the therapist at the centre stage of the drama known as *therapy*. Rarely is the client cast in the role of the chief agent of change. Nevertheless the research literature makes clear that *the client is actually the single most potent contributor to outcome psychotherapy*. (Miller et al., 1997: 25, original emphases).

The client is also the best judge of who is a competent practitioner for him or her: 'There is absolutely no evidence that emotional stress necessarily implies incompetence or an inability to judge what is helping or hurting in an attempt to alleviate that distress' (Dawes, 1994: 125).

The dangers of psychotherapy are, Hogan's words, 'not of such epidemic proportions that the arm of the law should intervene to curb the problem' (1979a: Vol. 1, 370). As a former Chair of the United Kingdom Council for psychotherapy ruefully admitted: 'It has been proved difficult to amass evidence that the public has a great need of protection from psychotherapists' (Tantam, 1996: 100).

Moreover, there is a notable lack of evidence that the risks are lower with licensed as opposed to unlicensed practice (Mowbray, 1995: 106-14; Howard, 1996: 22, 28, 47). Indeed, there is a significant danger that the elevated status accompanying professionalization would actually increase rather than reduce client vulnerability by encouraging the false assumption that safety had already been assured: 'Official recognition based on unconfirmed criteria *begets* vulnerability' (Mowbray, 1997a: 43, original emphasis).

Psychotherapists or counsellors are not experts whose efficacy derives from the application of an elaborate and specialist body of knowledge to a particular case. Nor do they act as 'agents' who do things 'for' their clients. Nor are they appropriately equated with professionals such as doctors, whose duties include actions performed on behalf of the state. Nor are they capable of functioning as expert witnesses who can make reliable diagnostic predictions about individuals appearing in court – statistical formulae do better (Dawes, 1994: 75-105). These occupations are not appropriate candidates for professionalization – statutory or otherwise – and claims that people would be protected from exploitation or incompetence thereby have little validity.

Viable alternatives to statutory registration (precondition 5) The situation regarding the regulation of psychotherapy and counselling in the UK does not in general require any specific remedial legislative interventions. However, various enhancements are possible: educational initiatives to make the public more aware of the relevant criteria for selecting a practitioner; the application of existing laws; the encouragement of clear practitioner-client contracting; practitioner 'self and peer assessment'; and the implementation of full-disclosure provisions as part of general legislative improvements in the area of consumer law. 'Non-credentialled registration' is not necessary overall, but is an option for serious consideration in medical settings where a model of psychotherapeutic 'treatment' for mental disorders holds sway (Mowbray, 1995: 203-12).

Jenkins (1997: 77-114, 296), amongst others has argued that general laws are inadequate as a means for addressing negligent practice because of both the costs of litigation and the difficulty in proving, as required by tort law, that a breach in the practitioner's duty of care actually caused damage to the client. However, this latter concern is mostly indicative of the inherent difficulty of establishing causality in this type of activity.

Difficulties in achieving justice through the general legal system on the grounds of cost point to a need for reform of access to the legal system and for the promotion of general systems of mediation and conciliation, rather than the development of further specialist law. The UK government's sponsorship of a 'no win, no fee' system for civil proceedings (White

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and Dyer, 1997) may go some way to addressing the issue of the cost of 'going to law' – given a reasonable case.

However, in view of the predominant role of the client in the determination of psychotherapy outcome, and the importance of relationship in that endeavour, contract is a more pertinent area of law than tort. By contrast, the drive for professionalization of psychotherapy and counselling can be seen as an effort to establish status rather than contract as the legal basis for these occupations.

Stone and Matthews (1996: 191, 292-6) argue that a contractual model of regulation is the most appropriate form for the related field of complementary medicine, rather than status-oriented mimicry of the medical profession, since the relationship between practitioner and client in most forms of complementary medicine is the antithesis of the legal relationship assumed by professional negligence cases on the basis of an allopathic medical model. In the latter cases, for example, contributory negligence on the part of the patient finds no place, whereas, from the point of view of complementary medicine. 'It is certainly arguable, at least, that a patient's responsibility to take an active part in his or her own health management should find expression in the law' (1996: 294).

These organisations cannot therefore simply ignore the 'case against' while lobbying for a change in the law. They are obliged to refrain from such political activity unless they can present a balance of evidence that statutory registration would actually protect the public as they claim.

De facto registration

In the UK, the principle role of statutory registration in this area to date has been that of a threat evoking fears of exclusions on the part of practitioners and training organisations. Misinformation about the inevitability or likelihood of statutory registration, as well as the supposed benefits, has served as an effective recruiting office for the would-be professional bodies. Their dominance of practitioner training and, increasingly, of eligibility for employment or fee reimbursement means that *de facto* registration through oligopolistic control of the market by these 'proto-registers' is a prospect to reckon with (Mowbray, 1995: 146-7). Since their criteria for entry are geared to future hopes for licensing and are typically inappropriate to the fundamentals of competence, these so-called 'voluntary' registers can have a negative impact on the field of practice approaching that which would apply if their statutory indorsement had already been achieved.

Conclusion

In view of the weight of argument and evidence against it, the starting point, the 'ground zero', for any discussion of the appropriateness of registration as a system of regulation for the fields of psychotherapy, counselling and psychology should be the exact opposite of the usual assumptions referred to earlier. *Statutory registration should be assumed detrimental unless proven to be both necessary and beneficial.* There is thus a clear ethical obligation upon the protagonists of professional registration to logically and empirically justify their position.

In the case of registered charities such as the United Kingdom Council of Psychotherapy, and the British Psychological Society and the British Association for Counselling, this obligation is not just ethical but legal as well:

> A charity must not base any attempt to influence public opinion or to put pressure on the government . . . to legislate or adopt a particular policy on data which it knows (or ought to know) is inaccurate or on a distorted selection of data in support of a preconceived position. (Charity Commissioners for England and Wales. 1997: 13)

These organisations cannot therefore simply ignore the 'case against' while lobbying for a change in the law. They are obliged to refrain from such political activity unless they can present a balance of evidence that statutory registration would actually protect the public as they claim.

Notes

1. At the time of publication of *The Case Against Psychotherapy Registration*, the notion that there was a 'case against' was distinctly novel in 'therapy' circles in the UK. In addition to that book, a considerable body of literature which addresses the issue is now readily available. Dawes (1994), Parker et al (1995), Saks (1995), Howard (1996), Stone and Matthews (1996), Brown and Mowbray (1997), House and Totton (1997), and Jenkins (1997) all contain pertinent material. Hogan's (1979a) inspiring and exhaustive is unfortunately out of print.
2. In particular, there are major differences in the intentions of work which is practised on the basis of a medical or behaviourist model as opposed to a personal growth model. These differing goals are not, however, reflected in consistency as to the titles adopted, which leads to much confusion and misunderstanding (Mowbray, 1995: 172-97).
3. The European Association for Psychotherapy, with close links to the United Kingdom Council for Psychotherapy, is promoting a European Certificate of Psychotherapy requiring a seven-year training (Deurzen and Tantam, 1997).
4. Forty years of research reveal that the factors which account for variance of outcome for variance of outcome in psychotherapy are, in descending order of importance: extra-therapeutic factors, that is, the client's pre-existing resources and concurrent life events (40 percent); therapy relationship factors (30 percent); expectancy, hope and placebo factor (15 percent); theoretical model and technique factors (15 percent) (Bohart and Tallman, 1996: 17; Miller et al., 1997: 24-31). Even if the validity of psychotherapy outcome studies is doubted, the fact remains that there is a dearth of empirical evidence in *favour* of the accreditation criteria being promoted. As Dawes says: 'there is no *positive* evidence supporting the efficacy of professional psychology. There are anecdotes, there is plausibility, there are common beliefs, yes – but there is no good evidence' (1994: 58, emphasis in original).
5 See note 4. The notable Georg Groddeck came to a similar conclusion many years ago (House, 1997b).

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Richard Mowbray's book *The Case Against Psychotherapy Registration* is available through Trans Marginal Press, London ISBN 0-9524270-0-1

Even if the validity of psychotherapy outcome studies is doubted, the fact remains that there is a dearth of empirical evidence in favour of the accreditation criteria being promoted.

ACA

Internet Resources Compiled by Angela Lewis MA.Ed

Angela Lewis (doctoral candidate) M.A.Ed, MACA (professional) practices as a corporate adult educator in Melbourne (computer training) Visit her at : www.AngelaLewis.com.au

Hi everyone,

Well last month I actually started Internet banking - what I hear you say with disbelief - a computer guru like myself was still standing in a bank queue??? Yes, I know - hard to believe - but I had never bothered to Net Bank before. I belong to the Commonwealth Bank, so for me the procedure went like this. First I had to go to the enquiry counter at the CBA and register the accounts that I wished to view online. Approximately one week later I received my client number and pin number and the Internet address for CBA Net Banking.

I duly logged on and there on a secure site, were the three accounts I had nominated. I can now go and look at the balances of my personal and business accounts and mortgage every day (if I want!), do transfers between accounts and utilise the Bpay option and actually pay business and personal bills online whenever I feel like it. If I sound like an ad for the Commonwealth Bank I apologise, but I have to say, Internet banking is one of the easiest things I have ever done - and what a timesaver! All the major banks have similar facilities, and it is just a matter of contacting your own, and making the arrangements - trust me - you will love it!

There are files that are 'zipped'. The extension of a file that has been zipped is '.zip'. Files that have been zipped are large, and if left in their original form can take hours to download from the Internet, so to speed things up, large files are zipped or compressed.

Zip it Up - what is WinZip?

Most people using the Internet will be aware there are files that are 'zipped'. The extension of a file that has been zipped is '.zip'. Files that have been zipped are large, and if left in their original form can take hours to download from the Internet, so to speed things up, large files are zipped or compressed. A file that has been zipped will download to your computer in a fraction of the time it would take if it had not been zipped. If you wish to send files to others that are very large, you would then run the zip program over your file prior to sending it. Most people already have it resident on their computer.

To check, click your **Start** button and then click on **Programs**. The program is called **WinZip**. If you do not have it, you will need to download it onto your own computer. To do this go to http://winzip.com/ddchomea.htm. You may download a free, unregistered version of this program for a trial run - this is generally enough for most people's needs.

To open a File That Has Been Zipped

Where you are likely to encounter zipped files, is when you download files, documents or software from the Internet.

1. For this example, let's say you come across a file you want to download from the Internet.
2. The instructions say **CLICK HERE TO DOWNLOAD**, so you do that.
3. A dialog box will appear saying what do you want to do with this file and the choice is to either ***Open it** or **Save it to Disk**.
4. You should have set up a directory or folder on your own computer for files that you download - something simple like 'my downloads' or 'downloads', so when you choose Save to Disk then you have a spot on your computer to put the files into. When asked where to save the file to, locate and click on your nominated download directory, follow the prompts to download and when complete you either need to open your file or if it is a program launch it by clicking the .exe file you will see there. This will perform the installation of the software you have nominated to download.
5. If it is a document or file, then double clicking it will launch **WinZip** and you need to select the file then click on **Extract**. You will also need to nominate a folder on your computer where you want the unzipped file to land. Close **WinZip program** when finished.

A file that has been zipped has this type of icon and the extension "zip".

*(If you open it then there is a chance that the Internet browser will delete the file once the browser is closed)

WEBSITES:

http://www.rainbow.net.au/~ausbinet/

Australian Bi-sexual network, located in Brisbane. This is a resource site offering links to conferences, meetings and support groups for bi-sexual men, women and partners.

www.nida.nih.gov/ResearchReports/Heroin/Heroin.html

Answers to commonly asked questions about heroin from the National Institute on Drug Abuse (NIDA).

www.wallpapervault.com and www.celebrity-wallpaper.com

These are both a source of downloadable wallpaper sites - wallpaper being the images you can put on the desktop (screentop) of your computer.

www.refugeecamp.org

Visit a virtual refugee camp and learn about the major issues faced by refugees and the people who establish these camps: shelter, food, water, nutrition, latrines, landmines, disease, and medical care.

Please note that these Internet addresses were correct at the time of submission to the ACA. Neither Angela Lewis nor the ACA gain any benefit from the publication of these site addresses.

ACA

A place for person-centred therapy

There is a tendency to 'think vertically' when we approach a disease model from a list of symptoms. It fits with the framework of deriving results from lower level causes and produces a hierarchical model which is also culturally satisfying. What **Simon Cole** *offers in this article is a horizontal perspective*

Referral practice within primary healthcare varies but all humanistic practitioners in the field encounter, in some form, the philosophical divide between the medical model of patient treatment and their own belief in client responsibility. This may involve ethics, referral policy, time limitation, confidentiality and other considerations. But perhaps a more fundamental issue is that of the medical classification of the patient's condition, compared with a counselling approach which is existential and holistic. This divide may be of more concern to counsellor than the patient – certainly it is unlikely to be perceived in these terms by the patient – but that does not make it neutral in effect. For the practising counsellor it may mean a temptation to incorporate techniques from a more interventionist approach, perhaps cognitive-behavioural, resulting in an uneasy integration.

The difficulty has its roots in the need for a 'scientific' system of knowledge which requires a means of classifying disease in order to derive treatments on the one hand – and therefore looks for patterns and quantitative verification – and on the other, a means of therapy which is validated by individual interaction. The need to bridge this gap arises from the context of primary healthcare where a patient's understanding is expressed in terms like 'symptoms' and 'treatment' and 'being well'. Alongside this is a cultural awareness of psychological difficulties as illness, perhaps with specific names, which coincide with medical terminology. So a patient is diagnosed with depression or anxiety or panic attacks or stress or even 'low mood' by their GP and is referred to the counsellor, having been told that about themselves. Or perhaps they request a referral to the counsellor, having been shunned by work colleagues for irrational outbursts of temper and told to 'get yourself sorted out', or having felt unaccountably low for a time and been told by family members to 'pull yourself together'.

But when the diagnostic and prescriptive voices are quiet, the individual's sense of themselves is what it is all about: feelings, and reflections on those feelings, in the context of their world as it looks to them – a psychological and physiological awareness – their felt sense of themselves in their world. And this felt sense is more than a slice of their experience; rather it contains the remembering of a passage, leading to and accounting for how they feel now.

For Buber (1958: p.25): 'All real living is meeting', and the currency of the meeting is dialogue. Talking therapy, as a dialogue, both mirrors and participates in the process which gives the individual his own sense of what is happening for him. Buber gives a frame for understanding the psychological awareness of our passage. He examines the nature and significance of relating and dialogue in the context of one person to another. The processes of 'experiencing' and 'relating' corresponding to the alternatives of 'I-It' and 'I-Thou' respectively, which he identifies, can also be applied to the individual and his world. We find equivalents in day-to-day usage. When we are feeling content and at ease and have a sense of boundary-less peace, we say we are 'at one' with the world (I-Thou); when we feel isolated and besieged, we say we are 'at odds' with the world (I-It).

Physiological awareness is contained within the internal dialogue of reflexivity. It is our reflexive awareness which allows us to say, 'I am thinking about…' or 'I feel…', which makes the self an object (in Buber's sense) and results in our *experiencing* rather than *relating* to ourselves. Perhaps here there is an explanation for the '*self* consciousness', or self-preoccupation, which we see in many clients and which I return to below, as the withdrawal and distancing which is seen in clients' distress. The fully functioning individual, in contrast, is reflexive only by intent, and is able simply to be. His relating to himself is more inclusive. We may say he is grounded.

The individuals sense of himself in his world, then, his psychological and physiological awareness, is known to him through dialogue, as his means of relating both internally and externally. The presence of dialogue offers the *possibility* of balance, a state of equilibrium, a stress-less state. But the nature of the dialogue determines whether there is actually a balance, a state without stress, or whether a lack of balance indicates a state of distress.

My central hypothesis, then, is that, while the medical world talks in terms of depression or agitated depression or anxiety, and society talks in terms of stress or nervous breakdown, when we meet the client, we are meeting individual distress, which has a unique origin for this person and is experienced uniquely by them. Rowan (1998) suggests a similar comparison: 'Once you give a person a label there is a real danger that you will respond to the label instead of to the person… it is a whole person who has to be met and engaged with…'

Unlike medication, which offers singular solutions to collective classifications of condition/symptoms deriving from multifarious sources, psychological therapy offers a means to address the multifarious sources of the client's unique condition. The link is the collective of symptoms, but, for the one, they are an inexact means of recognising a condition (and so themselves represent the condition), and, for the other, a present and vicarious set of physiological or psychological/behavioural responses to historical experience.

I will try to relate a symptom-based description of client conditions with what we might hear the client telling us. To start we can list the generally accepted range of psychological symptoms of depression, anxiety and stress *(see figure 1)*.

Running through these experiences of distress are three elements: loss of control (of thoughts and feelings), a sense of disconnectedness and a 'closing in' of the client's view of the world and their life. We can therefore associate depressed mood, lethargy and

When the diagnostic and prescriptive voices are quiet, the individual's sense of themselves is what it is all about: feelings, and reflections on those feelings, in the context of their world as it looks to them – a psychological and physiological awareness – their felt sense of themselves in their world.

A place for person-centred therapy – (Continued)

Depression	Anxiety	Stress
Depressed mood	Sense of anxiety	Sense of anxiety
Lethargy	Thoughts intruding on sleep	Mood swings and irritability
Sense of helplessness	Difficulty in concentration	Difficulty in concentrating
	Loss of control of thoughts	Whirling thoughts
Feeling of worthlessness	Irritability	Dulled Senses
Negative thinking	Feelings of unreality	Loss of interest
Loss of interest or pleasure	Constant negative anticipation	
	Agoraphobic tendency	
Sense of hopelessness	Obsessive preoccupation	Inability to cope
Suicidal thoughts	Forgetfulness	

Figure 1

helplessness in depression as aspects of *losing control*. *Disconnectedness* appears in depression as negativity, in thinking, feeling and arousal and as a 'switching off' from sensation, arousal and reality in anxiety and stress. The *closing in* of the client's view of life can be seen in the hopelessness and suicidal ideation of depression.

Starting from a diagnostic manual, we might question the client – or arrange the symptoms they describe – and achieve a 'best fit' into one of the conditions above. But if we listened to the client's description we might hear him say: 'I used to be normal, I went out, I had friends, knew how to have a good time but now I'm afraid to go out and it's really getting me down. My relationship is suffering because either I just can't be bothered or I'm flying off the handle. My life seems to be going nowhere and I can't stop thinking about that.' In this we would hear the client's distress, and perhaps despair, as a unitary experience linked to their awareness of aspects of their being and compared with some historical and seemingly disconnected sense of themselves. So where the doctor would extract symptoms from the client's description in order to classify a condition to determine the medical response (though increasingly with less differentiation), the humanistic counsellor would hear the client's distress at both their condition and their own inability to attribute a cause. One need not be right and the other wrong. Both are appropriate to their discipline and the possibilities, and limitations, of their interventions. We might say that, whereas the doctor was hearing the client's descriptions, the counsellor was listening to the client's story.

Normal relating is central to the therapeutic effect of therapy. In the person-centred tradition we see the potential for growth towards the 'fully functioning individual' as present in every human being and the desirable outcome, and will most often say that they 'just want to be normal again'.

If we stay with the client's experience, we pick up a sense that he perceives everything as happening around him: his condition is beyond his own intervention (a lack of comprehension of the change, a relationship deteriorating despite his awareness and will to keep it stable); coupled with this comes a feeling of being disconnected (an altered social pattern and lack of motivation); present as well is the sense of life closing in, 'going nowhere'. As humanistic counsellors we could relate these features of the client's experience to recognised antedotal processes in psychological therapy:

loss of control	**grounding**
disconnectedness	**normal relating**
closing in	**opening up the frame**
	(Mearns, 1999)

The extent to which we adopt these processes as intentional activities or simply observe that they can be an outcome of the work of therapy will depend on our feeling for a non-directive, or a more process-experiential, approach to our work. But their relation to Rogers' core conditions is clear. The presence of each condition in the relationship which the counsellor offers will contribute specifically to one of the processes, as well as collectively to a renewed experience for the client of 'normal relating'. They will help to restore the dialogue.

To the extent that empathy is confirming and validating, it will assist the client in grounding. 'Am I going mad?' is a frequent question from clients who are conscious of how they are behaving or reacting, see themselves as unable to change this pattern and seek to dissociate intention from apparent reality. The counsellor, who by empathic responding can stand alongside the client, is indicating the 'normality' of the struggle in which the client is engaged, and thereby bringing the client back into the bounds of being human.

Normal relating is central to the therapeutic effect of therapy. In the person-centred tradition we see the potential for growth towards the 'fully functioning individual' as present in every human being and the desirable outcome, and will most often say that they 'just want to be normal again'. 'Being normal' in this sense is close to being able to be normal with other people and experience normal responses from them. So the counsellor may be doing northing more than allowing the client to experience day-to-day responses, such as they may have received from others, before the cycle of withdrawal changed the nature of their contact with their world. For this, though, is needed the ability to offer the core conditions in the relationship and, foremost, unconditional positive regard for the client.

Not all clients can progress beyond their recovery towards the ideal of 'fully functioning'. My sense (not objectively researched) is that in primary healthcare the client has a feel for when they are 'well enough' and that this may account for the relatively larger proportion of clients who end counselling by failing to attend after a certain time. 'Opening up the frame', therefore, in the sense of fulfilling their growth potential, often has limited scope. But it can also be seen as the means and process of reversing the cycle of withdrawal. The congruence and transparency of the counsellor is vital to this process. Withdrawal invariably prompts rejection: there is a turning away

Symptom	Client's narrative
Agoraphobic tendency	"…used to be normal…have a good time…now pretty much afraid to go out…"
Depressed	"…that (remembering how he was and comparing with now) is getting me down…"
Disinterested and irritable	"…relationship is suffering because either I just can't be bothered or I'm flying off the handle…"
Hopelessness	"…Life just seems to be going nowhere…"
Obsessive preoccupation	"…can't stop thinking about it…"

Figure 2

and dialogue breaks down. This cycle is self-reinforcing and spirals. Only realness – the realness of the counsellor – can restore meaningful dialogue across the barriers of misconception and mistrust which have been built up.

The client-counsellor relationship and the core conditions offered by the counsellor address directly aspects of the client's being, behaviour and awareness of himself. What perhaps is added here is horizontal perspective. There is a tendency to 'think vertically' when we approach a disease model from a list os symptoms: it fits with the framework of deriving results from lower level causes, and produces a hierarchical model which is also culturally satisfying. But our awareness of ourselves is as much horizontal as vertical, and even the vertical 'depth' relies on a horizontal aspect. If we go back to our client above and look at what we might list as his symptoms, following the medical model, we find *(see figure 2)*

He is using the present tense and conveying an ongoing experience, 'getting', 'suffering', 'going', 'thinking'. Even when he talks about the past, 'I used to be normal…', we hear him looking over a span of time, thinking of his recent history. Thus, if we allow ourselves a horizontal perspective, we have a picture of distress rooted in the client's continuous experience. This is not easily seen in a symptom-conscious approach which is primarily concerned with what the symptom is, how bad it is and when it started.

None of this is intended as an argument against the use of medication. Neither is it intended to suggest that one form of 'treatment' is always more effective than another. It may, though, inform the mix of interventions used, for example that between pharmacological and psychological therapy. To some extent the decision is already being made by the patient: on the one hand, we find an increasing number of people who have an aversion to taking pills; on the other, we have many who simply want to 'feel better'. To be true to his philosophy, the person-centred counsellor must allow both and comparisons of effectiveness take second place. It could be that, by addressing the sources, as opposed to the symptoms, of the condition, susceptibility to psychological stress is reduced in the long term, but to demonstrate this demands a lengthier study than most medical-offset research currently undertakes. In the meantime attention to referral procedures may contribute most to the alliance of counselling and primary healthcare.

To be true to his philosophy, the person-centred counsellor must allow both and comparisons of effectiveness take second place.

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ACA

Victorian Conference

On 13th October 2001 the Victorian Chapter of the ACA held its first counselling conference which was a great success!

The conference was held at the Mercure Hotel which in Melbourne overlooking the beautiful Treasury Gardens. We all arrived at about 8.30am and after coffee and a brief introduction, Gayle Higgins, chairperson, spoke about the ACA Victorian chapter and outlined the conference program.

Very entertaining and friendly and by the end of this talk, everyone wanted to be supervised by him!

The first speaker was Sue Gavan a Family Therapist, who explained how to conduct the initial conselling interview for couples. She gave us some wonderful information and practical counselling skills for dealing with couples. She made the geneogram look so simple!

Sue was followed by Catherine Madigan a psychologist for Anxiety Disorders Association. Catherine discussed how to identify different types of anxiety and gave us a rundown on when clients needed to be referred for medication. Then it was morning tea and a great opportunity for everyone to get to know each other and swap details.

Daryl Cloonan from the Supervisors Unit at Melbourne University was the next speaker. He explained why supervision is so important and how this important process works. He was very entertaining and friendly and by the end of this talk, everyone wanted to be supervised by him! We then adjourned for lunch in the Mercure restaurant overlooking the gardens, and more networking.

Following lunch, we all settled down to listen to Frank Donovan an anger management expert. He conducted a three-hour workshop for the afternoon. It only seemed like three minutes and everyone was asking for more. Frank is very informative and entertaining and manages to take the anxiety out of anger management for counsellors. He brought his book with him 'Dealing with Anger' and everyone went home with a signed copy. We finished up exhausted but motivated and looking forward to the next conference. A wonderful time was had by all.

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Delegates at Lunch

Catherine Madigan
Speaker

Frank Donovan
Speaker

Delegates in Classroom

Sue Gavan, *Speaker*

Daryl Cloonan
Speaker

Delegates at lunch

Gayle Higgins
Chairperson

South Australian Counselling Seminar and Expo

Our first Counselling Expo was held 1 December, 2001, in Glenelg. We wish to thank the speakers and the participants for making the Expo a big success. We would also like to thank Carol Moore for her help on the day.

Kerry Cavanagh, the new ACA Counsellor Supervisor, gave a very informative presentation on supervision. The primary purpose of supervision is to protect the best interests of the client. Kerry sees the supervision process as educative, supportive, and managerial. The educational facet includes resolving discrepant feelings toward clients and examining the counselor's intervention with the client. The supportive element of counsellor debriefing assists with resolution and burnout prevention. The managerial function provides quality control and what Kerry calls "Blind Spot Control". The industry standards for supervision are: for each 20 hours of client contact, one hour of supervision is required, or monthly supervision if the counsellor is in the clinical category.

Wayne Trezona, from AON Insurance, discussed professional indemnity insurance. Litigation can result from: failure to maintain counselling skills, inexperience, unprofessional working habits, failure to maintain relationships, misunderstandings, conflict of interest, and so on.

Anthony Polkinghorne, from Pacific Access (The Yellow Pages), presented statistics showing that the White Pages, Yellow Pages, the online White/Yellow Pages, and web sites are a great way to reach a lot of people for a modest cash outlay. Pacific Access will also set up and maintain web sites.

Anne van der Zwaag, from the Bereavement Education Service, told us about the Service's classes that are appropriate for both clients and counsellors. There are two Grief Management Training classes that are 18 hours each, with a variety of schedule options.

Gillian Cordell, from the Domestic Violence Counselling Service, gave an eye-opening presentation. Gillian says that "Domestic Violence" has evolved to include any form of abusive behaviour that takes place within the family. Gillian's soapbox, as she calls it, is that children witnessing domestic violence is abusive, in itself.

Rin Minniti, from the Warinilla Drug and Alcohol Clinic provided some rather thought-provoking material. Statistically, 60% of clients presenting with an anxiety disorder will also have alcohol or benzodiazide problems, and 6% of schizophrenics are likely to have some sort of drug abuse. The audience participants asked many questions and indulged in some lively discussions.

Lynette Miller, representing COPE, told of their lending library, book shop, and their counselling courses (some to be accredited in 2002). COPE also hosts film discussion evenings and wine/cheese get-togethers.

Our chairman, Peter Papps, told members of the SA Chapter's plans to set up a phone directory entry under the ACA logo for practicing counsellors, and for short articles or advertorials in local papers across the Adelaide area (costs shared). If you wish to participate, get in touch with Peter. Peter also discussed the difference between the local chapter and the national body. The SA chapter deals with local support, eg seminars, publicity, etc (cost $11/year), while the national body concerns itself with standards, lobbying insurance companies, etc at the usual fee.

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The educational facet includes resolving discrepant feelings toward clients and examining the counselor's intervention with the client. The supportive element of counsellor debriefing assists with resolution and burnout prevention.

***Mary Rose** with **Angela Munoz**, winner of raffle prize*

Getting ready, almost clear table

***Anthony Polkinghorne**, Presenter and **Peter Papps**, Chairman*

***Peter Papps**, Chairman*
***Wayne Trezona**, Presenter*
***Kerry Cavanagh**, Supervisor*
***Mary Rose**, Secretary*

Around the room

Morning tea break

Counselling Using Attachment/Differentiation Principles (ADP)

By Miguel Barreiro

The need for emotional connection is at the heart of our nature. However, mature emotional connection is not ownership or holding on to others out of fear of losing them. It is a state of longing to belong with others while being secure in our individuality and conscious of our separateness. In our post- modern world many have lost the ability to connect intimately with others and rejoice in this connection while retaining their individuality. A longing for intimacy and fear of loss is at the heart of many couples and individuals presenting for counselling.

John Bowlby developed a comprehensive theoretical framework, which places attachment as a crucial motivating factor in human interpersonal behaviour. This theory addresses the human need to be close to others yet it neglects a second need: that of remaining faithful to our unique nature. The importance of maintaining our individuality is a central aspect of Bowen's differentiation theory. In this essay I will outline the key elements of Bowlby's attachment theory and the extension of this theory to adult romantic relationships. I will argue that attachment theory in combination with Bowen's differentiation theory offers a comprehensive theoretical framework for counselling individuals with relationship issues as well as for couples therapy. First I will outline the key elements of attachment and differentiation theories. I will then discuss the applications of these theories to the counselling process.

Attachment theory in combination with Bowen's differentiation theory offers a comprehensive theoretical framework for counselling individuals with relationship issues as well as for couples therapy.

John Bowlby's human attachment theory originated with his observations and thoughts about the nature and function of human attachment (Bowlby1969/1982, 1973, 1980). Originally, Bowlby set out to explain the emotional bond between infants and their caregivers. He believed that the attachment bond between the infants and their caregivers was a component of fundamental importance for human emotional development. According to Bowlby (1980), the powerful influence of early attachment patterns between infants and their caregivers has an impact on the way a person experiences close intimate relationships. Bowlby found that the themes of separation (from the caretaker usually the mother) and loss (of the caretaker) have a significant impact on the emotional bond between infants and their caregivers, with loss representing an irreversible case of separation (Bowlby, 1980).

A number of key assumptions inform Bowlby's theoretical framework.

1: There is an inborn predisposition for children to become attached to their caregivers.

2: Responsive attachment figures serve as a secure base from which infants can explore their environment and return to when they become fearful. The responsive attachment figure, generally the mother, then soothes the child who then resume his/her exploration of their world

3: Since attachment figures are central to children's survival, children will organise their behaviour and cognitions, regulate their emotions, and often sacrifice their own functioning in order to maintain their attachment relationships.

4: A caregiver's inability to provide a necessary level of emotional reassurance, comfort and security can results in attachment disturbances such as distortions in the child's cognitions, feelings and attachment behaviours (Bowlby1969/1982, 1973, 1980).

Bowlby also argued that during the developmental period from infancy to adolescence a person develops expectations about the availability and responsiveness of their attachment figures. These expectations form a cognitive affective filter or *"working model"* representing latent mental structures that guide the individual's cognitions, behaviour, and perception about relationships into adulthood. In addition working models create expectations of how we will be appraised by our intimate others, how they will respond to us as well as informing the strategies of how we should respond to them. Working models result in attachment styles, which are observable patterns of interpersonal behaviour.

Mary Main and her colleages (Main, Kaplan & Cassidy, 1985) extended attachment thinking and research into attachment processes in adults. Main devised a semi-structured interview, which investigates the respondent's early attachment experiences in relation to separation, loss and rejection *(The Adult Attachment Interview AAI)*. She discovered that patterns of representations in the parent's recollection of their attachment history were related to their children's patterns of interpersonal behaviour. From these studies Main engendered three adult attachment classifications, *"autonomous, dismissing and preoccupied"*. I prefer to use the alternative terms of **secure**, **avoidant** and **insecure** attachment and will use them throughout this article. The following are some of the characteristics of each attachment.

Individuals with Secure Attachment Style: are comfortable with emotional attachment; view themselves as a viable attachment figures for others; are comfortable relying on others for emotional support; maintain involvement and interest in intimate others; manage their emotions constructively.

Individuals with Avoidant Attachment Style: are suspicious, uncommunicative, overly self-reliant; fear that others will invade one's personal space; deny their need for closeness to others and avoid intimate relationships.

Individuals with Insecure Attachment Style: are overly dependent and have an insatiable need for the approval of others; have strong feelings of unworthiness; have fears of separation and of being alone; react emotionally when attachment fears are aroused.

Following Main's work, studies in the adult attachment field expanded exponentially beginning with Hazan and Shaver's seminal work on romantic love (Hazan and Shaver, 1987; Shaver & Hazan 1988; Shaver, Hazan & Bradshaw, 1988). The essence of these studies is the conceptualisation of romantic love as an attachment process. Individual's through their early social experience with their caregivers develop an attachment style analogous to those on the children's literature, secure, avoidant, or insecure. These attachment styles and their corresponding working models impact on how individuals relate to their

romantic partners. Shaver and Hazan's conceptualisation of romantic love as an attachment process has received intense validation in many studies that replicated and extended their findings Shaver & Hazan, (1993). Researchers have shown that an individual's attachment style can influence her experiences of relationships through such factors as affect regulation, overall thought monitoring and reflective abilities.

Shortcomings of Adult Attachment Studies.

A problematic conclusion drawn from attachment research is that secure attachment can be taken as the most important factor in relationship quality or in couples' satisfaction with their relationships. Adult attachment theory conceptualises individuals in relationship as being dependent on each other. The language used in relation to all attachment classifications implies dependency. Furthermore, the unstated assumption in the attachment paradigm is that substantial levels dependency are normal and in some way healthy for couples (Schnarch 1997; Firestone & Catlett 1999). Adult attachment researchers have not considered the possibility that a healthier level of relating may involve levels of secure detachment.

Thus adult attachment literature has a lopsided view of human development. It has, from its inception, only considered one dynamical force in the area of interpersonal relationship. This is the natural drive to bond with our romantic partners. Little or no consideration has been given in to the impact of a second natural force. The drive to differentiate from others in order to retain a sense of self (Kerr and Bowen 1988; Schnarch 1991;1997; Birtchnell, 1997; Yalom 1980; Rank 1945; Buber 1965; 1970). A sense of self which can only be unique, and can only be formed and maintained in relation to others. According to Kerr and Bowen (1988) detachment is a drive that is experienced more intensely in intimate relationship in parallel and as a counterpart to the attachment drive. Individuals struggle to manage these competing drives through out the duration of their relationships.

The term of successful or secure detachment is given as an additional attachment style. Individuals with this attachment style would be characterised by an absence of interpersonal anxiety. The securely detached person is not in fear of engulfment, abandonment or rejection. Confident in their sense of self the securely detached individual is comfortable in intimate interpersonal environments and does not feel compelled to isolate themselves from others. On the contrary the connections are stronger because a lack of dependency implies a greater degree of choice.

Many of the characteristics of the securely detached individual are likely to be found in the concept of differentiation of the self (Kerr & Bowen 1987). In all relationships where there is emotional significance between two individuals, Bowen's family systems theory postulates the interplay between two biologically embedded forces, individuality and togetherness. Individuality is a life force that drives people to follow their own course. Togetherness is a life force that drives people to remain attached to others (Kerr & Bowen 1987). The degree of differentiation of the self that an individual has achieved depends on the extent to which an individual manages to keep the individuality and togetherness forces in balance. Individuals who have achieved higher levels of differentiation have a clear sense of who they are and are able to maintain healthy boundaries between themselves and the people around them. These individuals are capable of maintain a clear sense of being a separate while seeking and enjoying intimate and emotional relationships. Secure detachment and differentiation of the self require further empirical investigation. However both concepts have strong support from humanistic, existential and evolutionary psychology as well as family therapy and Buddhist philosophy.

Despite its shortcomings, adult attachment theory offers a strong structure to understand the origins and perils of the immature dependency. More importantly, an integration of adult attachment theory with the concepts of secure detachment and differentiation provides counsellors and therapists with a meta-perspective on healthy adult coping. It is from this perspective that the following framework for individual and relationship counselling.

Counselling Using Attachment/Differentiation Principles (ADP)

By using ADP in counselling interpersonal distress is conceptualised as attachment insecurities. At its essence, clients are assisted in negotiating the balance between separateness and connectedness. A primary aim of this form of therapy is to help clients to own and validate their need for contact and security while accepting the inevitability of existential separateness. Thus a goal of ADP is to help individuals and couples to develop the ability to experience and enjoy intimacy even in the knowledge of their vulnerability to the possible loss of their partner. This involves developing the courage to allow themselves to derive comfort and security from their partners while accepting the responsibility to tap into their own resources when their partners are not able to support them. Counsellors facilitate a shift from rigid interaction patterns governed by fears of rejection and loss to an ultimate reliance on inner security, which allows non-dependent intimacy to occur.

Adult attachment literature has a lopsided view of human development. It has, from its inception, only considered one dynamical force in the area of interpersonal relationship.

Initial Stage of therapy

An assessment of the client's attachment style can be performed using one of the many instruments discussed earlier or see Crowell, Fraley, and Shaver (1999) for a comprehensive review of measurement issues in adult attachment research. This is followed by a discussion of the attachment styles and the impact that these have on the client's self-appraisal and their expectations of how significant others are likely to relate to them (respond, reject, abandon). This process enables the client to reestablish a sense of control through understanding. The individual or couple's interpersonal experience is framed in the broad context of human development while exploring the unique manner that their attachment style impacts on themselves and on their relationship. At the beginning the counsellor provides their clients with a strong explanatory framework from where they clients can begin to gain understanding and a sense of agency over their lives and relationships. An important part of this initial stage is that the client's developmental history is explored with the understanding that the past influences the present yet is not its master.

The client's sense of self-efficacy is reinforced with the knowledge that they have the ability to change the inaccurate emotional, cognitive and behavioural

Counselling Using Attachment/Differentiation Principles (ADP) (Continued)

aspects of their working model. The expectancy is raised that they are capable of managing their feelings, cognitions and behaviours to shape a future that is different and qualitatively superior to the past. The initial stage of normalising, validating and building a shared view of the world is followed by assisting the client's learning of cognitive, behavioural and emotional principles which result in positive coping strategies. This learning needs to be woven into the relationship between the client and therapist, which is paramount to the healing process. The therapist facilitates thoughtful self-exploration whilst modeling new adaptive coping strategies.

Working with insecure clients

Insecure individuals fear loss and rejection because they do not believe that their partners actually love or approve of them; they lack appreciation for their own self-worth. The insecure individual's self-worth is dependent on the praise, reassurance and encouragement of others. As such they are highly vulnerable to the disapproval of those with which they form close relationships. However, their attention is often selectively focused on cues that others disapprove of them. As such these individuals are prone to tolerate the mistreatment of others rather than risk their rejection. The dependency of their self-worth on others often results from experiences of helplessness and hopelessness and leads to frequent bouts of depression. In addition, their neediness means that they are not capable of forming authentic relationships with others. Insecure individuals depersonalise others in that they become an object to sooth their own insecurities.

Individuals with an avoidant attachment style do not seek reassurance or become emotionally reactive when their attachment fears are aroused.

With insecure clients the counsellor remains calm while intensively connected to the client's emotions. An attitude of curiosity and engagement by the part of the counsellor provides a secure holding environment from which the insecure client can begin to develop the ability to contain and manage their emotions. In particular clients are helped to accurately identify their emotions as they emerge during counselling. They are then encouraged to acknowledge and then simply let go of these emotions. This process of identifying, owning and letting go of emotions diffuses the power these emotions have on the individual. The pattern of experiencing strong emotions and automatically reacting to the anxiety that they generate begins to break down. Clients become adept at switching from a reactive state to a state of awareness. Calming techniques such as diaphragmatic breathing are introduced and modeled by the therapist. Emotions are understood and contained. More importantly individuals and couples can experience their transience.

A further challenge with these clients is to assist them in the strengthening of their self-worth without fostering dependency on the counsellor. A particular effective intervention is to examine and strongly challenge self-disparaging narratives. In this instance the counsellor protects the individual from unrealistic self-criticism. The therapist's message is that you are an OK person but I strongly disagree with your self-disparaging behaviour. A further intervention is to assist clients to tune in to subtle yet revealing cues of acceptance and acceptance or admiration of their partners. Since insecure individuals are hypersensitive to disapproval and criticism they do not notice the compliments of their partners.

This is very powerful in working with highly conflictual couples when it is important to switch partners from an interaction of blame and accusation to one of observing and identifying their relational pattern. It is then that each partner becomes aware of his or her own contribution to the relationship woes. Modeling emotional management allows partners to open their communications channels. Through intimate communication couples can and either achieve resolution to their conflicts or learn to live with some differences that may never be resolved yet that do need to harm the relationship.

Working with avoidant clients

The fear of abandonment and loss is also at the center of clients' with an avoidant relating style. The individual with an avoidant attachment style has developed different strategies to cope with the fear from the insecure. To protect themselves from loss avoidant individuals become progressively detached from interpersonal environments which requires substantial levels of intimacy. Individuals with avoidant relating styles become estranged from their social environments and find it difficult to trust others whose intentions are perceived as untrustworthy.

Individuals with an avoidant attachment style do not seek reassurance or become emotionally reactive when their attachment fears are aroused. Instead they have conditioned themselves to turn off from their emotional experience. Their mistrust of others means that they turn in on themselves and adopt a rigid self-reliance. These individuals feel as uncomfortable relying on others emotionally, as having others rely on them.

The therapist's task with these individuals is to help them reconnect with their emotional experience. Once again an expansion of their emotional vocabulary is helpful. These clients often present with anger and low frustration toleration level, particularly in interpersonal situations. Their anger however is short lived and functions as a switch to avoid, and turn away from those close to them. Examining the many emotions that anger is capable of masking is a useful exercise. In some ways the process is a reversal of the work with the insecure individual. In this case the therapist directs the attention to the emotional experience and asks the individual to allow him or herself to attach to and experience the emotion. The secure environment of therapy and the therapist modeling of emotional management fosters a sense of confidence in that they too are capable of understanding and managing their own emotions. Further explorations of emotional managing techniques such as self-soothing are necessary for avoidant individuals to harness enough courage to remain closely connected in intimate relationships.

Conclusion

Working with adult attachment theory involves assisting individuals and couples to balance their needs for connection and separateness. A primary aim is to move away from negative learned emotional reactive patterns. The goal of ADP is to help clients to identify their need to connect emotionally whilst self-soothing the fears and anxieties that are associated with the possibility of loss and abandonment. These fears are real in the sense of existential separateness. However, in individuals with insecure and avoidant attachment styles the anxiety generated by attachment deficiencies

in their childhood have resulted in problematic attachment styles and coping strategies. Intimacy depends on couple's accessibility and responsiveness to each other as well as a respect for each other's individuality and the responsibility to understand and manage their own emotional experience.

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ACA

Working with adult attachment theory involves assisting individuals and couples to balance their needs for connection and separateness.

Will you be one of the few who are financially independent in retirement?

By David Raits, Authorised representative, CIS Financial Services Pty Ltd

A recent survey shows that 80% of people will need an income of $20,000 pa in retirement, while 62% say they'll need more than $30,000 pa. Many people believe that current minimum compulsory superannuation (SGC) levels are not enough to provide financial independence in retirement.

Key strategies for those likely to fall short include: saving more, moving money to higher performing assets, retiring later or reducing retirement income expectations.

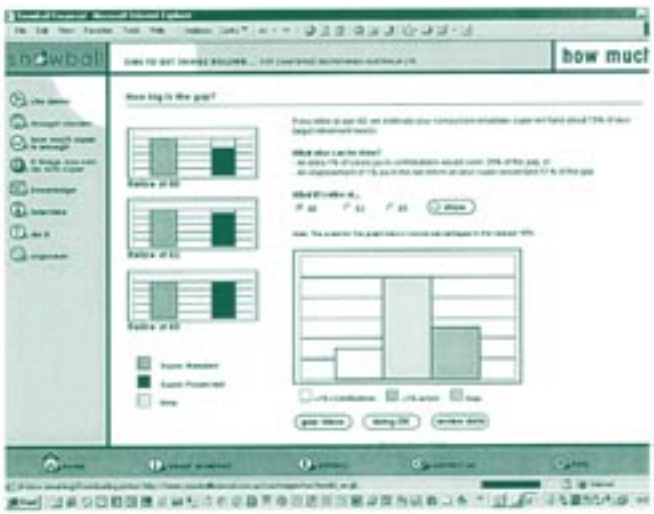
As the baby boomer generation nears retirement, superannuation is becoming a big issue. Baby boomers have enjoyed a pretty good lifestyle compared with their parents, but as retirement looms they are focusing on how to maintain their quality of lifestyle in retirement. Many are realising they won't be able to, unless they do something about their superannuation, and quickly.

A recent survey commissioned by the Association of Superannuation Funds of Australia (ASFA) was conducted in the marginal seat of Moreton in Brisbane*. The survey revealed that superannuation is likely to be a hot issue for the upcoming election. Ninety per cent of Moreton residents nominated saving for retirement as an important issue, ranking it well above issues such as the GST, the budget, and tax cuts.

From the survey, it is clear that many people believe the current level of SGC is not enough to provide adequate retirement savings.

From the survey, it is clear that many people believe the current level of SGC is not enough to provide adequate retirement savings. Further, more than 80% of people said they will need $20,000 pa or more in retirement; 62% said they'll need $30,000 pa or more. (Of the baby boomers, 70% said they'll need $30,000 pa or more.)

To achieve these retirement income goals, most people believe it is up to individuals to take responsibility for themselves, while being supported in their efforts by government (eg with tax cuts on super).



It is those who are between 40–50 year old that are most affected by a lack of savings. Younger generations have generally been better at accumulating retirement savings as they have benefited from the super preservation rules and compulsory contributions. Even so, once you reach 35 years of age, it is a good idea to think about your retirement needs and work out a rough plan for ensuring you'll have the necessary funds. Mortgages, school fees and other household expenses tend to be the major financial focus in these years, but saving a moderate amount into super each year will make a comfortable self funded retirement that much easier to achieve.

For 40–50 year olds, however, superannuation is an issue of crucial importance. If you are in this age group, you should not only be thinking about your retirement needs, but actively implementing a plan to ensure you will have adequate funds to achieve your retirement goals.

The ACA-Snowball website (www.snowballfinancial.com.au/aca) has a handy calculator 'How much super is enough?'. The calculator quickly lets you know how you are faring on the superannuation front. Enter a few simple figures – your age, current superannuation balance, current salary before tax, expected income level prior to retirement (in today's dollars), and the annual income you need in retirement – to find out whether your superannuation contributions are enough.

WHAT IF I DON'T HAVE ENOUGH?

If you are still young, or if you have been contributing regularly to superannuation for some time and have a healthy superannuation balance, you may be right on track to achieving your retirement income goals. If you have not been saving into superannuation regularly over many years, the calculator may show that your current level of superannuation contributions is not adequate for your retirement goals. There's no need to panic! There are several strategies you can adopt to remedy the situation (these are discussed in detail on the website):

1 Start saving more

Increasing your contributions to superannuation will help reduce the gap. The calculator shows the difference made by increasing your contributions by 1%. Salary sacrifice may be a tax effective way to do this.

2 Improve investment returns

If your superannuation is invested too conservatively, you could boost returns by moving some or all of it into more growth-oriented investments. The calculator

shows the difference made by increasing returns by 1%.

3 Delay retirement

By working a few extra years you may be able to save the necessary funds. Use the calculator to work out the financial differences between retiring at 60, 62 or 65.

4 Reduce retirement income expectations

This can be a tricky one, but you may need to reconsider your budget in retirement.

It goes without saying that the level of your retirement savings will make a crucial difference to your standard of living in retirement. The calculator five minutes at the website checking your retirement savings progress with the calculator. Your current level of superannuation contributions may be enough – but it will pay to check.

For further assistance call Snowball on 1800 22 88 11, or email us at enquiries@snowballfinancial.com.au or visit the ACA-Snowball website www.snowballfinancial.com.au/ACa

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** Full ASFA survey results available at http://www.asfa.asn.au/policy/rpm.cfm?page=reports*

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If you are still young, or if you have been contributing regularly to superannuation for some time and have a healthy superannuation balance, you may be right on track to achieving your retirement income goals.

Register of ACA Approved Supervisors

Name	Contact number	Qualifications	Cost hr	Medium
Philip Armstrong	Qld 07 3356 7262	B. Couns, Dip Psych SOA Supervision	$80.00	Phone & face-to-face
Nora Huppert	NSW 02 9181 3918	Family Therapy	$120.00	Face to face
Dawn Spinks	Qld 0417 633 977	BA (Psych) M. Pub. Hlth	$88.00	Phone & face-to-face
Martin Hunter-Jones	NSW 02 99734997	MA Ad. Ed BA Psych. Philos	$90.00	Phone & face-to-face
Kaye Laemmle	Qld 07 55911299	Dip Prof Couns SOA Supervision	$80.00	Phone, group Face-to-face
Miguel Barreiro	Vic 03 8801 4966	B.B.Sc (Hons)	$80.00	Group, phone Face-to-face
Anne Warren	Vic 03 9431 4922	R.N. Dip Prof Couns.	$80.00	Phone & Face-to-face
Kerry Cavanagh	SA 08 8221 6066	BA (Hons) M.App.Psych.	$100.00	Phone & Face-to-face & Small Group
Brian Johnson	Qld 07 3806 9338	Psychotherapist	$90.00	Face-to-face

REGISTER AS A SUPERVISOR

ACA invites professional supervisors to register their names with us. All registered supervisors will be placed on the above list for a 12 month period. They will also be placed on a list that goes out to all new members as part of the Application/Information Kit. ACA receives on average several calls a month from counsellors wishing to engage supervisors. Supervisors who are registered with ACA will be recommended to all enquirers. The cost of registration is $100.00 per annum for ACA members and $180.00 per annum for non-members.

This cost can be tax deductible. When you consider the coverage given through the journal, application kits and phone enquiries, you will not get a better return for an investment in marketing than by registering your name with ACA. Remember, if you are prepared to conduct supervision over the phone you are not restricted to your immediate geographical area. Counselling Australia is distributed to every state within Australia and all major regional areas. You will not get that sort of coverage for such a small cost anywhere else. Call us to receive an application for registration. ACA

Assessing the needs of men: analysis of calls to the men's help line – By Stephen Harrop

Acknowledgements

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Abstract

The needs of men have been identified by examination of calls to the Men's Help Line over the past six years. This service was operated as a voluntary telephone hotline and has been available to meet the needs of men and those who care about them. Analysis from the 17,000 calls to the Men's Help Line is used to address the question: *"what are the needs of men?"* Some leads indicate that calls dealing with legal and relationship issues have a high representation followed by personal crisis. By determining why men access services we seek to define risk factors associated with situations and how they affect the individual, the family and the community. An outcome of this study is the recognition of the needs of men within the healthcare system and also to allow healthcare workers to be able to identify with men's issues, particularly those men who feel isolated or marginalised. More recently, a Queensland funded telephone counselling service has been commenced in addition to a Commonwealth funded national telephone service for men.

The service was available for all in order to meet the needs of men and those affected by men. It was born out of the need to assist men who were experiencing difficulties, particularly emotional crisis.

The Men's Help Line was set up in 1994 as a Queensland based telephone information and referral service. The service was available for all in order to meet the needs of men and those affected by men. It was born out of the need to assist men who were experiencing difficulties, particularly emotional crisis. It was a major initiative of Men's Health and Wellbeing Association, based in Brisbane. This voluntary service received in excess of 17,000 calls over the six years of operation. To study the types of calls received by the men's Help Line and to analyse the nature and outcome. The need for the provision of focused men's health services in Australia has not been clearly defined and this data may play a role in assisting the formation of a national men's health policy.

The service provided information and referrals to men and those who care for them. The roles of telephone services in Australia are becoming increasingly recognised as important contact points for those in need of information, but moreover, those who need a friendly and non-judgmental contact. Health outcomes for males in Australia reflect rather poorly with overall longevity for males falling seven years short. Men are reluctant to seek counselling and are also more resistant to take advantage of general health care facilities and services. This telephone help service was set up to address the needs of men and allow easy and confidential contact in a non-threatening environment.

The advent of telephone help and counselling services

It was probably not imaginable, some 130 years ago, that the telephone would become such a ubiquitous communication device. The inventors: Boursel, Reis and Bell rather saw only the crude potential of transmitting voice messages, a far cry from its now routine use in this arena for information, support and counselling.

A number of important successful health initiatives use telephone services either as a large part of their operation or are solely dependent upon it. The telephone provides a convenient and economical medium as Philip (2001) points out in his discussion of a number of services that deal with breastfeeding; especially since breastfeeding generates many enquiries, and many mothers are unable to easily leave the home to seek counselling and support. Stewart and colleagues (2001) found that a twelve-week telephone support intervention for caregivers to haemophiliacs affected with HIV/AIDS was very positive. The carers shared information and the support groups were formed that then decreased their feelings of isolation and loneliness. In another controlled study, telephone services were shown to reduce health risks of targeted high risk individuals (back care, cholesterol control, eating habits, exercise and activities, stress management, tobacco use, and weight control) with a 1.8 to 3.5 fold reduction in specific risk (Gold et al, 2000) The researchers suggested that this telephone intervention may also help individuals develop behaviour-change skills they can apply to other lifestyle issues.

In a Dutch study by van Balen, (2001) telephone based volunteers who had experienced infertility treatments, spoke to callers about "the real experience of treatment and the behaviour and quality of medical staff". This service was praised for it accessible and empathic nature. Moreover, a Mexican based study of telephone counselling was used to identify the concerns of adolescents, especially in the areas of sexuality and health with some considerable success (Rasmussen, 2001). In a metanalysis review of telephone counselling for smoking cessation (Stead, 2001) it was concluded that the telephone service could be effective compared to an intervention without personal contact. However, the benefit of telephone counselling as an adjunct to regular counselling or drug therapy is equivocal, but they suggest that it may be a useful part of a treatment regime, but, telephone based counselling has not been without its critics (Anon, 1996) and the debate will be ongoing.

Interestingly, health counselling via electronic mail or e-mail health counselling has used in the workplace with some success also (Kurioka, 2001). The advantages of email as support to counselling are many (Lewis, 2001) and it has great potential, once the appropriate problems have been dealt with (Mackay, 2001). Furthermore, a plethora of web-based counselling services are currently in operation.

Special needs of men

A major black hole in many western health programs is the area of men's health and emotional wellbeing. As part of immediate strategies aimed at surveying men's health-related behaviours a national men's health policy initiative has commenced (Butler, 1996) as we know that men are less likely to seek either immediate help or preventative support for health and

emotional concerns (Dept of Health & Aged Care, 1998). The focus of this field of study is to recognise the needs of men within the healthcare system and to allow healthcare workers to be able to identify with men's issues, particularly those men who may feel isolated or marginalised (Lo, 1999).

History

The humble beginnings of the service sprang from a weekend men's festival in May 1994 where one man put the idea forward to set up a Brisbane Men's Centre using his own house A subsequent meeting of four interested men the next week decided that a telephone service would be a good first step They each put in $200, put an entry into the new phone book (listed under 'M' as a men's information and referral service in the telephone directory.), bought pagers, an answering service and used and an annotated *Lifeline* (generic telephone counselling service) contact manual. The lines open on 01 June 1994 coinciding with the launch of the book 'the myth of male power' by Warren Farrell who knew of the scheme, and was in Brisbane at the time being interviewed on radio. He mentioned the service on the ABC radio network, and the first calls were received that day.

A coordinator was used in a fill gap capacity September 1994 the first formal training session was run, and each six months thereafter was run for the volunteers, many of which had already had previously experienced personal crisis. There were numerous problems with other services that were available at the time: a particular complaint of callers was that they were predominantly handled by women; additionally, formula counselling was seen to be transparent to many men in crisis (particularly evident when you call a generic service twice and are asked the same series of questions), however, the overwhelming remark was that other services were often engaged. Men's services essentially did not exist at this stage. Male volunteers ran the Men's Help Line on a small budget of $4000-6000 p.a. of the Men's Health and Wellbeing Association (Qld) Inc. that was drawn from fundraising activities.

The Study

A retrospective analysis of documented calls was performed using call proforma sheets from the help line volunteers for the period. Descriptive statistics of the service are also given. All calls that were logged during the period were included in the dataset. Callers were given the opportunity to talk out their issue in confidence and relevant information and referral to other agencies or persons were offered. The study evaluated the time of call, the type of caller, the reason for the call and the outcome of the call. Data was analysed using the SPSS for Windows software program, release 10.0.05, standard version.

Results

During the six-year life of the men's help line, over 17,000 calls were logged. The descriptive data during the period April 1997 to May 2000 are presented here. This set consists of all the available data for the period and is comprised of 4239 individually documented calls, which represents a response rate of approximately 50% for the period.

Chart One displays the considerable variation in the number of calls for the weekly period. Apparently many potential callers erroneously believed that the service only operated during weekdays. Little consistent seasonal variation by monthly analysis, if any, in the amount of incoming calls is evident in Chart Two. It is, however, noticeable that mid-year troughs tend to punctuate the data set. There is no clear correlation to school holiday periods, but this warrants further investigation.

CHART ONE

Percentage call frequency to men's help line by day

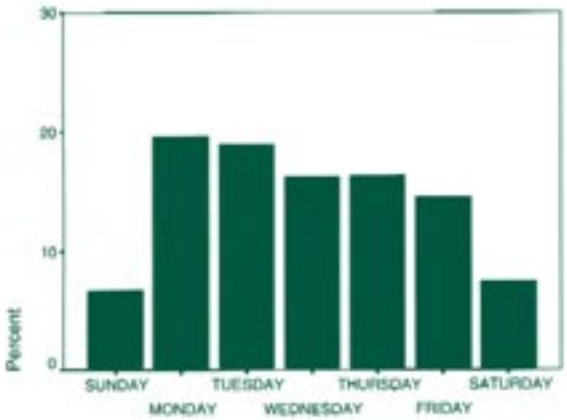

CHART TWO

Call frequency to men's help line by month

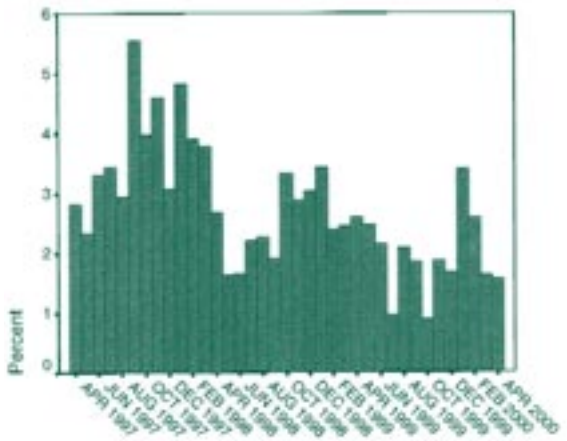

Chart Three depicts a breakdown of the primary reason for the call to the help line and can be compared to the call referral data in Chart Four. Interestingly, both legal and emotion issues featured strongly being 18% and 22% respectively. Professional calls (8%) were made by other agencies or volunteers with respect to help line users and proxy calls (8%) describe those made on behalf of men especially spouses and loved ones. The only other valid category above 5% was 'not listed'. This describes a caller who wants to make contact and wishes to talk to another man without necessarily having a primary objective for the call. Crisis issues (5%0 and non-emergency issues (4.8%) also had a presence. The major referral groups are shown in Chart Four and are dominated by the legal category (32.7%), counsellor referrals (25.6%) and men's

The study evaluated the time of call, the type of caller, the reason for the call and the outcome of the call.

Assessing the needs of men: analysis of calls to the men's help line – (Continued)

group's referrals (8.1%). The 'not specified' grouping (11.3%)describes men who do not seek referral, rather the caller was generally satisfied that they had ways of dealing with their immediate situation.

CHART THREE

Category breakdown of calls to men's help line

CHART FOUR

Call referrals by class by men's help line

We seek to define risk factors associated with crisis situations and how it effects the individual, the family and the community.

A breakdown of the referral categories is more revealing of the nature of the needs of the callers. More specifically, legal referrals included access to children (22%), custody of children (20%), settlement problems (11%), information about child support agencies (10%), and domestic violence issues (perpetrator 7%, victim 1.1%) and maintenance (6%) with other issues making up the remainder.

The breakdown of call referrals for emotional issues is a follows: wants counselling (36%), wants to talk (25%), relationship problems (18%), domestic dispute (10%), and wants support group (9%).

Discussion

Men called the help line for a number of reasons. Overwhelmingly, legal and emotional issues dominated the calls with many referrals going out to legal specific services and counsellors and counselling services. Interestingly, about 8% of calls were made without any specific reason, and similarly, about 11% of calls required no referral. This suggests that men wish to talk to other men, especially those who have experience a personal crisis themselves. The very fact that the call was made indicate this 'need to communicate' by men. This telephone based service provided a primary contact point for many men in distress and provided a specific resource for men.

Counsellors, counselling services and men's groups provide men a forum to deal with their issues; however, the telephone service provides anonymity and safety for those men who are not ready to communicate face to face. Men's groups provide an alternative for mainstream counselling services that can engage the target group to move them on where there feelings become normalized. The scope of the data shows that men want to communicate and wish to be offered an appropriate service or services that is directed towards men.

On-going services

There is a number of current men's telephone counselling services available in Australia. Two major free services which have Governmental endorsement by way of funding are 'Mens *infoline*' and 'mensline australia'

Mens *infoline* (since 2000) operates in Brisbane Metropolitan and South East Queensland and provides a weekday telephone counselling service. It is an initiative of Kinections, a division of Anglicare, and funded by Families, Youth and Community Care, Queensland Government. They provide advice on relationships, health, family and domestic violence counselling, support & referrals. More especially, they provide assistance for men and their families regarding abuse or violence.

The national service *mensline australia* (since late 2001) is auspiced by Personal Emergency Service Inc., a non-profit organisation and is part funded by the Commonwealth Department of Family and Community services as part of its Men and Family Relationships initiative which was set up in 1997. The service. An initiative of the Commonwealth Department of Family and Community Services as part of the Department's Men and Family Relationships program

Conclusion

By determining how men define tomes f need, what services they wish to access, and the perceived outcomes, we seek to define risk factors associated with crisis situations and how it effects the individual, the family and the community. An outcome of this study is the recognition of the needs of men within the healthcare system. The success of the men's telephone service indicates to workers in the field that they need to be able to identify with men's issues and deal with them appropriately.

Quo Vadis?

In light of the current developments in the insurance industry, with rising premiums and onerous liability, volunteers and professionals are loath to provide independent services. Umbrella organisations now provide much protection, but they, need to provide staff training, quality assurance and indemnity cover. The Queensland 'Good Samaritan Act' (1974) does not provide for people acting in good faith outside emergency physical assistance.

Whether a person or a service provides counselling, information or referral, it is hard to escape onerous

legal liability that is thrust upon one. The corporatisation of volunteer help groups is an outcome of this present environment. The recognition of men's need for emotional support services is now apparent. Men are a special case. It is only when the health and wellbeing of all groups in the community is addressed that the overall benefit to the community is realised.

Authors

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("Mens infoline" operates Monday to Friday 9.00am - 5.00pm via 1800 600 636 other contacts are available at mensinfoline@kinections.com.au and www.kinections.com.au)

("mensline australia" is open 24 hours a day and can be called from anywhere in Australia for the cost of a local call via 1300 78 99 78 and can also be contacted electronically talkitover@menslineaus.org.au and www.menlineaus.org.au)

'Good Samaritan Act', 1974 refers to the Queensland provisions contained in the Voluntary Aid in Emergency Act 1974.

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Whether a person or a service provides counselling, information or referral, it is hard to escape onerous legal liability that is thrust upon one.

Cyber-literacy. - Are you e-literate in the *Docuverse?

By Angela Lewis MA.Ed

Last Sunday afternoon I caught myself yelling at my son over the fact that I never saw him use a book for research, rather his first port of call was using the Internet. Didn't the school encourage him to use printed media for research?… I harangued….. Why did he take the easy way out and use the Internet, what was wrong with going to the library? This made me think about the concept of being information literate and the attendant issue of the critical examination of information we locate on the Internet.

Most of us are familiar with the concept of literacy as it applies to reading and writing and it is generally accepted that being literate means being able to decipher the written word and compose written work.

However there is a new skill that is fast becoming a mandatory requirement for everyone and that is e-literacy or cyber-literacy. This skill requires a person to be both information literate and computer literate. Computer literacy can be defined as being able to operate the software and programs on the computer as well as being familiar with the use of the computer hardware, for example the computer itself, the printer, the modem etc. Information literacy I will define using Bundy's definition: *'…to locate, evaluate, manage and use information in a range of contexts'* (Bundy 1998).

In fact the 1992 Mayer Report on key competencies for Australians, (a report written as a type of 'blue print' for a 'clever Australia') lists as the number one key competency ….*"the capacity to locate information, sift and sort information in order to select what is required and present it in a useful way and evaluate the information itself and the sources and methods used to obtain it"*. This still remains true I believe in the digital or electronic environment, however the challenge is in decoding and understanding the additional unwritten media (visual, oral, and symbolic) as well as the written text and the agendas behind them. To be information literate in an electronic environment, i.e. e-literate then means to read, write and interpret texts of a wide genre, i.e. words, sounds, pictures, symbols iconic representations, video symbols, etc in a cyber or electronic environment, i.e. the Internet).

The reason I found myself uncomfortable with my son indiscriminately gathering information from the cyber-world was precisely because of its 'free for all' nature, which allows anyone to publish their point of view, with no caveats on the veracity of the information, nor its agenda. True, one could say that anyone can publish a book, but it is a far more rigid process that requires auditing of information and has a better chance of ensuring the information will have some reliability. Compare this to posting information on the Web - it is an easy process that allows anyone, anywhere in the world to posit themselves as an 'expert' in any given field and to present information with any chosen agenda.

I also feel that there is a tendency for some people (children in particular) to view any information coming from the computer as having an intrinsic worth above other sources (e.g. books) specifically because it is online, and therefore somehow more current or valuable. Lester Faigley (1999) makes the point that while we as a society see pornography as the great risk to children on the Internet, the threat of misinformation should be viewed as a far greater risk.

Sandra Kerka (2000) says that the time has come for us to develop a 'critical literacy' in electronic environments - or perhaps critical e-literacy. This involves us in asking questions of the electronic media we locate on the Internet such as: "How good is the information, how can I trust it, what agenda is being served by the originators of the information, how does the text position the reader, what value systems does the information espouse, who is in the text and who is written out of it, who is communicating and why, which type of readers would find this offensive, what type of readers would find this text acceptable, what sort of value and belief systems would they espouse?

An oppositional argument might be that the Internet and electronic information changes the way we assimilate information in that it is a way of reading text that is dominated by the reader, who utilises hypertext to jump from one piece of textual material to another, and by taking this path the reader encounters the text in a way that allows them to construct a 'version' of the text i.e. the reader can almost become the writer. However, who put the hypertexts into the documents in the first place - the originator of the piece of work we are viewing, so while we may **think** we are creating our own information, we are merely being led down path (hypertextually) that the author intended.

Alan Bundy (1998) in a paper that examines the role of libraries and librarians in relation to information literacy, starts his paper with these words…"there are two certainties about the 21st century - change will be constant and it will be a century of data and information abundance".

Perhaps before we drown in a sea of data I feel we have to start being discriminating about which wave we catch. Or to use Lester Faigley's (1999:p134) analogy, *finding information on the Internet is like drinking from a fire-hose.* We cannot assume that just because we found the data out on the Internet, that it somehow makes the information automatically a real, right or sound source of knowledge; and the added issue - out in a virtual environment that is attractive and fun to use, we probably have to be a little more discriminating than usual when researching information. This is not to insult anyone's intelligence, however Web sites are designed to sell a message to us as potential consumers of a point of view, a product or a concept.

Perhaps the last word to Nancy Kaplan (1995), who says "there are lots of pointers to "Cool Stuff" all over the Web…but I have yet to see much in the way of thoughtful analysis of the Web as a human construct, creating itself through a confluence of human motives and shaping its users' communications through its entitlements and restriction."

**somewhere in my meanderings out on the WWW I found this term, but am unable to credit it to its originator, it means the 'universe of documents', otherwise known as the Internet.*

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Book Reviews

Internalization

By Wallis KC & Poulton JL,

This book forms part of a series entitled "Core Concepts in Theory". Each book in the series seeks to examine the comparative positions of different therapeutic schools with regards to key ideas in psychological therapy.

If you are looking for a practical work to help you in everyday practice then this *is not* the book for you, but then neither does it pretend to be. As a text book on an important aspect of psychological theory Wallis and Poulton have done a better than adequate job of bringing together the approaches of five major but quite diverse schools of thought – from the classical psychoanalytical to the humanistic/existential. The real value for this reviewer however was found in the last chapter where the authors critically examine the validity of internalisation theory as a conceptual construct.

The book is well laid out, indexed, and referenced with sixteen pages of "further reading" for the keen researcher. For those more visually orientated in their learning style there is however a disappointing lack of graphs, Venn diagrams, flow charts or even tables. One can't help but feel that the inclusion of such learning aids would have added that extra dimension to one's understanding of some of the more complex issues under discussion.

Wallis & Poulton's 'Internalization' is written in typically "text book" fashion requiring a certain commitment to perseverance from the reader. That said, it is a work fairly typical of its genre and those of us who have had to plough through its ilk in the course of our studies will recognise the value these tomes have with regard to the general knowledge database that all healthcare professionals need to develop in order to be better than merely average practitioners in our chosen field.

Available from Allen & Unwin tel (02) 8425 0100
$45.00

Reviewed by Adrian Hellwig
a Pastoral Care Worker at Villanova College and Vice President of Clinical Counsellors Association Inc.

Solution-Focused Stress Counselling,

By B. O'Connell

This is the fifth book by this publisher in a series on Stress Counselling.

Like the other books in the series O'Connell's book is for the practitioner. Though the theory is sound and well expounded and the research extensive (there are five pages of book references plus a page of internet site references) it is the way it is all carefully linked to actual practice that most appealed to this reviewer. In this day and age, where no professional publication could be called cheap (and this one is no exception retailing for $55 AUS) and most private counselling practitioners are far from well off, I for one look for something I know I'll find time to read *and* feel will better equip me in my day to day practice.

I suppose that when looking to build up one's professional library one, initially at least, needs to examine needs rather than wants; the "I could really use that" rather than the "Oh, that would be nice". So why should this book rate? As I see it O'Connell's book rates on two counts.

Firstly, stress is definitely one of *the* most commonly encountered traumas of the late twentieth, early twenty-first century. As such it is frequently encountered by counsellors, if not as the major presenting problem then at least as a significantly contributing factor.

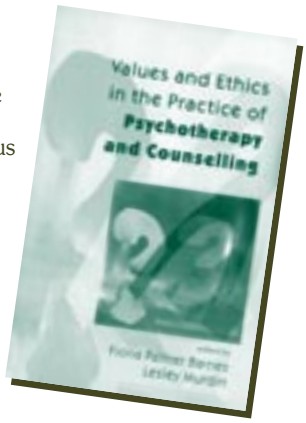
Secondly, solution focused brief therapy, by its very nature, concentrates on finding a way beyond the problem rather than centring attention on the problem itself. In practice this means that, depending on the client's personal resources, the number of counselling sessions can be reduced without affecting either the quality or longevity of the resolution reached – a situation that greatly benefits both client and counsellor in the long term.

Although unable to go into any great depth in a review of this length this is a worthwhile book and any purchaser will find benefits in it to both their personal professional development and their practice.

Published by Continuum, London, 2001
ISBN 0 8264 5311 2

Reviewed by Adrian Hellwig
a Pastoral Care Worker at Villanova College and Vice President of Clinical Counsellors Association Inc.

Values and Ethics in the Practice of Psychotherapy and Counselling



By Fiona Barnes and Lesley Murdin

This book is about the values that underlie the theory and practise of psychotherapy and the hope that examining these values will enable us each to make choices more consciously and freely. It emphasises that everything we do, say or radiate can be a form of suggestion or influence on clients, coloured by our own value system. The 13 authors have professional backgrounds in medicine, philosophy, social-sciences and the arts. Values and ethics are shown from different perspectives. The authors look at fundamental principles of ethics and morality as an academic study of varying definitions and the therapists responsibility to the patients. Several chapters look at how therapists express their value systems through the process and techniques they use, their assessments, dealings with erotic transferences and views on success and failure. Others describe the effects on the client's immediate and wider environment, which touches the ethic principle of

Book Reviews – (Continued)

confidentiality. The final part deals with the therapists' view on society, culture and their own Spirituality " Why do we do this work?" This book is not a handbook "What we should do", but a good basis to examen our own ethics and values. The variety of approaches encompasses:

- self reflection
- the ability to put those thoughts, feelings and actions into words
- attend the necessary boundaries in the therapeutic intimacy
- communication and a more professional and open exchange between therapists.

The authors confront, challenge and look at us as human beings with all our facets.

All 13 writers show their experience and deep involvement in their work. Their questioning and research even challenge existing ethical values and open up a platform for ongoing free, honest and authentic discussion and the development of new ways. We therapists can allow a level of personal communication between us. We can help each other to open to unconscious aspects and transform them to new ways of interacting with our clients. We can help each other not to feel so isolated in our work. It is a recommendable book to understand better attitudes, belief systems and how to deal with the inevitable influence on your patients. A push for us becoming aware of all positive and negative feelings incl. prejudice and erotic responsiveness that arises in the inner world as a result of the intimacy of therapy.

Available from Allen & Unwin tel (02) 8425 0100 $49.95

Reviewed by Uma Bone
a Psychoanalyst and Counsellor in NSW.

Wise Therapy

By Tim LeBon

The author is a London based teacher of philosophy, counselling and personal development, who in addition practises as a counsellor and is the editor of a journal "Practical Philosophy". This short account of his identity is important in understanding the intent of this book and in turn in deciding to read it.

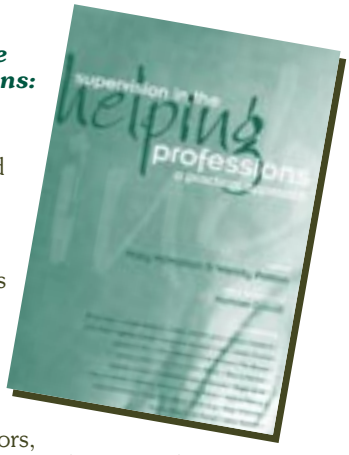
The book Wise Therapy endeavours to describe the place of philosophy in counselling. It asserts that the act of rational, logical, and critical thought can add, in a practical way, to the act of counselling by supporting the reader to better understand and explain the underlying assumptions informing their actions as counsellors.

In doing this "Wise Therapy" describes a significant range of philosophical arguments derived from the western philosophical tradition in terms of their relevance to counselling. It succeeds in crystallizing very complex ideas in a succinct and accessible way, using "real life" examples of their application. It also provides an account of each arguments' weakness, and largely invites the reade4rs personal consideration of the strength and relevance of these arguments to them. Further to this it provides a fine range of references with which the reader can continue to uncover the depths available within the range of philosophical ideas presented.

I believe this book is appropriate for people with little experience of academic philosophy given it's mode of presentation and encyclopaedic intentions, however a background in philosophy sure wouldn't hurt. Having said this, the book attempts a very large subject in a relatively small space. As such it left me with many more questions than answers…..which is, I guess, ultimately not a bad thing.

Available from Allen & Unwin tel (02) 8425 0100 $39.95

Reviewed by Martin Hunter Jones
a private practitioner and
Chair of the ACA NSW Chapter



Supervision in the Helping Professions: A Practical Approach.

By McMahon, M. and Patton W. (editors). (2002).

Supervision in the Helping Professions is a useful and practical guide for those who participate in supervision and comprises input from leading supervisors, counsellors and lecturers within Australia. It includes a sample of a supervision contract, models of supervision, and useful questions for both the supervisor and supervisee to ask when negotiating a supervision relationship.

There is an interesting chapter on peer relationships that were reciprocal in their supervision. It quotes research that found such relationships tended to be more intimate, longer lasting, and characterised by trust, higher self-disclosure and emotional support. There was a decreased dependency on "expert" supervisors, the use of peers as models, mutual benefits through sharing and increased skills, and responsibility for assessing one's own skills as well as those of one's peers.

The pitfalls of peer supervision were reported to be not keeping to assigned roles, losing objectivity and the focus of reflective practice by becoming sympathetic, not challenging inappropriate values and actions and so becoming collusive through not wanting to upset the other, and exploiting the closeness of the relationship by giving supervision less priority.

The book proposes that email supervision can also be useful, especially when a face-to-face relationship has been established, especially for brief consultations, requests for potential strategies, and other supervisory input of an informational/educational nature. It is seen more as a supplement for ongoing face-to-face or telephone supervision. It is less appropriate when

the supervisee needs to explore in depth some aspect of their process with a client, and where a lengthier, more considered interaction with the supervisor is necessary. By its nature, email tends to produce short "off the cuff" and uncensored pieces of material and this should be kept in mind by supervisors when they respond using email.

The book also argues the pros and cons of group supervision, supervision within and external to an employing agency, telephone and email supervision and other supervision models. A very worthwhile book, especially for those providing clinical supervision.

Available through Pearson Education Australia: tel (02) 9454 2222

Reviewed by: Ken Warren
an experienced counsellor and supervisor in private practice in Maroochydore. Queensland

ACA

Chapter News

West Australia

"The ACA WA Chapter is off to a good start this year with the committee members working collaboratively to promote the WA Chapter. We achieved our first goal (ahead of time!), which was to produce a brochure introducing the WA Chapter. A copy of the brochure is enclosed for WA members. Congratulations to all the committee members for such a great effort! We are obviously delighted with the news that health rebates are now available for ACA, only, members in West Australia and thank the National Office for their hard work making this a reality. We understand we are the first counsellors (non-psychological services) in Australia to receive this wonderful benefit.

In the future, we will be looking at ways to satisfy practitioner needs in terms of both business and professional development through networking, seminars, and other avenues.

The committee meets regularly to discuss any new initiatives and strategies to increase awareness of the ACA WA Chapter and counselling in general. It is very important to increase the awareness of the WA Chapter if we are to assist with the growth and credibility of the local counselling industry in Western Australia. We would welcome any new members who wish to join our local WA Chapter, just simply contact the ACA's National office for details on becoming a member, and support your local Chapter".

SA Chapter News

We hope all of you had a pleasant holiday season. Now that 2002 is official, we are looking forward to an active year with our chapter members. Our main goals for this year are to increase the profile of the ACA and its members, to set up some group advertising for our independent practitioners and to provide continuing education opportunities for all.

Yellow Pages Advertising

We have received expressions of interest for a group listing under the ACA logo. The details will soon be arranged. If you want to be in on this, please contact Peter Papps as soon as possible.

Advertorials

We are continuing to pursue the project of Advertorials in the Adelaide area, to be printed under the ACA logo. All costs will be shared between the participants. If you are interested, please contact Peter Papps.

Coming Seminars

Mandatory Reporting, presented by Robyn Nader of the University of South Australia, will be held on 27 April at the Patawalonga Motor Inn, Glenelg. Cost per person: $80. There will be a limit of 25 participants, so book early once the flyers come out!

Youth Suicide & Depression / Stress Management Program is tentatively scheduled for late June. Stay tuned for more details.

The Chapter is currently discussing with Dr John Potter of the the possibility of a special speaker, Dr Rienie Venter from the University of South Africa to run a workshop. Dr Venter will be visiting the Paraclete Institute (Adelaide) in June and has offered to speak at a ACA workshop.

Students

We can offer you a low cost refresher class on study skills, reading for comprehension, and writing techniques if enough people are interested. We're thinking of a 2-hr workshop for about $20 per person. Contact Mary Rose via email: mrose@roxbynet.com or phone 8671-0759

Suggestions, Comments, Questions

- Feel free to contact us!
- Peter Papps, Chairman: 8363-5822 (w) persontoperson@picknowl.com.au
- Mary Rose, Secretary: 8671-0759, mrose@roxbynet.com

Queensland Chapter

Firstly, I need to offer my apologies for the delay in getting started with the Queensland Chapter. Due to a chronic illness that has caused me to be incapacitated since November last year – has resulted in major setbacks. However, I am recovering and getting back to my normal routine.

There is a meeting set down for Saturday March 30th at 2pm at Carearm 56 York St Beenliegh. If you are unable to attend please contact me on the following

We would welcome any new members who wish to join our local Chapter, just simply contact the ACA's National office for details on becoming a member, and support your local Chapter.

numbers (w) 07 3807 3644 (h) 07 3200 8309 (mob) 0427482041.

I thank the Queensland chapter members for the patience in this matter.

Malcolm Lindridge, Chairperson

NSW Chapter

The NSW Chapter has now been broken up into 2 sub Chapters, Sydney and Hunter Valley sub Chapter's. Each sub Chapter will have an equal number of representatives on the NSW State Chapter. Martin Hunter-Jones is the Chairperson of the Sydney sub Chapter and the State Chapter with Dr Ted Heaten being the Chair of the Hunter Valley sub Chapter and Vice Chair of the State Chapter. The Hunter Valley Chapter will cover the Newcastle and Northern region of NSW with the Sydney sub Chapter covering the Sydney and southern region including the ACT.

Sydney sub-Chapter news

The Sydney Chapter of the ACA began the new year on a good note with a successful and well attended meeting.

In this first meeting, Jane Walton, a professional member presented some ideas on counselling couples via a case study, then facilitated an engaging discussion on the subject. Feedback from this presentation suggested that it was very well received.

There has been a lot of networking between chapter members with everyone gaining knowledge about counselling and running your own private counselling business.

We were also able to discuss the upcoming ACA NSW conference. It was determined that the conference will take the format of a day long series of practically oriented workshops. Participants can then choose form a number of subjects ensuring there will be much of interest and relevance to all.

Future Chapter meetings will take place bi monthly, and continue to include presentations and discussion on issues relating to counselling practice in addition to consideration and action to promote counselling and the ACA.

Our next meeting will be Sat April 13 between 3 & 5pm at the Police Citizens and Youth Club, 224 Falcon St, Nth Sydney. The presentation will be facilitated by Jeff Spenser on the subject of *"counselling micro skills, the basic counselling tools"*.

All ACA members (or prospective members!) are welcome.

For information and or to RSVP contact Martin Hunter Jones on 0438 336 535 or e-mail martinhj@tpg.com.au

Hunter Valley sub-Chapter

The Hunter Valley sub-Chapter will start meeting soon and members will be informed of the time, venue and content as it becomes available. The following is a short biography of Ted Heaton, the Chapter Chairman: Age 70 this month, co-owner since 1992 of Gracegrove Colleges, along with Toni. Together they have 6 kids, one deceased. Ted holds the following qualifications: a Diploma of Esoteric Sciences from Claregate College (London 1972), Doctorate in Metaphysics from SEEK University USA (1974), Honorary Bachelor of Esoteric Psychology from Claregate College (1995) and a Doctorate of Esoteric Psychology from Claregate (1997). Ted has been published in US and Canada. He has done considerable radio and some TV work overseas as well as counselling professionally for about 30 years in a number of countries (Canada, US, England, Australia, Hong Kong, Japan). Currently Ted teaches the following subjects: Esoteric Self Empowerment, Esoteric Psychology, NLP, TA, Gestalt, Psychotherapy, Dream Therapy, Psychosynthesis, Intensive Counselling Skills (with Toni), Advanced Counselling (with Toni), Meditation and a few other subjects.

We welcome Ted to the association and are grateful for his time and dedication to the forming of a new chapter that will represent ACA members in the Hunter Valley region.

Victorian Chapter

The Victorian Chapter is now in its second year and continually growing in numbers. There has been a lot of networking between chapter members with everyone gaining knowledge about counselling and running your own private counselling business. ACA Chapter meetings are a wonderful way for student counsellors to meet other students as well as graduates and 'older' more experienced counsellors who are already out there practicing counselling. Us older counsellors are still learning as well. Chapter meetings are also a good opportunity to meet counsellors from different schools and backgrounds. If you haven't already joined the Victorian chapter, please do so. You will then be contacted about future meetings. If you have any further ideas about the chapter or what you would like to see happening, please email me at gaylehig85@hotmail.com. We are planning our next meeting for March. Our goal for this year is to provide the opportunity for more ongoing education. Look forward to meeting you. Gayle Higgins, Chairperson, Victorian Chapter.

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Canadian Counselling Association

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For on line membership information and details about . . . *the* Association for Counsellors in Australia please visit the **ACA Website** at **http://www.theaca.net.au**

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