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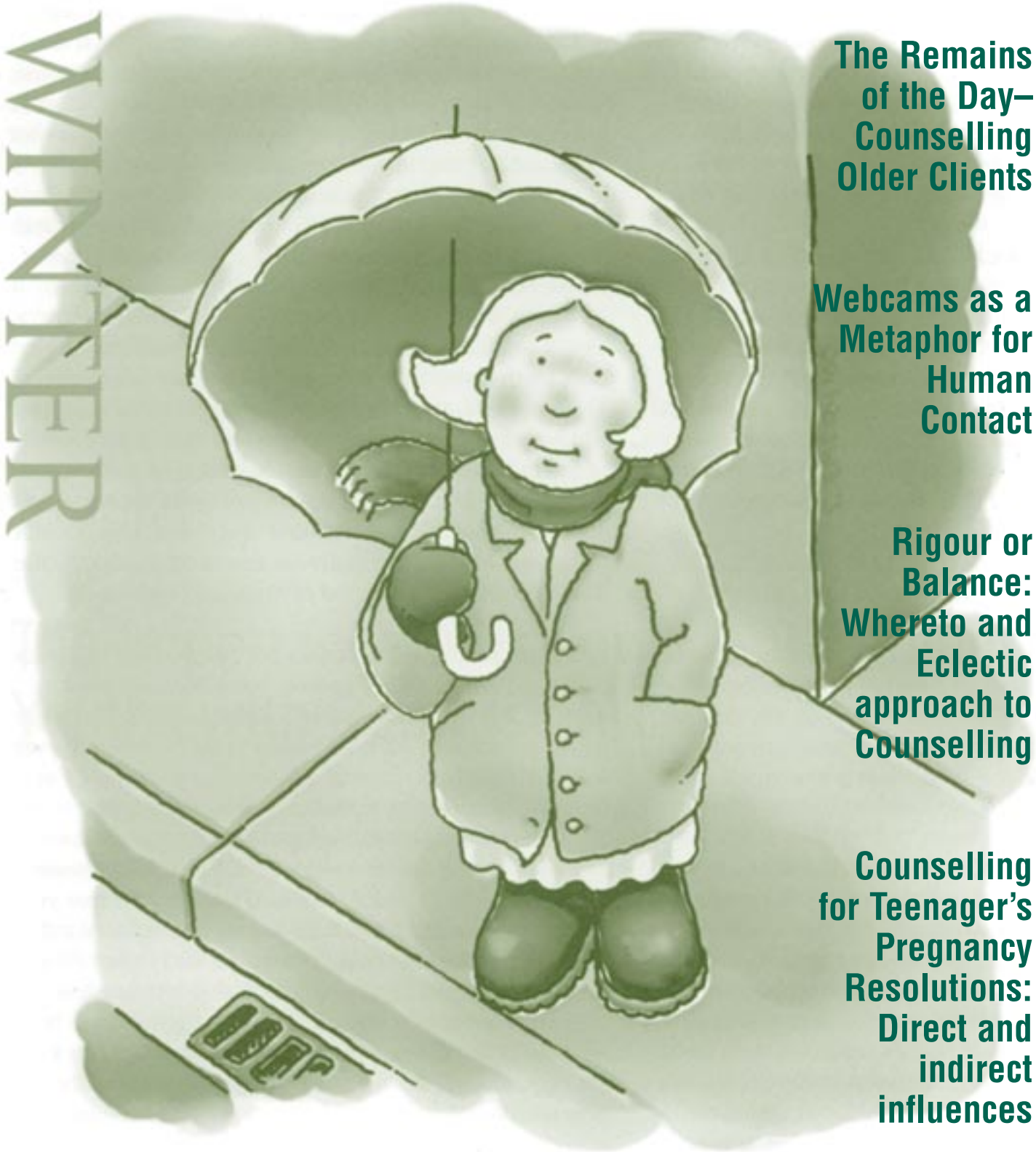
COUNSELLING AUSTRALIA

Australian Counselling Association Journal
ACA AUSTRALIAN COUNSELLING ASSOCIATION



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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 By Philip Armstrong

The first quarter of this year has been a very fruitful one for ACA in relation to new membership and developing new benefits for members. Unfortunately, we have also been faced with the issue of insurance again. For the second time in 12 months we have been informed by AON that the underwriters of the Health Practitioners' Policy, St Paul's International, are no longer offering the appropriate insurance. This has left those new practitioners out in the cold, with no insurance available for them. It seems at the time of writing this editorial that there is no insurance available through AON for new policies. Current policies are still valid till September this year. They have assured us that they are investigating new avenues. ACA is also investigating new avenues, as we cannot be forever at the mercy of insurance brokers.

The advertisement below this editorial is the outcome of several months of negotiations and meetings with a possible employer. The positions that may become available for counsellors are very good starting points for new counsellors.

We also have spent the first quarter of this year being involved with Community Services & Health Training Australia, with the redevelopment of the current accredited Diploma qualifications for Counsellors in Australia. With the help of our members in Western Australia and Tasmania, the national office has ensured that ACA's involvement has been proactive and positive. This type of involvement reflects the standing of ACA in the industry. Employment for counsellors is a very important issue for us at ACA and is, and will continue to be, a primary concern. Earlier this year, we sent out a questionnaire to some members in relation to employment for counsellors.

We have been able to identify growth areas in the market and have now been able to attract a major employer. ACA has been approached by an organisation to act as a referral base for the hiring of counsellors.

The advertisement below this editorial is the outcome of several months of negotiations and meetings with a possible employer. The positions that may become available for counsellors are very good starting points for new counsellors. The positions require counsellor training, and membership of ACA will carry some weight, as our standards for membership will be taken into consideration when hiring.

ACA would encourage all its members who are looking for full-time work to consider these positions. There are several hundred nationally. Although the positions may not be specifically for full-time counselling, they will give you the experience you need to move on to further positions within the industry. ACA has advised the employers of the necessity of such things as professional supervision and on-going professional development. It is our understanding that the employer is interested in students of counselling as well as those who have completed their courses. This is possibly a great opportunity for ACA members and we encourage all those looking for full-time employment to at least investigate this opportunity.

ACA

New ACA Partnership

In May 2002 the ACA became a Supportive Partner of depressioNet.com.au, Australia's number one ranking Health and medical information Internet site. depressioNet aims to empower people with depression and related conditions whilst also offering vital information to carers, families and health professionals. **www.depressionNet.com.au** attracts thousands of visitors each week.

The ACA partnership with depressioNet will provide a number of benefits for the ACA and will raise the profile of ACA Counsellors in this key target group. Most importantly it offers an exciting opportunity for depressioNet and the ACA to work together to reduce the impact of depression and related conditions on the lives of Australians!

Individual ACA members will also benefit from this relationship through the site's referral service. Many people visit depressioNet.com.au seeking referrals to professionals who treat and manage depression. In addition to depressioNet's email based individual referral service, the 'help in your area' section on depressioNet.com.au enables visitors to find information about a broad range of professional help and support groups available. The ability to find detailed information about health care professionals can make what is often a big step to seeking help easier.

In recognition of the support of the ACA, depressioNet offers a **40% discount** on individual depressioNet registration for counsellors who are ACA members. Benefits of registering with depressioNet and to become part of this nationwide referral network include:

- Personalised page within depressioNet containing information about you, the work that you do, how you can help (counselling), work you are involved in (research) etc.
- Inclusion of any workshops, information nights, support groups, etc you are conducting in the depressioNet 'What's On' section, and Newsletter(s) as appropriate;
- Inclusion of research projects on depressioNet and newsletter (participant recruitment);
- Inclusion in depressioNet personal 24-hour email support and referral services;
- depressioNet.com.au email address if required. Visitors can email you directly or you may chose for them to email you at yourname@depressioNet.com.au and our 24 hour Visitor Care Team will forward this to you via email, phone or 'snail mail' as desired.
- depressioNet wallet cards for Counsellors to give clients who may benefit from the services depressioNet provides.

Standard Registration: $500 (+GST) pa

ACA Member Registration Fee: $300 (+GST) pa

depressioNet is also a valuable resource for your clients. To request brochures and /or depressioNet 'wallet cards' contact

Contact depressioNet on (03) 9898 9165 or email lou@depressionet.com.au for further information on how to register.

Visit www.depressionNet.com.au to find out more about the extensive resources it offers to the public and health professionals, including a list of upcoming conferences, assistance with research participant recruitment and for more information on its referral service.

The ACA partnership with depressioNet will provide a number of benefits for the ACA and will raise the profile of ACA Counsellors in this key target group.

Use the ACA logo to help improve your bottom line

The ACA logo is recognised throughout Australia and stands for quality, integrity and professionalism. We have received many calls from course providers and workshop presenters for permission to use our logo on their marketing material. To date we have been reticent to allow others to use our logo to promote their services, however we have now devised a new system that will ensure only those who meet our high standards will be able to use the logo on their marketing material. We have designed two new logos that can be placed on marketing material to demonstrate to potential users of the services that the service meets our high standards and is recognised by ACA.

Workshops/seminars

If you are a presenter of workshops/seminars, the ACA logo will give you the edge over other similar presenters. This is very important, as the added benefit of using the logo will improve your bottom line, due to the workshops' being recognised by ACA for On-going Professional Development (OPD). You will also be able to attract ACA members (several thousand nationally), who look for this type of validation of quality and high standards. OPD is a mandatory requirement for all practising members before they can renew their membership. ACA receives calls daily from members wanting to know where they can attend OPD recognised workshops. You now have the opportunity to offer OPD training. Workshops/seminars must meet ACA standards before being eligible to use the ACA logo. For further information and application forms to use the workshops/seminars logo, ring 1300 784 333.

Training Providers

Training providers can gain the advantage by having the ACA logo placed on their advertisements to reflect to potential students recognition by a National Peak Body. This gives students the peace of mind that, on acceptance to their course, they will be eligible for student membership of ACA and, on completion, they will be eligible for full membership. ACA receives on average four calls a day and several emails from our website enquiring as to what courses are approved by ACA for membership purposes. By displaying the ACA logo, providers will ensure that potential students will automatically go straight to that provider. Courses must first meet our standards' criteria before providers can apply for use of a logo. The ACA Course Recognition document can be requested by ringing 1300 784 33.

ACA

If you are a presenter of workshops/ seminars, the ACA logo will give you the edge over other similar presenters.

NSW Chapter of the Australian Counselling Association 2002 Conference

Consisting of Nine Workshops at YWCA's Y on the Park 5 - 11 Wentworth Avenue Sydney NSW 2010 on Saturday 22 June 2002

The Workshops & Presenters

SESSION 1

Music Therapy – *Ruth Bright*

This workshop will provide a brief overview of music therapy and provide ideas for counsellors in using recorded music during therapy.

Ruth has been involved in music therapy for over 40 years with a focus on assisting those with drug and alcohol who are psychiatrically ill. She has been a pioneer in the establishment of professional music therapy in Australia, has trained and taught extensively overseas, participated in international forums, held the position of President of the World Federation of Music Therapy and authored numerous books and academic papers.

Suicide Prevention - *Cate Sydes*

This workshop aims to raise the level of suicide awareness within the community by helping participants toward identifying and helping suicidal persons by the implementation of the S.A.L.T strategy.

Cate is the National Manager of LifeForce (part of the Wesley Mission). She has worked in education for 20 years and has been a registered psychologist for the past 15 years. She has been intensively involved in suicide intervention throughout this time.

Transactional Analysis/TA – *Elizabeth Crichton*

TA is a theory of personality development, human behaviour and social interaction. In this workshop Elizabeth will introduce the building blocks of TA, namely the Ego States (different parts of the personality), as well as a useful concept for looking at the roles we play called the Drama Triangle.

Elizabeth is a qualified occupational therapist and completed her TA training in 1988. She currently runs a full time practice, teaches in various colleges and runs a TA training group for aspiring TA teachers.

SESSION 2:

Art Therapy - *Annette Coulter*

Expression through art can offer the opportunity to begin to verbally explore issues in a metaphoric and symbolic content of artwork. Art Therapy is most effective when a client, family or group have difficulty verbally communicating their problem(s).

Annette is a registered art therapist and clinical family therapist with 26 years experience specialising in child, adolescent and family art therapy. She is a co-founder of the Australian National Art Therapy Association in 1987 and has taught art therapy since 1984.

Men's Issues - *Paul Whyte*

This workshop will address the particular cultural issues faced by men in our community. It will support participants to develop their understanding of men's place in our culture and also identify some of the challenges, opportunities and techniques which can make counselling more accessible and successful for men.

Paul has worked as a leader in developing the men's movement for over 20 years. He has an international reputation for his writing and presenting on this subject. He has initiated many of the pioneering events of the men's movement in Australia, including bringing Re-evaluation Counselling to the men's movement, founding the Sydney Men's Network, and with others, launching the inaugural Australian and New Zealand Men's Leadership Conference

Mindfulness, Neutrality and Couple Therapy – *Geoff Dawson*

Counsellors trained in individual therapy often struggle in mastering this skill as they move to working with couples. Mindfulness meditation is a valuable methodology to help develop a deeper sense of compassionate neutrality within the person of the counsellor. This workshop will demonstrate the principles of mindfulness meditation and apply it to working with couples through role playing.

Geoff Dawson is a full time psychologist in private practice at Katoomba and the Metta Clinic, Pymble. He worked for many years with Relationships Australia as a clinical supervisor and trainer of marital and family therapy. He has also been practising Zen meditation for 25 years and is a teacher in the Ordinary Mind Zen School. He has presented at many conferences in Australia on Buddhism and Psychotherapy and has written papers on this subject for psychological and Buddhist journals.

SESSION 3:

Intensive Journalling – *Kate Scholl*

Journal writing can be a means of expressing the pain and difficulties we experience and witness, as well as the breakthroughs. It can also enable us to be more centred and self aware and act with clarity and purpose. This workshop will introduce some gentle reflective journalling exercises, introducing a few different methods including quiet meditative time, as well as time on your own to journal and some time to share insights. Kate will also share briefly the work of Dr. Ira Progoff and the Intensive Journal work he developed out of his practise as a therapist and his study of depth psychology.

Kate Scholl, from Sydney, is the executive Director of the Eremos Institute (a National ecumenical organisation promoting spiritual awareness and conversation), an adult educator and a keen journaller. She has led journal workshops of all sorts for over 20 years, including the Intensive Journal workshops developed by Ira Progoff for which she is an accredited consultant.

Buddhist Practice in Psychotherapy - *Subhana Barzaghi*

Buddhist mindfulness practice has been used for over two thousand years as a primary tool for cultivating wisdom and compassion. Mindfulness directs our attention to what is actually happening to us and in us in successive moments of perception. When used in psychotherapy it enables a person to access core

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The Remains of the Day – Counselling Older Clients

John was in his early 90s when he was referred for counselling by his GP because of depression and anxiety concerning his physical health and the approach of death. His history was of achievement and a mainly positive disposition in younger days, turning into a dark and guilt-ridden perspective as his health deteriorated. Counselling took place in his home, owing to his poor mobility and failing eyesight… ***David Richards*** *looks at the challenge of working with older clients*

OLDER people have never been a central part of the world of counselling and psychotherapy – except of course as theorists and clinicians. As clients they have tended to be overlooked or ignored and, I would like to suggest, often misunderstood and perhaps feared. I want to look here at why this is so, to examine the history of the client group and its meaning for us as practitioners and to suggest a natural place for older men and women within the frame of our work as counsellors and therapists.

My own experience as Counselling Service Co-ordinator for a central London branch of Age Concern has provided an opportunity to think about why and how older people use and relate to the process of counselling. The term 'older people' itself, of course, is in some ways unhelpfully wide, encompassing at least two generations if one imagines old age or later life starting at the customary 60 or 65, and obviously embracing many variations in role and experience. But I feel it is probably the most appropriate, neutral term psychically developmentally.

No longer educable

From the earliest days of the analytic tradition, therapeutic work with those above middle age was presented by Freud as impossible or irrelevant: 'Near or above the age of 50 the elasticity of the mental processes…is as a rule lacking' … 'old people are no longer educable' (1905). Freud was speaking perhaps in a particular context (culturally, societally) but he was also just 49 when he wrote this. It is hard not to imagine a projection into his own future and I have always felt that personal fear in the face of ageing is quite powerful in these lines (even though it is easy to say that his fear was misplaced, bearing in mind his later achievements). It is a fear or ambivalence many of us might share or certainly understand and I think it is central to the question of therapeutic work with older people.

How do we see and experience the aging process? What do we anticipate (and what have we already experienced through our relations with parents, grandparents and others)? Do we feel we have the resources to cope well enough with what is to come and what unresolved business might be left us as our life moves towards its close? The concerns and questions older clients might bring to us will very often be reflected in our own minds and confront us with our own ageing and ultimately our own mortality. So it is not necessarily an easy or comfortable area in which to work.

The other side of this troublesome equation s provided by a perspective most eloquently stated by Jung (Stevens, 1990) who saw later life as a time of consolidation and completion, with not only desirable attributes but essential tasks to be performed. If Freud's view is characterised by darkness and anxiety and a fear of closing down, Jung's view tends much more brightly towards achievement and continuing development, the completion of individuation and further/final change and growth. Erikson (1965) neatly encapsulates these polarities with his concept of 'ego integrity versus despair' as the challenge for the last stage of life.

A central part of this challenge is the potential for growing dependency which can powerfully mirror the dependency of childhood. Our cultural familiarity with this connection (Shakespeare's old age as 'second childishness' in the seven ages of man (As you Like It, Act II/Scene vii) should not distract us from recognising how painful and frightening such a return to an early state of dependency might feel. Equally, unmet dependency needs from childhood can be fearfully relived, as Martindale has described (1998). The experience of failed dependency in early life or the absence of a good enough holding environment in childhood, becomes internalised and perhaps traumatically re-experienced as independence diminishes in later years. Dependency can be difficult but the fear of not getting the help and support one needs may be terrifying. the counselling room may provide the ideal place for these feelings to be experienced and possibly worked through.

How do we see and experience the aging process? What do we anticipate (and what have we already experienced through our relations with parents, grandparents and others)?

The last stage of life

The two extremes of Erikson's last stage, and the many emotional vicissitudes that surround them, can powerfully shape the work we do with older people where both parties know and may acknowledge to each other that the context is the last stage of life, the end perhaps known or felt to be relatively close. This brings us to one of the most significant elements of the therapeutic dyad where the client is old(er): the age difference, with the likelihood of the client being perhaps considerable older than the counsellor.

As people and as practitioners we may feel a sense of audacity or anxiety in sitting down with someone as much as 40 or 50 years our senior: what can we offer them? How might they see us? What might they expect or be able to accept from us? Martindale has written eloquently (1989) on the fears a younger practitioner may feel in the face of seemingly endless (in fantasy, at least) demands from an older person. The counsellor will be offered an anticipatory identification with her own old age and its losses, vulnerabilities and dependency and thus have to work during the sessions with her own fears and anxieties

The Remains of the Day – Counselling Older Clients – (Continued)

about the future. Equally, counsellors in early adulthood or middle age may have or anticipate difficult demands from dependent parents which are mirrored in the needs of the client. Either way, it may be a disturbing or frightening process for the counsellor.

For the client there may be a significant difficulty in accepting help from a much younger person and particularly in settling into an intimacy with someone perceived as less experienced in life and potentially unable to identify with or understand the problems faced in the later life. However, older clients have the same capacity as younger ones to experience their counsellor in many (transferential) ways, and if they need themselves to be young while with their counsellor, the latter may assume a parental or older/care-giver role in the transference. Envy of the younger person's perceived ability and liveliness may also be powerfully felt, creating the kind of reverse Oedipal struggle described by Daniel (1997).

The notion of counselling itself can seem very alien to older people with the belief that one should be self-sufficient or supported by the immediate family unit or the fear that there must be serious mental health problems if counselling has been suggested or offered. However, my experience has shown that both resisting the comparative youth of one's counsellor and feeling an ambivalence towards the idea of sitting down and talking intimately about oneself, can be overcome in many cases if sensitively responded to. So, if the client is able to commit to the process, what might he or she talk about?

Depressive and anxious states of mind, bereavement and relationship problems, for example, are common presenting issues as with younger clients – but they are presented within a context of growing older and the changes in role and identity that are likely to be part of this process.

What might they talk about?

The presenting issues of older clients are both essentially the same as those of younger clients and qualitatively different. One way of conceptualising this is the notion of 'unfinished business' and 'different business' predicated by Daniel (1997). As we grow older we will naturally continue to experience life and relationships within the parameters of our internal world and our individual development; equally, as our life draws towards its close, we will be faced with new and unique challenges which we either meet and engage with or seek to avoid.

My experience is that older clients come to counselling with familiar issues shaped and coloured by the challenges of ageing. Depressive and anxious states of mind, bereavement and relationship problems, for example, are common presenting issues as with younger clients – but they are presented within a context of growing older and the changes in role and identity that are likely to be part of this process. This significantly affects both the exploration of the material and the unfolding relationship between client and counsellor even if the client has used counselling before as a younger person. Furthermore, there are particular emphases in working with older people that tend to be less common or less intense in younger clients: specifically, the impact of physical ill health and disability and the wider focus of bereavement and loss.

These two issues are obviously linked and suggest the broad background of loss that is, I think, the single most pervasive element of working with this client group. Older men and women will often come to talk about multiple experiences of loss, in terms both of bereavement through the death of loved ones (and possible many of these) and equally the loss of abilities, health, status and a positive sense of self that are a possible accompaniment to ageing. (Our society's general disregard for its elders is also a significant factor here.)

Developmental issues are still explored (often, interestingly enough, with a vivid return to very early experience and family relationships) and I would not wish to suggest that the work is shaped exclusively by the experience of loss. But the natural, inevitable and cumulative process that leads us all towards our own death creates a background which, as practitioners, we should not ignore, As Daniel says, therapeutic work with older people is thus essentially different business although naturally it may contain much unfinished business from earlier in life.

Case histories

I will now briefly describe two people I have worked with at Age Concern and look at some of the themes and dynamics of the work and relationship. Most of my clinical work for the organisation is assessment and supervision but I see occasional clients for longer term counselling and these two men present contrasting experiences and ways of relating to me and the therapeutic space. Names and various details have been changed to preserve confidentiality; the originally agreed contracts were for a year of work.

Peter

The first client, a Czech man whom I shall call Peter, was referred by his GP for depression. When we first met he was in his early 70s. His second wife from a 25-year marriage had been diagnosed with Alzheimer's Disease five years earlier. Peter presented as lonely and fearful but initially tended to defend against this by concentrating on all that was good in his life and be seeking a new partner for companionship and sexual comfort. He is a man with significant history of loss and painful endings and partings: from family (parents dying in his teens, a sister he lost touch with 50 years ago after settling in England) and native land, a first wife who committed suicide after five years of marriage and now potentially the loss of his second wife and of his own younger and healthier self. At assessment I felt that part of his depressed mood was a reaction to ageing as he clearly prided himself on being healthy and active and was indeed in very good health for his age.

My initial sense was that Peter's search for a new partner was essentially a defence against the loss of his wife; certainly he could not easily talk about her, what it meant to him to see her as confused and uncommunicative as she was and what he feared for the future. But I came to realise that he was also terrified of being left alone by her death and that the thought of a new partner was more about his wellbeing, and ensuring a secure and settled domesticity for himself than it was about sexual needs, important as those obviously were for him. The idea of being alone now, having experienced significant aloneness in the past, had become very frightening for him, although as we worked on he became

increasingly able to depend on my presence as a companion on his journey and as a container of his feelings, past and current.

My own difficulty as time passed was in establishing an end date with him. I found it uncharacteristically hard to raise the issue of ending and I came to see how I had introjected his need not to face an ending with its varied associations and transferences. Ultimately I was able to address this and through careful exploration we moved towards a separation which he could share and discuss with me. The parting was not easy and he developed what appeared to be psychosomatic symptoms during the last few weeks but he seemed to experience a degree of calm and hope through the sharing of a process which had previously always been a solitary one. The notion of sharing and self-exposure, initially hard for Peter as it is so often for older clients, become a more natural and realistic one and he was ultimately able to trust my reliability and constancy and I was able to let him go with sufficient trust in his ability to survive.

John

The other client I shall describe offers a rather different picture of late life struggle and the power of internal processes. John was a man in his early 90s who was referred by his GP for depression and anxiety concerning his physical health and the approach of death. His history was of achievement and an essentially positive disposition in younger days, turning into black and guilt-ridden perspective as his health deteriorated, the denial of growing older, which had marked his younger attitude, becoming untenable. The fear of punishing after-life dominated his thoughts and he looked back with great misgiving on the sexual infidelities he felt had harmed his (male) partner of over 60 years. Counselling took place in his home owing to his poor mobility following several strokes and his failing eyesight.

John reacted to my presence positively insofar as he felt grateful to have a responsive ear and said he 'enjoyed' the sessions but he also questioned their ability to achieve any significant change of heart or shift in perspective and continually asked me if it was really worth persevering. I think he continued for his own part essentially out of desperation. I wanted to help him and hoped we might together make some difference to how he felt but knew that, that was not guaranteed and feared it was unlikely in the face of his intense anxiety and negativity about himself and his prospects. (Equally, as he often said to me, we could not change the past, although he said again that he enjoyed talking about it in many ways.)

John was a man with a highly ambiguous internal world. He thought well of his work as a published writer, for example, but lacked an ultimately benign sense of himself, questioning his relationships past and present, despite the durability of his partnership. he was highly fearful of the consequences he anticipated after death of his 'immoral' behaviour during life. (For John, the thought of being reunited with family members after death was a hugely ambiguous idea, threatening rather than reassuring.) The work was cut short after four months by his death following a further major stroke. This was simultaneously a sadness and a relief to me: I liked him and for my own part enjoyed seeing him and found the work engrossing if tough, but equally as I have said I could not feel confident of achieving significant movement. My hope that the relationship itself would bring him some peace and inner security was never sufficiently fulfilled.

These two clients' stories tellingly display the opposite poles of Erikson's final stage: Peter's sufficient degree of ego integrity and John's despair in the face of death. I feel the work with John was valid despite the uncertainties (a final visit to him in hospital revealed a mentally as well as psychically frail man who could yet recall our previous sessions with gratitude) but it highlights both some of the challenges of this work and also its limitations when confronted with our morality.

Working with an older people's service raises many powerful psychological themes. Equally, there are practical challenges which need to be thought about. Will we work with people on high levels of psychotropic medication (many older people, particularly women, are on long-term prescriptions of anti-depressants or tranquillisers, sometimes to clearly addictive levels)? At what stage might the development of dementia preclude any value in therapeutic work? (I think both of these require individual consideration and careful assessment.) And what about the accessibility of the service for those too frail or disabled to travel to the centre? My own service provides home visits as my work with John indicates, and while I think this is essential for the oldest or frailest of clients, it also clearly raises questions around boundaries and containment. The work and the process are quite achievable in the home setting but the situation demands particular care and attention from the counsellor (and in many ways from the client, too) in order to hold the frame. There are other ways in which flexibility is important: sometimes a frailer client may not be able to sustain concentration for a whole 50-minute session or to manage a session every week and these things need careful thought and responses from the counsellor.

Will we work with people on high levels of psychotropic medication (many older people, particularly women, are on long-term prescriptions of anti-depressants or tranquillisers, sometimes to clearly addictive levels)? At what stage might the development of dementia preclude any value in therapeutic work?

If we see therapeutic process as essentially focused on itself, the weekly sessions leading towards a hopefully good (enough) separation, then work with older clients presents us with a challenge. It is possible to achieve that satisfactory and developmentally appropriate ending and parting with clients in the last phase of life who may be confronted with their ultimate ending? Yes, I think it may be but the general context is one where this will not always be possible and where we may not feel confident or comfortable in leaving our clients to carry on without us.

Time-limited work takes on a sharper focus in this area and can give us troubling dilemmas. There is the possibility that the client will die in the course of the work, as John did, perhaps taking with them the ending we cannot share with them and leaving us without the closure that we would ideally prefer both personally and professionally. but most of the time there will be a future in this world for the client after the cessation of counselling: an uncertain future, maybe (although quite possibly a happy and fulfilled one) but a future we are unlikely to know about or directly share in.

The Remains of the Day – Counselling Older Clients – (Continued)

If we as counsellors and psychotherapists can struggle meaningfully with our own ageing into life then we can offer a worthwhile experience to older clients who face difficulties they wish to explore in their later years.

The fact of ending and separation, in life as in therapy, means that we need to work with our own internalised experience of these processes in order both to assist our clients to move on into later life and whatever awaits them there and to help ourselves to deal with the feelings evoked for us by the inevitable parting. This challenge most of all, I feel, may be behind the neglected place older people have had for too long in the therapeutic world. If we as counsellors and psychotherapists can struggle meaningfully with our own ageing into life then we can offer a worthwhile experience to older clients who face difficulties they wish to explore in their later years.

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Webcams as a Metaphor for Human Contact

By Angela Lewis

I am an advertisement for a version of myself

(David Byrne)

An article published in both the Melbourne Age and An article published in both the Melbourne Age and The Brisbane Courier Mail (10/11/01 Kathyrn Torpy) entitled 'Virtual Lolitas', focussing on the entrepreneurship of teenage girls and young women who sell their images via webcams on the Internet, is the impetus for this article on human contact and the Internet.

So, let's first define the 'technical terms' first. A webcam is a camera that is in some way connected to the World Wide Web, or Internet. As you may imagine given this broad a definition, webcams can take many different forms and flavours (e.g. filming traffic, weather conditions, landmarks or scenery). In the context of this article I am speaking of one of the most common types of webcams - personal cameras that are connected to a home computer. When used with specific software, these webcams allow the user to share a moving image of themselves with others. Depending on the user and the software, this image may be publicly available to the Internet, or only available to the user's friends who know the proper connection.

Generally these cameras are only operational when the user's computer is turned on and they are connected to the Internet. With the rise of Broadband1 and Cable2 modems, users can leave their cameras running for extended periods of time, however transmitting (and also viewing) webcam images can be very slow for those people running on a typical 56k modem.

The moral issues and social dilemmas of broadcasting personal images are not really my concern in this particular article, rather I am more interested in the attempts of an increasing number of people to bend and shape the tools of technology to engender a state of human contact. Most of us have come into contact with the 'chat room', it appears for all ages, all interests, all over the place on the Internet – in fact you can't click for too long without being invited in for a virtual 'chat' somewhere. I see webcams as simply one more step in our virtual journey in seeking contact with others.

What do you suppose people are thinking, when they train an electronic eye on themselves and then step onto the virtual highway of the Internet? "Please look at me I am lonely, please look at me and find me attractive, please look at me and start a relationship with me, please look at me and justify my existence"? If you are one of the Lolitas in the Melbourne Age/Courier Mail article as mentioned above, you are perhaps simply a savvy teen who sees it in the black and white terms of 'my image – your money', without thinking too much further about moral issues or otherwise. Couldn't one of these webcam users simply go and knock on their neighbour's door and invite them in for coffee, or go down to the local park and walk their dog and start a conversation, or join a group, go to yoga, visit friends or family or join the local tennis/bowling/golf team – any of the traditional methods of interacting with others?

Apparently not, say the thousands of adults who utilise the Internet for human contact with a person on another continent or in the next street – or maybe they do pursue traditional methods and still do not get the type of contact they feel they need in the 21st Century. Is it perhaps the desire to get to the point, not being interested in the social niceties of getting to know someone over coffee/dinner/an extended number of dates, but rather going somewhere (webcam land) where it is already assumed you are there for the same reason, the same needs, without having to explain your motivations? Or that it can all be done (the getting to know you, bonding part) in 'hyper-speed' – the very thing that the Internet excels at - quick (if not instant) intimacy and relationships for those of a like mind.

The deployment of electronic contact media by children and teenagers however, appears to be a slightly different story. Their utilisation of instant messenger services (for example MSN Messenger, ICQ or Pal-talk) as well as webcams appear to be more a natural extension of their day to day living, they are just as likely to be chatting to their friends on the mobile at the same time they are viewing a friend's image or typing them an email message. The generation that has/is growing up with these technologies seem to use them more holistically and as simply one more tool or adjunct if you like to their lives, rather than a substitute to contact with others.

Most of us have come into contact with the 'chat room', it appears for all ages, all interests, all over the place on the Internet – in fact you can't click for too long without being invited in for a virtual 'chat' somewhere.

So is it somehow safer to present a 'version' of yourself, as characters on a screen in writing, via speakers and a microphone or digitally with a webcam trained on your 'good side'? Or is it mankind's post-modern obsession with communication in all its forms that drives us to what appears to be the height of narcissism – the global transmission of our own images? As a society it is true we are currently enamoured with all things 'real' through the lens of some type of media such as television for example – think the TV shows 'Big Brother' and 'Survivor' for a start. With the advent of webcams we have been given the opportunity to write our own narratives to present to the world, so we have both the ready-made performers and the ready-made audience – who are one and the same in this new media….sort of like…"I've been watching you, watching me…."

I have heard anecdotally that either using webcams or simply watching others broadcast via their webcams (you don't need one to view others) can be become addictive – just as chat rooms are addictive, for the same reasons - you are greeted, remembered, welcomed – the same can happen when you put your image out into cyberspace, only your admirers can become more intense, depending on what you are displaying. On some of the 'adult rated' webcam sites – easily accessible by clicking a button that says you agree the user is 18 years and over (and any 8 year old could do that) – the adulation, idolatry and flattery comes in thick and fast via typed messages that could easily be mistaken for the crazed fan mail a superstar receives. It is easy to see why having others fete you with attention could be a great ego boost to a lonely, isolated or shy person who ordinarily would not have the courage to speak to the person next to them in the bus queue.

Webcams as a Metaphor for Human Contact – (Continued)

It is a brave new world out there, with millions of people comfortable with sharing their lives and 'being star for the day' for the price of a webcam and an Internet connection.

Of course how much you display and when, is strictly up to the person who puts themselves under the scrutiny of a webcamera and not all webcam users show their breasts or masturbate – some simply present themselves doing something innocuous like brushing their own hair. The original 'web cam girl' is Jenni Ringley, an American who for the past 4 years has been living large portion of her life under a camera and beaming it out into the Internet (she has them in every room of her home evidently). Jenni thinks nothing of cleaning her teeth, sleeping or kissing and eating in the public arena and says that she received upwards of 7,000 emails daily. She charges a subscription to her site of US$10 per month and is located as **www.jennicam.org**.

It is a brave new world out there, with millions of people (2.5 million in America alone have webcams3) comfortable with sharing their lives and 'being star for the day' for the price of a webcam (you could pick one up at any computer retailer starting at $100) and an Internet connection. Coffee with a neighbour, or the heady praise of 100 strangers that you can switch off and on when you feel like it…..when Shakespeare wrote his immortal words "..all the world's a stage', he could never have dreamed of the reality he was foreshadowing….

Explore this phenomenon yourself by visiting **www.webcam.com** or **www.webcamnow.com** – both are free and will keep you amused for hours. As I only have a regular 56k modem, I found watching webcams particularly slow – sort of like watching people swimming underwater, however the comments from those watching along with me were priceless!

Visit her at ***www.angelalewis.com.au***

1 Higher speed connection for which the Internet user pays a premium price, usually fixed per month and on a separate line to your standard telephone line.

2 Also a higher speed (e.g. normal modem 56kb per second, cable 520kbs per second) and utilises cable technology as per cable television.

3 See the site www.nielsen-netratings.com for a comprehensive range of data, or www.glreach.com/globstats/ for similar information.

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Rigour or Balance: Whereto an eclectic approach to counselling? by Judy Boyland

It has been said that an eclectic approach is an excuse for not being rigorous enough in one therapy. However, others have argued that it provides the counsellor with a more balanced approach to counselling. In analysing and evaluating the argument for and against an eclectic approach to counselling, the following paper presents an overview of eclecticism, identifies historical context and profiles the primary thrusts associated with an eclectic approach to counselling – technical eclecticism, theoretical integration and common factors. Concerns of key proponents are analysed, the writer's personal thoughts are outlined and future directions explored.

OVERVIEW

Contemporary psychotherapists have come to realise that given the complexity of human behaviour, no one theory can suffice to explain all situations, all disorders and all clients. Nor can one system of procedures and techniques serve to enhance the well-being of those seeking help in coping with problematic situations or 'turning around' problem behaviours, dysfunctional thinking and/or irrational feelings. Eclecticism deals directly with the person in his/her rapidly changing world, taking into account that person's developmental state and his/her cultural, social and personal values.

Eclectic counselling is the process of selecting techniques and/or theoretical concepts from a variety of systems. It involves (a) identifying and selecting valid concepts and methods from a variety of systems and integrating them into a mutually consistent whole, (b) considering all pertinent theories, methods and standards for evaluating and manipulating clinical data and (c) keeping an open mind while continually experimenting with those formulations and strategies that provide valid outcomes (Corey, 1996; Gilliland and James, 1998). Those who practise eclecticism focus directly on the behaviours, goals and problem situations that are outside the client's ability to control in his/her day-to-day living. By making the client fully aware of the problem situation and teaching him/her consciously and intentionally to choose to exercise control over the problem behaviour, they assist the client in developing a higher level of integration through proactive choice (Gilliland and James, 1998).

HISTORICAL CONTEXT

Eclecticism as a point of view has existed for a very long time. Lunde (1974 cited in Norcross and Grencavage, 1990) speaks of the third-century biographer, Diogenes Laertius, who refers to an eclectic school that flourished in Alexandria in the second century AD. Frances (1988 cited in Norcross and Grencavage, 1990) speaks at length of Freud's struggle with the selection and integration of diverse methods. Norcross and Grencavage (1990), Goldfried and Newman (1992) and Young (1992) discuss the more formal synthesising and integrating of therapeutic approaches appearing in the literature in the 1930s. It is against this backdrop that the trend towards eclectism in counselling has been gaining momentum since the mid 1940s with Fredrick Thorne being credited for developing the first systematic position: which he referred to as an *eclectic collection and evaluation of all known methods in terms of empiric experience* (Thorne, 1950. p xiii cited in Gilliland and James, 1998. p364).

Today, the eclectic trend is twofold with (1) more and more clinicians identifying as adhering to some form of eclecticism and (2) existing schools of therapy moving towards a broader and more eclectic stance (Norcross and Newman, 1992; Gilliland and James, 1998). Three main thrusts have become evident: technical eclecticism, theoretical integration and common factors.

TECHNICAL ECLECTICISM

Many therapists who adopt the approach of technical eclecticism place a strong emphasis on research so as to determine what techniques work with what problems for what clients: the primary focus being 'what works' (Todd and Bohart, 1999). While being guided by a preferred theory, therapists use procedures and draw techniques from different sources without necessarily subscribing to the theories that spawned them and with no necessary connection existing between metabeliefs and techniques (Lazarus, 1990, 1992; Norcross and Newman, 1992). The ultimate aim is to *reduce psychological suffering and promote personal growth as rapidly and durably as possible* (Lazarus, 1992, p236). The hallmark of technical eclecticism is *the use of prescriptive treatments based on empirical evidence and client need rather than theoretical and personal disposition* (Lazarus, 1990, p40). Beutler and Consoli (1992) outline three guiding principles underpinning technical eclecticism. First is the consideration that all psychotherapy approaches are potentially beneficial to some clients: second is the assumption that therapeutic procedures can be implemented independently of their originating theories: third is operation from a theory of change that gives credence to a variety of technical procedures.

Eclecticism deals directly with the person in his/her rapidly changing world, taking into account that person's developmental state and his/her cultural, social and personal values.

THEORETICAL INTEGRATION

Theoretical integration is an open framework, espousing commitment to a conceptual or theoretical creation beyond a technical blend of methods. The integrationist draws from diverse systems that may be epistemologically incompatible by virtue of their origin, nature and/or method and ontologically incompatible by virtue of their view on the nature of being (Norcross and Grencavage, 1990; Norcross and Newman, 1992). As a transtheoretical therapy, proponents see therapeutic integration as the differential application of the processes of change being emphasised during specific stages of change, according to identified problem level (Prochaska and DiClemente, 1992). As an integrative psychodynamic therapy, proponents seek to provide an internally consistent theoretical approach to personality functioning and a way of proceeding clinically within the therapy session (Wachtel and McKinney, 1992).

COMMON FACTORS

Given the above, one may conclude that both the Eclectics and the Integrationists are all talking about the same thing – the best outcome for the client. As Todd and Bohart (1999) note, this observation is consistent with the premise underpinning the common

Rigour or Balance: Whereto an eclectic approach to counselling? – (Continued)

factors approach which tends to view eclecticism as a synthesis or integration of method and theory: determining the core ingredients different therapies might share in common with a view to developing more effective treatments based on these components (Norcross and Grencavage, 1990; Norcross and Newman, 1992; Garfield, 1992, Todd and Bohart, 1999). Proponents of the common factors approach espouse to create a model with sufficient flexibility to continue to assimilate new ideas, to be accommodated to the schemas of the individual therapist and to be adapted to the schema of each client. Ultimately, the focus for the common factors clinician is discovering what works best for the client who is sitting in front of him/her (Beitman, 1992).

CONCERNS

At its best, the eclectic approach to counselling can be characterised by attempts to move beyond single-school approaches in a bid to enhance learning and maximise benefit to clients (Arkowitz, 1992). As noted by Garfield (1992), there is a large degree of freedom in not having to adhere to one theoretical orientation or to refrain from using procedures that may be inconsistent or frowned upon by any particular orientation.

With respect to the theoretical integration approach, Lazarus (1992) warns against a fundamental incompatibility among the theoretical viewpoints it attempts to integrate.

However, not everyone supports the movement towards integration, irrespective of what approach is advocated. There are those who believe that different schools are conceptually incompatible – eg behaviour therapy and psychoanalysis. There are those who argue that some clients might benefit from following a psychodynamic path while others would benefit from an existential-humanistic approach: those from a reality or behavioural approach and those from a rational emotive approach (Todd and Bohart, 1999).

Messer (1990) cautions that the efforts to integrate the therapies will inevitably compromise one or another of the visions they encompass and proposes the notion that it is not merely stubbornness or inflexibility that promotes opposition to an eclectic approach. Rather, he suggests, opposition emerges from deeply held beliefs about what constitutes human nature, what the 'proper' goals are for therapy and the kind of therapeutic process most likely to bring about the desired outcomes.

At its worst, the eclectic approach can become a haphazard picking of techniques without any overall theoretical rationale (Corey, 1996. p448) or a *hodgepodge of techniques selected probabilistically because they have seemed to work with patients possessing similar characteristics* (Wachtel and McKinney, 1992).

Lazarus (1990), the major proponent of technical eclecticism, expresses concern when he suggests that therapists, in a quest for flexibility, may be guided by selective perception and personal preference rather than searching for guided principles and concepts. Beitman (1990) warns against the lack of emphasis on the individual personality of the counsellor in Lazarus' approach (Multimodal Approach - outlined in Lazarus, 1992; Corey, 1996; Nelson-Jones, 2001) and expresses concern with regard to issues of transference, resistance and counter-transference in the client / counsellor relationship. However, Lazarus (1996, cited in Carey, 1999) counters this claim by maintaining that although ethical guidelines should always be observed, an effective therapist should have a range of flexible relationship styles to use with different clients and at different stages of therapy. Beitman also raises a further concern with reference to the varying abilities, predispositions and training of counsellors who gravitate towards using *many bits of data* without considering the relevance to the particular situation (Beitman, 1990, p54).

With respect to the theoretical integration approach, Lazarus (1992) warns against a fundamental incompatibility among the theoretical viewpoints it attempts to integrate. His concern focuses on the aptness of therapists to employ techniques and procedures from various sources while seeking to harness greater power by combining different theories or aspects of particular schools of thought rather than drawing on observations from diverse sources. As proponents of the integration approach, Wachtel and McKinney (1992) express concern that in certain respects, evolving points of view may have led to the psychodynamic aspect of the approach now resembling a theory of personality in its own right. However, while acknowledging this evolution as a signal of danger, they also see it as a *sign of progress* in generating new ideas for how to proceed clinically (Wachtel and McKinney, 1992, p364).

PERSONAL VIEW

As a nocice practitioner, my stage is an open book and on reflecting on the above data, I am wondering if I am in danger of falling into the trap of what Corey describes as the *haphazard picking of techniques* (previously cited). However, my leaning at this point in time is towards a common factors approach. It is my belief that no one theory has all the answers: nor does any single methodology encompass all formulations and strategies that provide valid outcomes. To focus on collective application of theoretical principles without a corresponding appraisal of the diversity of techniques and procedures is to deny clients access to the cumulated knowledge of time. Likewise, to focus on technique and procedure without an understanding of the underpinning theoretical framework may be considered akin to fumbling around in torch light when a more clearly defined path may be accessible by turning on the light.

While this may be somewhat of a naive, 'grab bag' approach, it is also tempered with professional discretion. I tend to concur with the thoughts expressed by Norcross and Newman (1992, p14) who advocate that in practice, *the distinctions among the three thrusts of psychotherapy integration are not so apparent*. Are the distinctions really semantic and conceptual? How functional are they in practice? Can a technical eclectic totally disregard theory? Can a theoretical integrationist ignore technique? Can the most ardent proponent of common factors practise nonspecifically? These are the questions I am still exploring. It is interesting to note that despite the myriad of techniques, theories and approaches associated with the practice of counselling and psychotherapy, it would seem that *forty years of*

sophisticated outcome research has not found any one theory, model or package of techniques to be reliably better than any other (Miller et al, 1997, p2; Miller et al, 2000, p35).

FUTURE DIRECTIONS

While the trend towards eclectic practice has promise, it also has its pitfalls. The challenge is to enhance the optimal match between patient and treatment: with the ultimate goal being to achieve maximum effectiveness, applicability and efficiency of therapy by tailoring it to the unique needs of the individual client. This is what Norcross and Grencavage (1990, p21) imply when they suggest that the question is not so much, Does it work? Rather, the question is, *Does it work best for this client?* Maybe one could add, …… *dealing with this issue, at this stage of therapy*.

In discussing the future direction of technical eclecticism, Beutler and Consoli (1992) highlight the need for continuing research to determine which procedures and techniques, irrespective of the theories they attempt to integrate, are sufficiently broad and flexible to encompass most client patterns. They also consider the question of what to do to enhance outcome when a client / therapist relationship is incompatible and referral is not possible. While acknowledging a continuing need for research in training effective therapists, they question the degree to which proficiency based training enhances therapeutic outcome. This question is also posed by Spinelli (1999) who cites the research outcomes of Roth and Fonagy (1996) who present a growing amount of data to suggest *that successful outcomes may be just as likely to occur when the persons who apply them have no training whatsoever in psychotherapy*.

Lazarus (1992) identifies the need for greater rigour in therapist decision-making processes so that treatments of choice and different therapies will be accurately matched to client need. Duncan and Miller (2001, p22) and Todd and Bohart (1999, p478) express similar thoughts when they assert that *the client's map provides that best guide to the therapeutic territory* (Duncan and Miller) and refer to understanding, respecting and working within *the client's model of reality* (Todd and Bohart). For Lazarus, the need is to establish training institutes that offer courses in technical eclecticism, articulate the value and limitations of integration and provide technically eclectic supervision.

Prochaska and DiClemente (1992) identify the most important issue to be addressed in the future is how to best apply emerging knowledge in relation to the basic levels of human functioning and the basic processes of change, so as to develop the maximum impact strategy for work with clients with multilevel problems. This issue is also addressed by Carey (1999) who posits the notion that agreement on the effective ingredients of therapy will not be reached until agreement on the nature of human beings is reached.

For Wachtel and McKinney (1992) an essential focus for future direction is a psychologically oriented examination of social processes and the broader social context within which people's difficulties develop.

From a common factors perspective, Garfield (1992) advocates a greater consideration of the role that both common and specific factors and variables play in securing positive outcomes. For Beitman (1992), the need is to overcome ideological boundaries: to integrate through the discovery of similarities and the respect for differences: for the therapist to challenge personal beliefs when confronted with apparent anomalies or surprises.

As suggested by Young (1992), the practitioner of tomorrow will need to be able to incorporate the newest findings about effective counselling techniques and at the same time, be able to communicate coherently to clients and colleagues a rationale for the treatment plan. Whatever the global dreams, visions and aspirations of both the purist and the proponent of eclecticism, ultimately there will be those who embrace a diversity of methods while others remain enmeshed in a particular methodological or theoretical mode of operation. There will be those who embrace full integration or eclecticism and there will be those who hold on to a favoured system while slowly assimilating elements from the multitude of therapeutic approaches.

Perhaps the title of Beitman's paper says it all by way of future direction: but only time will tell. Maybe theorists and technicians will cease to wave their systemic flags and integrate therapies by combining the *fundamental similarities and useful differences among the schools*. Maybe they will expand the blanket of integration to spread across (rather than among) the schools whereby engendering what Norcross and Newman (1992, p32) describe as an *open system of informed pluralism that leads to improved efficacy*.

Perhaps the title of Beitman's paper says it all by way of future direction: but only time will tell. Maybe theorists and technicians will cease to wave their systemic flags and integrate therapies by combining the fundamental similarities and useful differences among the schools.

Perhaps as Spinelli (1999) suggests, a little scepticism is called for and perhaps the counsellor of today – and tomorrow – needs to keep in mind his/her own experience as client. Perhaps, as he further suggests (Spinelli, 1999, p32):

> *Most importantly, remind yourself not to rely quite so much upon the skills that you have been taught, that you have learned and that perhaps you teach to others, and instead, make that dangerous attempt towards finding a greater willingness to enter the realm of the unknowing. A position of openness. A stance of attentiveness towards a human being, towards yourself being with another human being. And remind yourself that all the current models and theories of therapy are principally useful as a means for therapists to challenge and explore their own assumptions, beliefs and values. But they have no value, no function, no worth, when they are merely – and arrogantly – applied to clients.*

Perhaps the answer lies in the adage, *Treasure our sameness and respect our difference*. No one technique, no one theory has all the answers: nor one approach, nor one school, nor one system. Ultimately, it is the client's perception of the effectiveness, applicability and efficiency of treatment that will give credence to the validity of approach and to the competency of the counsellor in interpreting his/her map and tapping in to his/her model of reality.

Rigour or Balance: Whereto an eclectic approach to counselling? – (Continued)

Written by Judy Boyland an ex-school principal who now runs her own private practice and is a qualified member of ACA. Judy has a Masters degree in Education, a grad Dip in Religious Education and a Diploma of Professional Counselling.

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Counselling for Teenager's pregnancy resolutions: Direct and indirect influences. By Peta Dale

Abstract

A case example illustrates the limited counselling that many clients report having received prior to an abortion. Current research on abortion indicates that Australia has the second-highest teenage abortion rate in the Western world. When added to the growing rate of repeat abortions, there is concern that warrants further investigation into the influences that lead young women to this choice. A recent study from Family Planning Perspectives (Evans, 2001) provides an example of the influence of significant others on Australian teenager's decisions about pregnancy resolution. Although this retrospective, self-report study may have limitations, it was found that both direct and indirect influences were associated with the teenager's decisions either to abort or have the child. Other possible indirect influences are considered. These include the developmental stage of the adolescent and social norms. The well-informed counsellor has a valuable role in promoting autonomous decision-making.

Megan came to the counselling centre at Open Doors with a familiar story. She had an abortion sixteen months previously. At the time when the child would have been born things started to go terribly wrong. Megan presented herself to us having recently lost her job, generally lost interest in life and with a drug related problem. Her life had changed dramatically and she was only 18. During the counselling it was revealed that the doctor who confirmed the pregnancy handed her a card with information on an abortion provider, her mother suggested that she ring the clinic and other family members told her that she had to have an abortion. The boyfriend didn't want his parents to know about the pregnancy and offered to pay half the costs at the clinic. Megan felt that she should have the abortion because it was what everyone else wanted.

Within a few days the abortion had taken place but a year later, Megan was left with a sense of regret and inner turmoil. One of the most disturbing aspects of Megan's story was the counselling that she reported to have received at the clinic. This consisted of the question of whether this was what Megan wanted to do. Megan replied that she was not sure. The counsellor also asked whether Megan understood what was going to happen. In this case, young Megan's doubts were not heard and she was abandoned to the pressure of other's desires based on their own motives and fears.

(Certain identifying aspects of this case have been changed in order to maintain client confidentiality.)

Current trends in abortion

Australia has the **second-highest teenage abortion rate** in the Western world according to a U.S. study compiled by the Alan Guttmacher Family Planning Institute (1999). Australia came second to America (33.6) with an abortion rate of 23.9 per 1000 women under 20 years of age. A Department of Human Services report of abortions notified in South Australia for the year 2000 indicated that the abortion rate for teenage women was 22.4 per 1000 women. It was also reported that 3.6% of the under 15 age group had a previous abortion. Of the 15-19 group, 18% had previous abortions in the range of 1-3 abortions.

A Cycle of Repeat Abortions

The number of repeat abortion is quoted to be an area of concern to the Department of Human Services, "Of the 1635 women who had previous abortions under the Act in S.A., more than half (853 or 52.2%) had an earlier termination either in the same year or in the previous two years" (Thirty-first Annual Report, 2000). The high number of teenage abortions, coupled with an alarmingly high rate of repeat abortions raises questions about the influences that lead women into this cycle. The decision making may be complicated by a number of factors both internal and external to the adolescent. This has implications in the delivery of counselling services for teenager's pregnancy resolutions.

Influences on teenage decision making

The decision-making that leads to these statistics is not isolated, as there are many steps along the road to an unexpected pregnancy. Education experts concentrate on the role of sex education and other pre-conception influences are studied in an attempt to prevent teenage pregnancies (Kirby, 2001). However, it is often not until the stage of the unexpected pregnancy that the teenager presents herself for assistance. In light of the high rate of teenage abortions, the disturbing number of repeat abortions and the fact that the teenager is often vulnerable and in crisis when approaching the counsellor, an understanding of influences in decision-making at this stage may assist the counsellor to facilitate a more comprehensive understanding and autonomous decision for the client.

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Direct influences

Providing a space in which there can be an autonomous decision made may be particularly difficult in light of the scope of these influences. A study published in Family Planning Perspectives (Evans, 2001), addresses the influence of significant others on Australian teenager's decisions about pregnancy resolution. Direct and indirect influences are examined using data drawn from the Young Women's Pregnancy Survey (YWPS), which was conducted in 1998 in Australia. This was a case-control study on 1,324 pregnant teenagers who were younger than 20 years and had either given birth or terminated a pregnancy. It is noted in the study that there is a lack of research on "how" teenager's decisions in relation to pregnancy are made. The questions of whether significant others have an influence on young women's decisions to continue or terminate a pregnancy and if so, which significant others most strongly influence the decision were also investigated.

The results of this study showed that the majority of these teenagers in both the motherhood group and the abortion group reported no direct influence either consistent with or contrary to their choice and that they came to their decision entirely on their own. As

Counselling for Teenager's pregnancy resolutions: Direct and indirect influences. – (Continued)

these teenagers do not live in a vacuum, their reporting may reflect a lack of awareness of the influences that are present in their lives and the adolescent's characteristic developmental desire to gain independence. If this is so, then these results may only reflect the tip of an iceberg of influence. The researchers state "Among those who chose abortion, 34% said their partner influenced their decision, 14% said their mother did and 6% said their father did. Among those who chose motherhood, 15% said they received direct influence from their partner, 6% said there was influence from their mother and 2% said there was influence from their father" (Evans, 2001,p.227). Thus, larger proportions of young women who chose abortion than of those who chose motherhood reported receiving direct influence consistent with their eventual decision.

The type of influence reported by these young women was directly associated with their decision either to abort or continue the pregnancy. Overall, 39% of the teenagers who chose abortion reported direct influence towards abortion with 34% saying that their partner influenced them towards abortion, while 25% of those who chose motherhood reported this influence towards abortion with only 6% of this from the partner. The influence to abort was quite marked for both groups (39% and 25%). There was less direct influence from the partner reported by those who chose motherhood (6%) compared with those who chose abortion (34%). Direct influence from parents for both groups was not significantly associated with the teenager's decisions.

When considering the developmental stage of the adolescent, it may need to be noted that this is the stage when there is a learning of cultural norms and gender-appropriate sexual behaviour.

In the case in which abortion became the choice, the recognition of direct influence was quite marked with more than a third of this group reporting this type of influence. In this case, the teenager's ability to make an autonomous decision may be questionable. Sobie and Reardon (2000) state that "No matter what form the pressure or manipulation of her situation takes, any attempt to influence a woman toward abortion during this time of crisis when she is most vulnerable can be almost impossible to resist" (Sobie and Reardon, 2000,p.2).

An essential consideration in the decision-making is the influence from the partner and the quality of that influence. It may be important to consider whether there is an intention to influence or not. The partner may not consciously intend to influence the decision but his response may be perceived by the young woman as pressure, for example if the partner is unenthusiastic when he is told about the pregnancy, this may be understood as a desire not to support the young woman and their child. The influence may also be subtle as for example through the withholding of care and approval unless she agrees to have an abortion.

Indirect Influences

Indirect influence or sometimes called the normative influence was found to be a significant factor in the decision-making. Indirect influence in this study was defined as whether or not the mother, sister or a friend had either become a mother as a teenager or had ever had an abortion. Teenagers whose mother had become a mother as a teenager were found to be influenced towards motherhood and those whose mother or sister had ever had an abortion had increased odds of choosing abortion

Where there was indirect influence a larger proportion of teenagers in the abortion group reported this towards abortion (32%) than those in the motherhood group (17%). Those in the motherhood group reported indirect influence towards birth (57%). The analysis may have limitations due to the retrospective nature of the data. This could have led to both underreporting and overreporting of the influence of others. However, the results have important implications when considering the counselling of young pregnant women. These women come to the counselling situation in crisis, within a particular family environment where the "norm" may be to resolve an unexpected pregnancy through abortion or birth and where the partner has a powerful and direct influence. Other normative factors such as the wider societal norms and the counselling environment may also need to be considered. These influences when added to the adolescent stage of development could be seen as increasing the vulnerability of the pregnant teenager to an unprecedented extent.

Adolescent Development

When considering the developmental stage of the adolescent, it may need to be noted that this is the stage when there is a learning of cultural norms and gender-appropriate sexual behaviour (Erickson, 1963). The young child's egocentrism means that he sees the world mainly from his own perspective. Elkind (cited in Rappoport, 1972) also sees the adolescent's thinking as subjective in that the teenager places too much emphasis on what others will think of him. There is also the ability to think in an abstract way and in terms of possibilities (Piaget cited in Rappoport,1972).

The development of a sense of identity is a critical task associated with adolescence (Erickson,1963). The social environment may have an impact and indicate some of the problems that young women might have in relation to abortion and identity. According to Greer (2000) the feminist movement of the Seventies was about liberation struggles concerned with asserting sexual difference with dignity and prestige. However, this focus changed to issues around equality that takes the male status quo as the condition to which women aspire. In this social environment young women work to be independent, self-reliant, strong and successful. The young woman who finds herself unexpectedly pregnant is faced with a situation in which she could no longer attain these qualities in the short term. Vulnerable and needing to be able to depend on the significant others in her life, the young woman's self-esteem and her world could easily be seen as crashing down around her. According to Swope (1998) many young women have developed a self-identity that simply does not include being a mother. He goes on to say " … the sudden intrusion of motherhood is perceived as a complete loss of control over their present and future selves (p.32)". In fact, unplanned motherhood is said to represent a threat so great that it is perceived as equivalent to a death of self (Swope, 1998). As with other vulnerable states, the young woman would be more susceptible

than normal to the influence of those holding any perceived authority.

The teenager is particularly vulnerable because of the stage of development. In 1988 it was noted that adolescents do not adjust as well as adults following an abortion (Campbell, Franco and Jurs, 1988). The study explored differences in 35 women who had abortions during their teenage years with 36 women whose abortions occurred after the age of twenty. Although both groups expressed similar levels of suicidal ideation post-abortion, adolescents were found to have made more attempts on their lives after the abortion. Other findings were that the adolescents were less likely to recall feeling coerced into their decision yet reported having nightmares more frequently. These differences were attributed to the adolescent's poor impulse control and the nightmares, as an indirect and less mature way of dealing with the abortion. In a review of studies, Sobie and Reardon (2001) have also reported teenage abortion being linked to a number of physical and psychological problems, including drug and alcohol abuse.

Societal influences

To extend this to an even wider scale that affects anyone involved with the pregnant teenager, there is a societal acceptance of abortion often with an underlying belief that women have won their "right" to choose and finally have control over their reproductive capacity. Often the implication through making available this choice is that it has not only become a norm but has also become a "duty". Germaine Greer (2000) writes "If the child is unwanted, whether by her, or her partner or her parents, it will be her duty to undergo an invasive procedure and an emotional trauma and so sort the situation out. The crowning insult is that this ordeal is represented to her as some kind of privilege. Her sad and onerous duty is garbed in the rhetoric of a civil right…. Her autonomy is the least important consideration (Greer, 2000,p.113)".

Doka (1989) suggests that abortion can constitute a serious loss. An abortion can take place without the knowledge of others or the recognition that a loss has even occurred. Disenfranchised grief is defined as the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned or socially supported (Doka, 1989,p.4). Society generally does not recognize the loss of an embryo or foetus through abortion as a serious loss. Those who affirm a loss may not condone the act of abortion while those who sanction the act may minimize any sense of loss. When added to the fact that the choice is seen as being freely made, the bereaved is in a position in which it can be difficult to recognize her own "right" to grieve. The disenfranchised griever has many potential reasons to avoid the work of grief. Without social recognition that an abortion constitutes a loss, the adolescent is led to believe that her experience could only lead to positive outcomes. On a personal level, however, there is the possibility of a lifetime of unresolved grief.

There is also the societal notion that teenage childbearing is a devastating event. This is often evaluated in terms of economic disadvantage. An article in Family Planning Perspectives 1998 questions this notion. A review of the literature suggests that a teenage birth is not the single cause of negative socioeconomic effects. A host of other social disadvantages contribute to their poorer economic circumstances and simply changing a woman's age at first birth would not necessarily change those conditions. Sobie (2000) argues that research indicates teen mothers as being as well adjusted or even better adjusted than their peers, relying less on coping strategies such as denial.

Another normative influence may involve the counselling setting itself. When an adolescent finds out that she is pregnant while at a Clinic that performs abortions, there may be a particular vulnerability to immediate situational cues in making pregnancy resolution decisions (Cobliner, cited in Worthington, 1989). The adolescent presents herself to the abortion clinic counsellor, who may have difficulty promoting a fully informed and independent decision about the pregnancy. The counsellor is employed by the clinic that exists to perform abortions. Employment of the counsellor is based upon this performance. The term "conflict of interest" is used to describe a situation where an individual or organization has competing interests that may influence important decisions or evaluations, which should be made impartially. The organization must perform abortions in order to survive while the counsellor, dependant on the clinic for a wage, is expected to provide objective counselling. An individual who has a conflict of interest is not necessarily biased. However, working with women in the abortion provider setting can appear to influence the counsellor's judgements and perhaps impact on the care received by clients.

Conclusion

With the second highest teenage abortion rate in the world, Australian society's complacency is placing pregnant teenagers at risk of a cycle of unwanted abortions. Due to the developmental immaturity, the vulnerable teenager is highly suggestible to direct and indirect influences. If these influences are accepted without question and overlooked, they may remain powerful determinants of the client's life choices and future.

When counselling these teenagers it is important that there is awareness and consideration given to every conceivable form of influence ranging from direct and indirect influences, to a broadened view of society's norms. The counsellor's awareness of these indirect influences may be an essential ingredient when aiming for autonomous decision-making. Norms can be questioned. They do not always fit well with the individual's needs and desires. Recognition can be given to the normative status of abortion. This status may suggest to the young pregnant teenager that it is a procedure she should have in order to please others. For the decision to be fully informed, attention needs to be given to possible negative effects and grief associated with abortion. Consideration could be given to the environment in which the decision-making takes place, and the independence of the counsellor. This could well necessitate a complete separation of counselling services from abortion referral and the abortion clinic.

An autonomous decision is made when there is independence or self-government. It cannot be assumed that the adolescent has an awareness and

Although both groups expressed similar levels of suicidal ideation post-abortion, adolescents were found to have made more attempts on their lives after the abortion.

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knowledge that would enable a quality of decision-making that is equivalent to that of an adult. This is where the counsellor's value can be most appreciated. Adult decision-making is characterized by an integration of cognitive and social-emotional factors (Rappoport, 1978). For the adolescent the new development of possibility thinking may not always extend to the consideration of social-emotional aspects. The counsellor is in a unique position to be able to encourage the integration of these factors.

For the adolescent the new development of possibility thinking may not always extend to the consideration of social-emotional aspects. The counsellor is in a unique position to be able to encourage the integration of these factors.

Written by Peta Dale, Psychologist at Open Doors Counselling and Educational Services.

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Problem Solving Counselling

By Michael Neenan

Problem-solving counselling programmes, designed to teach individuals social, workplace or interpersonal skills, have increased in the last 30 years. Here ***Michael Neenan*** *and* ***Stephan Palmer*** *describe an approach which tackles both the emotional and practical aspects of a problem.*

Problem-solving is a structured and systematic method of teaching clients to identify current problems or stressors in their lives and then learn a series of graduated steps or skills in order to tackle these difficulties. Programmes designed to teach individuals social, workplace or interpersonal problem-solving skills have increased in the last three decades (e.g. D'Zurilla and Golfried, 1971; D'Zurilla, 1986; Palmer; 1997). These problem-solving approaches have in common a number of sequential steps that include problem definition, generation of alternative problem definition, generation of alternative problem-solving methods, decision-making and evaluation of the chosen course(s) of action.

The problem-solving counselling we describe here is a double-headed or dual systems approach, i.e. tackling the emotional and practical aspects of a problem. As Walen, et al (1992, p. 52) observe: "Dealing with the emotional problems gets rid of emotional disturbance; dealing with practical problems leads to self-actualisation and improvements in the patient's quality of life. Both are important."

The emotional problem is tackled first as clients are not usually effective practical problem-solvers when they are emotionally disturbed. For example, a man who is depressed (emotional problem) about his lack of friends (practical problem) fails to develop a social network. This is because his view of himself as unlikeable and unattractive militates against making any successful social overtures. By helping him to challenge and change his negative self-image and depressagenic thinking, he is then able to focus his restored energies on initiating the necessary practical measures (e.g. joining a singles group, adventure weekends) in order to provide opportunities to find a suitable partner.

The dual systems approach to problem-solving we practice is essentially a cognitive-behavioural one because it emphasises the significant impact our thinking has on our emotions and behaviour. The specific cognitive-behavioural model we employ for emotional problem-solving is Ellis' (1994) rational emotive behaviour therapy (REBT); the model for practical problem-solving is the one proposed by Wasik (1984). The ultimate aim of this dual systems approach is to teach clients to become their own counsellors or problem solvers.

Emotional problem solving

The cornerstone of REBT rests on the assumption that individuals are not so much disturbed by events as by the views they take of these events (Ellis and Bernard, 1985). For example, two people fail the same job interview: the first person is disappointed but realises that nobody has to give him a job and thereby dips on applying for other ones; the second person becomes depressed and angry because he believes he absolutely should have got the job and the interview panel have revealed his worthlessness by not appointing him - he now concludes that it is futile to apply for any more jobs. The ABCDE model of emotional disturbance and change presents clients with a means of understanding and tackling their emotional problems:

A = activating event) past, present or future, internal or external)
Being passed over for promotion

B = beliefs in the form of rigid and absolute musts, shoulds, have-tos, got-tos, oughts
'I absolutely should have been promoted, its not fair.'

C = emotional and behavioural consequences
– hurt and withdrawal ('sulking') leading to both decreased productivity and interpersonal contact at work

D = disputing the client's rigid beliefs that produce her emotional and behavioural reactions at C
'Just because I very much wanted the promotion there is no reason why I have to get it. Too bad that I didn't. I'd better stop moping about and get on with the job I have got.'

E = a new and effective rational outlook based on flexible thinking which reverses the workplace decline and ameliorates the disturbed feelings noted at C.

From the REBT viewpoint it is B rather than A that determines C (though it is important to emphasise the significant contribution that A brings to C). This is known as *emotional responsibility*, whereby the individual accepts that her emotional problems are largely determined by her rigid beliefs. In order to achieve E, the client usually has a lot of hard work (homework) to carry out through the disputing (D) process. This is known as *therapeutic responsibility*. The use of the ABCDE model is illustrated in the following case study.

John - a case study

John had been referred by his GP for anxiety and stress. He was a 32-year-old single man who lived in a block of flats. He worked part-time in a local supermarket and described his life as 'quiet and uneventful' with few friends and little social life. However, his 'quiet' life was frequently shattered by the couple in the next flat who played their music loudly and for long periods. He described himself as 'always being on edge' when at home and felt ashamed that he was not able to confront the couple in the next flat. The therapist was keen to find out what prevented him form doing this:

Client: I'd get anxious if I went next door.

Therapist: Because....?

Client: They wouldn't pay any attention to me. They'd laugh at me or tell me to 'get lost'.

Therapist: And if they said or did those things, what then?

By helping him to challenge and change his negative self-image and depressagenic thinking, he is then able to focus his restored energies on initiating the necessary practical measures (e.g. joining a singles group, adventure weekends) in order to provide opportunities to find a suitable partner.

Problem Solving Counselling – (Continued)

Client: Well, all the sneering and horrible looks I'd get form them on the stairs, meeting them in the hallway or in the car-park outside. I did once ask them to turn the music down and that's how they responded.

Therapist: And what are you anxious about if they do behave like that.

Client: I'd feel very uncomfortable knowing how much they dislike me or that they're laughing at me. I don't want to feel like that. I try to avoid any arguments or unpleasantness in my dealings with other people.

Therapist: Is that what you are most anxious about: that you wouldn't be able to cope with the intense personal discomfort you would experience if you confronted them?

Client: Yes, that's it. I just want a quiet life.

Therapist: That seems to be precisely what you're not getting at the moment.

The therapist has located the reason John's anxiety (C) blocks him form taking any effective action with his noisy neighbours (A) - his avoidance of interpersonal tensions or conflict. In REBT, this is hypothesised as *low frustration tolerance* (LFT) or *discomfort anxiety*, i.e. the worry individuals experience when anticipating pain, discomfort, agitation, unpleasantness, etc.

Exercises teach clients to expose themselves for their perceived defects and to distinguish between criticising a behaviour or trait but not condemning themselves on the basis of it.

Implicit or explicit in this anxiety is a demand that the anticipated discomfort must not be too great, otherwise it will be unbearable. This point of view is offered to the client:

Client: That sounds a lot like me. I'm always trying to avoid unpleasantness in my life because I believe I can't cope with it but avoidance doesn't make me any happier.

Therapist: So how would you state you belief in precise terms so we are both clear what it is that you what to change?

Client: I must avoid at all costs any unpleasantness or conflict with other people because I just can't cope with it (B).

Therapist: In the case of your noisy neighbours, would you be interested in working with me to lower your anxiety and increase your ability to cope with this difficult situation by challenging and changing that belief?

Client: I suppose I need to do something about this situation but I just can't go round there now and have it out with them.

Therapist: I'm not asking you to do that. Let's first deal with the ideas that drive your anxiety because they prevent you from taking effective action with the couple next door.

Client: OK, I've got nothing to lose but my mind if that music doesn't stop.

During subsequent sessions John agreed to undertake a variety of homework or self-help assignments in order to weaken his disturbance-producing beliefs and strengthen his newly emerging emotional problem-solving beliefs ('I don't like these unpleasant situations or feelings but I can learn to deal with them better):

Cognitive tasks - compiling a list of the advantages and disadvantages of not tackling his problem and then revisiting the advantages to examine whether they were genuinely advantageous; reading a self-help book which encourages individuals to court and tolerate discomfort in order to achieve their goals (Dryden and Gordon, 1993).

Behavioural tasks - undertaking a series of 'stay-in there' exercises (Grieger and Boyd, 1980) which consisted of remaining in situations he usually avoided in order to work through his disturbed thoughts and feelings, e.g. visiting his parents who nearly always criticised him for not 'getting on in life', going to the dentist for a much delayed check-up.

Emotive tasks - engaging in shame-attacking exercises (Ellis, 1969). As John said he felt ashamed of himself - 'I'm weak and pathetic for not standing up to them'. These exercises teach clients to expose themselves for their perceived defects and to distinguish between criticising a behaviour or trait but not condemning themselves on the basis of it. Exercises that he carried out included asking directions to the local railway station while standing outside it and walking down the road with an umbrella open when it was not raining. After eight sessions of tackling successfully the emotional aspects of his problem, John then focused on its practical aspects.

Practical Problem Solving

He said that he wasn't always sure what to do when he had practical problems to deal with and this often meant he ended up with more rather than fewer problems. The model taught to him was Wasik's (1984) seven-step problem-solving approach which includes self-questioning:

Steps	Questions / Actions
1. Problem identification	What is the concern
2. Goal selection	What do I want?
3. Generation of alternatives	What can I do?
4. Consideration of consequences	What might happen?
5. Decision making	What is my decision?
6. Implementation	No do it!
7. Evaluation	Did it work?

Step 1

John's obvious problem was his noisy neighbours who made his home life unpleasant. This was the biggest current problem in his life (if he had a multitude of difficulties to be addressed then a problem list would have been drawn up).

Step 2

His goal was to find some means of influencing his neighbours to reduce their music playing to a more tolerable level - 'so that I no longer feel I'm living in the same flat as them'.

Step 3

Here John was encouraged to come up with as many possible solutions to his problem no matter how ludicrous or unrealistic some of them initially appeared; in other words, to brainstorm. At first, he

had trouble suggesting solutions, so the therapist offered some as a means of prompting him and then he produced these:

a. Ask the council for a transfer
b. Let their car tyres down
c. Knock on their door every time they play their music too loud and ask them to turn it down. Be persistent.
d. Find out the council's rules and regulations regarding the playing music and what enforcement powers they have.
e. Ask the other neighbours if they are upset over the music levels and try to get up a petition.
f. Blast them out with music!
g. Let the noisy couple know what my plan of action will be if they ignore me.

Step 4

This involved John considering the advantages and disadvantages of each solution produced from the brainstorming session. The client may wish to rate the plausibility of each possible solution on a scale of 0-10: 0- the least plausible...10- the most plausible:

a. 'It's running, or literally, moving away form the problem. I've done too much of that in my life.' **1.**
b. 'Too childish and may make the situation worse.' **1.**
c. 'This sounds more like it. It will be hard for me to do that but if I don't, I'm never going to get any peace. Stand up and be counted.' **8.**
d. 'This is a very sensible step and I will contact them if the couple don't turn down their music.' **7.**
e. 'If there are other people in the block who are also fed up with the music, then force of numbers either through a petition or knocking on their door might prevail.' **6.**
f. 'A non-starter then I'll get a double dose of loud noise.' **0.**
g. 'I'll certainly use this tactic if I get no satisfaction from them.' **6.**

Step 5

John now chose which solution to pursue based upon the calculus of probable success decided in the previous step: 'I'll start with c, and fall back on d, e and g if the going gets really tough'.

Step 6

This involved role-play: the therapist took on the role of one of the neighbours while John made repeated requests to him to turn the music down. John's voice faltered at times and he often looked down at the floor. Coming out of the role-play, the therapist commented upon John's indecisive manner and changes were made in his inter-actional approach John then practised the new behaviour in the session as well as agreeing to act it out in imagery for a homework task. The therapist can also prompt the client to suggest ways of handling the situation if setbacks occur (they usually do).

Step 7

At the next session, which is after the client has carried out the agreed solution, therapist and client evaluated its outcome:

Therapist: How did you get on?

Client: They're still playing their music too loud but the good news is that every time they do that I've been straight round there to complain.

Therapist: And how did they respond?

Client: As expected: rude, slammed the door in my face sometimes and, at other times, didn't even bother answering it.

Therapist: Any threats of physical violence?

Client: No, but if there are, I will immediately call the police which I didn't put on last week's list.

Therapist: Were there any moments or times when you wanted to forget the whole thing?

Client: On several occasions. The old ideas came back.

Therapist: Such as....?

Client: 'I cant stand all this unpleasantness. Why won't it go away? I just want a quiet, uneventful life.'

Therapist: How did you deal with those ideas?

Client: As you taught me in the earlier part of therapy - vigorously dispute them.

Therapist: Did it work?

Client: Yes, it did. I told myself to stop running away when things become unpleasant or difficult in my life and see the problem through to the bitter end. I think I'm beginning to get some backbone.

Therapist: It's good to hear you're making progress. So what's the next step with the noisy neighbours?

The therapist can also prompt the client to suggest ways of handling the situation if setbacks occur.

Client: Well, I told them yesterday that I've had enough and I'm officially complaining to the council and demanding that action be taken. I'll also be seeking the views of other residents.

Therapist: How does it feel to be doing all that?

Client: To be honest, I feel quite proud of myself. At last I'm really carrying something through.

In the following weeks, John reported that the music level of these neighbours had dropped appreciably. 'They still give me icy stares when they see me but I can live with that.' Another benefit he enjoyed was that he finally got to know and became friendly with other residents in the block of flats: 'We were strangers until I knocked on their doors.'

The practical problem-solving section of counselling had lasted for five sessions. To return to step 7, if the proposed solution(s) has been successful, the client can then pick another problem from his list and follow steps 1-6 again.

Ending

Now that he had success in one area of his life, John said he had experienced a 'sea change' in his outlook and wanted to do more with his life such as leaving his part-time job in the supermarket and pursuing 'a career that will be interesting and challenging for me in ways which the supermarket has never been'. He also wanted a more exciting social life and new felt he had the confidence to meet people and make more friends. Follow-up appointments were arranged for three, six and 12 months to monitor his progress in

Problem Solving Counselling – (Continued)

maintaining his therapeutic gains as well as finding out about the other developments in his life.

In conclusion

Problem-solving counselling is a psychoeducational approach that teaches clients how to remediate their present problems and prevent or reduce the occurrence of future ones. It is an approach that can be used in a variety of clinical settings (e.g. schools, colleges, industry). Problem-solving counselling is ideally suited to brief therapy regimes used in, for example, employee assistance programmes and general practice. Whether the emphasis is on emotional problem-solving or practical problem-solving or both, we believe that this approach has a great potential for helping individuals to accelerate the process of change in their lives and adapt more effectively to the increasing demands of a complex society.

Problem-solving counselling is ideally suited to brief therapy regimes used in, for example, employee assistance programmes and general practice.

Michael Neenan is Associate Director of the Centre for Stress Management.

Professor Stephen Palmer is Director of the Centre for Stress Management.

Correspondence address: Centre for Stress Management, 156 Westcombe Hill, Blackheath, London, SEJ 7DH.

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ACA

2002 Business Achievers Awards

Australian Counselling Association is a finalist in the North-West News Business Achievers awards for Professional Services. This is the second consecutive year ACA has been a finalist in this award. We would like to thank all those who voted for us. I believe this achievement is due to the continued high quality of services that ACA continues to give to its members and the public. The award is a reflection of the quality of membership we have and our continued efforts to represent the Counselling industry to the public and government sectors as a professional service.

Internet Resources Compiled by Angela Lewis

Angela Lewis
MA.Ed, CTDP, MACA,
is a qualified Counsellor and practices as a corporate adult educator (computer training) in Melbourne.

www.angelalewis.com.au

Hello everyone,

I thought we would go back to basics in this issue and take a look at the mouse attached to your computer. We all use one – but probably without thinking about it too much!

Mousing around: As you move a mouse, a ball on the underneath turns in the direction you move in. There are two rollers which connect with the ball and are placed at 90 degree angles from each other. One roller responds to vertical movements, the other to horizontal direction you move to. These rollers are attached to a wheel which is known as an encoder; this encoder creates an electrical signal which travels via the cord (the mouse tail!) attached to the mouse sends these signals to the program you are using (e.g. Word) which then converts these signals into where your mouse pointer should appear on your screen.

A recalcitrant mouse: When the mouse no longer feels like it is responding correctly when you move it around, it is time to feed it to the cat…I mean give it a good clean! You can use either mentholated spirits or purchase bottle of Isopropyl alcohol from the chemist plus some cotton buds for the job. Open the underside of your mouse and take out the ball. You will see a circle with two arrows – simply twist in the direction of the arrows. Once open you will see two rollers which are at 90 degree angles from each other – these are what you need to clean. There will probably be dust and fluff and grime around the rollers. Use your chemical of choice and the cotton buds to gently rub off the dirt. Give the mouse ball a good wipe as well and put the lot back together.

It is probably a good idea to give the mouse pad a good clean or think about buying a new one – and try not to eat your lunch or snacks while using the computer to avoid more grime getting into the mouse or keyboard!

NEW AGE MICE

The Trackball Mouse: The upside down mouse it has movable ball on top of a stationary device that is rotated with the fingers or palm of the hand. These are good in confined spaces such as on a laptop, but do take some getting used to – just like a conventional mouse does in the beginning!

Optical Mouse: This is the newest type of mouse available. Instead of an old fashioned ball, this mouse has an optical scanner on its underneath. This replaces the mouse ball which means no more cleaning! The sensor scans surfaces 1,500 times a second to track movement and can be used on surfaces other than the mouse pad.

The Little Mouse for kids: (a Minnie Mouse!) This mouse was designed for small children and is approximately 2/3 the size of a standard mouse the buttons are marked with bright dots to aid learning.

If there is a particular topic you would like me to focus on in future issue, please email your request – and if it is feasible I would be more than happy to deal with it.

WEBSITES

www.healthycomputing.com

Extensive and very helpful site covering the health aspects of working with computers, giving tips on setting up your working area ergonomically, information on injuries such as carpal tunnel syndrome and recommended stretches and exercises. A top site!

And speaking of injuries, here are the workcover sites:
Workcover Authority Victoria: *www.workcover.vic.gov.au*
Workcover Authority NSW: *www.workcover.nsw.gov.au*
Workcover Authority ACT: *www.workcover.act.gov.au*
Workcover Authority SA: *www.workcover.sa.gov.au*
Workcover Authority QLD : *www.workcover.qld.gov.au*
Workcover Authority WA : *www.workcover.wa.gov.au*
Workcover Authority TAS : *www.workcover.tas.gov.au*

www.clinicaltrials.gov/ct/gui/

Top of Form

U.S. National Institute of Health, through its National Library of Medicine, has developed ClinicalTrials.gov to provide patients, family members and members of the public with current information about clinical research studies. You may search by disease, location or treatment, browse by conditions and get information explaining and describing clinical trials

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.

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

ACA

Try not to eat your lunch or snacks while using the computer to avoid more grime getting into the mouse or keyboard!

News from the Chapters

On-going Professional Development (OPD). Attendance at Chapter meetings is counted towards OPD. Joining your local Chapter and attending meetings is a very cost-effective way of accumulating OPD hours. Chapter meetings are free to all Chapter members. To join your nearest Chapter please ring toll free 1300 784 333.

VICTORIAN CHAPTER

Unfortunately, Gail Higgins has stood down as the Victorian Chapter Chairperson. Gail was the driving force behind the setting up of the Chapter and was primarily responsible for the success of the Victorian Conference in 2001. On behalf of the members of ACA, I would like to say Thank You to Gail for all her hard work. Miguel Barreiro has now stepped into the role as the Chairperson of the Victorian Chapter.

Miguel is a psychologist and Clinical member of ACA, who has extensive experience in counselling and psychotherapy with individuals, couples and families. Miguel supervises probationary psychologists for registration with the Psychologists' Registration Board of Victoria and is also a registered supervisor with the Australian Counselling Association. He is the founder of Combined Community Counselling and Corporate Success Consultants and is currently managing director of both. Miguel can be contacted on 8801 4966 or email commcounselling@aol.com.

Joining your local Chapter and attending meetings is a very cost-effective way of accumulating OPD hours. Chapter meetings are free to all Chapter members.

Chapter Meeting: The next meeting of the Chapter will be on Thursday, 8th August at 6pm, Level 1, 337 Latrobe St, Melbourne. The guest speaker will be Dr Robert Macnili. Robert Macnili has been a General Practitioner for ten years and has studied with the late Milton Erickson to concentrate his energies on dealing in a respectful, dignified way with human dilemmas that affect both individuals and couples. Over the last 20 years, he has been teaching hypnotherapy, psychotherapy and counselling locally, nationally and internationally. Rob is co-author of a book titled "Healing With Words" and author of "Healing the Whole Person", published by Wiley. In 1988, Rob and his wife, Cherry founded the Centre of Effective Therapy, Melbourne.

SOUTH AUSTRALIAN CHAPTER:

Conference: International Guest Speaker The South Australian Chapter will be hosting a South Australian State Conference on 13th July, at Tiffins on the Park, Parkside. The guest international speaker will be Dr Rienie Venter, from South Africa. Dr Venter will be followed by a local speaker, psychologist Rin Minniti, and the manager of ACA, Philip Armstrong. The conference will be followed by a dinner. Please ring our toll-free number, 1300 784 333, for further information about registration for this exciting conference.

SYDNEY SUB-CHAPTER

The Sydney Chapter (formerly NSW Chapter) continues to meet on the second Saturday of every second month at 3pm at the North Sydney PCYC. Our meetings follow a format of an informal presentation and discussion on a particular aspect of counselling, followed by general Chapter business.

Our April meeting was no exception, with Chapter member Jeff Spencer presenting on "Drugs – a Counselling Perspective with a Legal Twist". Jeff's presentation inspired a lively group discussion amongst the fifteen members who attended.

Our next meeting on 9 June promises to be similarly engaging, with a presentation on "Microskills Practise" giving participants an opportunity to revisit the very important microkills of counselling.

Also, we are very excited about our "not to be missed" upcoming conference, Saturday 22 June 2002. The conference consists of nine interactive and practice oriented workshops in three strands. We have a great range of topics and a high quality of presenters, some of whom are known internationally for their work.

New Chapter members are always welcome, and for more information on chapter meetings and conference details please call Martin Hunter Jones on 0438 336 535 or email me on martinhj@tpg.com.au.

The Sydney Sub-Chapter will be hosting a New South Wales State Conference on 22nd June, at YWCA's Y on the Park, in Sydney. The Conference will consist of nine workshops, including Music Therapy, Suicide Prevention, T.A., Art Therapy, Men's Issues, Couple Therapy, Intensive Journaling, Mindfulness and Focussing. Please ring our toll-free number, 1300 784 333, for further information about registration for this exciting conference.

HUNTER VALLEY SUB-CHAPTER

The Hunter Valley Sub-Chapter held its inaugural meeting on 11th April 2002. The Chapter was formed as an initiative of Gracegrove College in Newcastle. The Chapter Chairperson is Dr Ted Heaton and foundation members include counsellors and psychotherapists, as well as student members. An immediate goal of the Chapter is to contact counsellors and interested groups in the Hunter region to broaden awareness and invite membership.

Bi-monthly meetings will include a presentation by a Chapter member or guest on a variety of topics relevant to counselling. The July meeting presentation, by Jane Meulman, will be about Group Counselling Processes. For further information about the Hunter Valley Sub-Chapter, you can contact Ted, on 4962 5650 or email white@bmr.net.au .

Chapter Meeting: The next meeting is at 5:30pm on 4th July, at Level 1, 723 Hunter St, Newcastle West.

BRISBANE SUB-CHAPTER

Conference: The Brisbane Sub-Chapter will be hosting a Queensland State Conference on 14th September 2002, at the Virginia Palms International in Boondal. The first guest speaker will be Dr John McPhee, who will be discussing Ethical Standards for Patient Care, including such things as the Privacy Act and litigation. Dr McPhee will be followed by Jenny Chaves, from the Health Rights' Commission Queensland, and Jenny will be discussing the Commissions' function, its impact on counsellors, and understanding health rights and responsibilities of the counsellor and patient. For more information about the conference, ring ACA on 3857 8288.

ACA

ACA South Australian Conference

Special international speaker

Dr Rienie Venter – Will discuss "Process of mind control in religious, commercial, psychological and political groups"

Dr Venter has addressed two international conferences, one in South Africa in 1998 *(South African Christian Counselling Association: Therapy to mind control victims)* and one in New Jersey in 2001 *(Cults in South Africa: Approaches of the Cult Information and Evangelical Centre in towards cult mind control in South Africa)*. She has also been a lecturer for 10 years, (seven years at Unisa, Faculty of Education), in the following subjects:

- Identification of talents and counselling of gifted learners and parents
- Child development: birth to late adolescence
- Family therapy, especially working in the family system
- Marriage therapy
- Individual therapy
- Psychopathology and its relevance in counselling
- Idiographic approach in a group - very relevant for counselling
- School guidance: personal, academic and career development
- Trauma and bereavement counselling

(All of the above, except trauma and bereavement counselling, on postgraduate level)

Dr Venter has held membership with the Cult Information and Evangelical Centre for more than six years. This is the only counter cult organisation in South Africa. Members are an interdenominational group, and all specialise in one or two groups. Rienie works in the counselling section, assessing and working in therapy with those who need emotional and psychological assistance.

In 1997 Dr Venter completed her doctorate on Therapeutic guidelines for ex-members of cultic groups. Rienie has conducted extensive research on the process of mind control and unethical and even totalistic control of individuals in religious, commercial, psychological and political groups, and in marriage and family relationships. As a psychologist she has worked in therapy with at least 20 victims of mind control.

Rin Minniti – Senior psychologist with Drug & Alcohol Services

Rin is a Senior Clinical Psychologist in the Drug and Alcohol Services. He has over 20 years experience in this field together with private practice, and specialises in dealing with all forms of addiction in relation to drugs and alcohol. Rin holds Honorary lectureships at Adelaide and Flinders University's as well as Lecturer of Psychology Counselling at Flinders University.

This presentation will be in relation to addictions and the process of "Motivational Interviewing" which is directed towards enhancement of change and developing new decisions in relation to lifestyle of the addict

Philip Armstrong - National manager of ACA and well-known national speaker. Philip will be discussing ACA member benefits and industry relevant issues.

Saturday 13th of July 200
Tiffins on the Park
176 Greenhill Road
Parkside SA 5063

Cost (GST included):

$130 – Per Participant (non members)
$110 – ACA non-Chapter member
$100 – ACA SA Chapter member
$ 85 – ACA student concession
add $ 40 - to attend informal dinner

Non-ACA members and the public welcome.

To register phone toll free number 1300 784 333

ACA

Dr Venter has held membership with the Cult Information and Evangelical Centre for more than six years. This is the only counter cult organisation in South Africa.

NSW Chapter of the Australian Counselling Association 2002 Conference

(Concluded from Page 32)

beliefs, it helps the client to study their own mind/body process, recognise internal patterns and reactions that block them from living life to their fullest potential. Subhana's recent therapeutic work has been influenced by the Hakomi method, in which she is currently training.

Subhana Barzaghi, is a Zen Buddhist and insight meditation teacher. She is the resident teacher of the Sydney Zen Centre, and founder of the Kuan Yin Centre in Lismore. Subhana has 25 years experience in Buddhist meditation practice and leads regular intensive Sesshins and Insight retreats throughout Australia, New Zealand and India. Subhana is a qualified, experienced psychotherapist and workshop leader and runs a private therapy practice in North Sydney.

Focusing - *Jane Quale*

Focusing is a method of self-knowledge and healing originally researched and developed by Eugene Gendlin who is a philosopher and psychotherapist, who worked with Carl Rogers at the University of Chicago. Their research was based on the question, "Why is it that some clients have a successful outcome in therapy and some do not"? Focusing is an inward attention of the body that accesses the edge of our awareness (the border zone between the conscious and the unconscious) and moves our lives forward in creative and healing ways.

Jane is a psychotherapist and bodywork therapist who has completed a diploma at the Jansen Newman Institute, in psychotherapy and relationship counselling and is currently working there as a therapist. She has also undertaken an extensive three-year experiential training program with the Focusing Institute and is a certified focusing trainer. Jane is committed to assisting people to learn ways to live fuller, deeper and more self-accepting lives.

For More Information ring 1300 784 333.

MAKING YOUR COUNSELLING PRACTICE ACCESSIBLE

Anna Fisher - Northern Rivers Community Services Worker for The Australian Quadriplegic Association

As a counsellor you provide an important service to the community. Have you ever thought about the difficulty people with severe physical disabilities face when trying to access your service? People with disabilities may need to use your service so it is important to consider their needs and make your service accessible for all.

The Disability Discrimination Act (DDA 1992) states that all providers of services must provide premises and services that are accessible to all people including people with disabilities. You could be liable in a disability discrimination claim if your current premises are inaccessible and you do not provide any alternative options to ensure equal access for people with disabilities. In the following article I have attempted to ask and answer questions that you may face as professionals in order to provide an accessible counselling service.

According to the ABS Ageing and Disability Survey (1998) 19% of the population have a disability. Approximately 10% of the population have a physical disability of which half use a mobility aid. A mobility aid could be a walking frame or crutches, walking stick, wheelchair or scooter. Frequently people who use wheelchairs or have some form of mobility impairment face a number of barriers when trying to access services and buildings in the community.

Frequently people who use wheelchairs or have some form of mobility impairment face a number of barriers when trying to access services and buildings in the community.

A disability arises when a person with an impairment is not able to access services and premises due to limiting environmental circumstances and attitudes.

What are my legal Responsibilities?

Existing premises, including heritage buildings, are covered by the Disability Discrimination Act (DDA 1992). Where equitable access is not provided, people who are responsible for premises may be subject to a complaint.

What is the DDA?

The DDA is complaints based Commonwealth legislation. It aims to eliminate discrimination against a person on the grounds of disability including access to premises and services. It also ensures that people with disabilities have fundamental equal rights, promoting their recognition and acceptance in the wider community.

What does access mean?

Access doesn't just mean providing entry onto or into your premises. It also includes access to parking and facilities within the building ie: toilets, treatment rooms etc. Access for people with disabilities is about being able to move ***independently*** from the point of arrival to and through the premises in a ***continuous accessible pathway*** free of ***physical*** and ***attitudinal*** barriers. Attitudinal barriers could be refusing entry, talking to the persons carer rather than the person with a disability, use of discriminatory language etc. Some people argue it isn't necessary to make their premises accessible because they don't have any clients with a disability. Or is it that they don't have any clients with a disability because their premises are inaccessible?

Basically, the services you provide to the general public need to equally be provided for people with a disability.

What are the benefits of providing access?

It is estimated that 35% of all people benefit from accessible design and considering Australia's ageing population this figure is likely to increase over time. Seven out of every ten people over the ages of 65 are affected by some form of disability. Hence providing accessible premises has significant benefits for not only people with disabilities but also the wider community, allowing you to access:

- Increased number of clients
- Provide access for the wider community, eg: mothers with prams, older people etc

What are alternatives if I don't have access?

- Use of alternative accessible premises if you have a client with a mobility impairment
- Home visit at no extra charge
- Lodge an disability action plan with Human Rights and Equal Opportunity Commission (HREOC) outlining modifications to be completed within 3-5 years, how much money is put aside to do these etc. This will cover you against a disability complaint during this time frame.

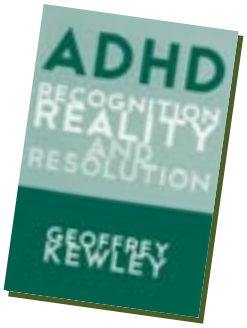
What if I need help or more information?

If you would like further information about physical access requirements for your premises phone Amelia Starr (Access Coordinator) at AQA on (02) 9313 9424. AQA is a community-based organisation that supports and advocates for people with severe physical disabilities.

Book Reviews

ADHD: Recognition, Reality and Resolution

By Geoffrey KEWLEY



Geoffrey Kewley is an Australian paediatrician based in the United Kingdom. In 1993 he established the Learning Assessment Centre, an independent clinic for the assessment and management of people who have ADHD and related problems. His book *ADHD: Recognition, Reality and Resolution* does exactly what the title denotes: it presents a comprehensive overview of Attention-deficit Hyperactivity Disorder, outlining and discussing in clear and every-day terms key aspects of ADHD such as causes, core features, presenting symptoms, common problems, complications, assessment and management. Designed as a reference for parents, teachers and professionals directly involved with children with ADHD, the book includes detailed tips and other useful tactics for both day-to-day and long term management. A guide for school based policy development is also included. Kewley also addresses issues confronted by adolescents and adults who have the disorder.

- The book is well laid out incorporating combinations of figure / text descriptors (eg 'conditions that may be found coexisting with ADHD' and 'a multi-modal approach to therapy')
- Cartoon style drawings illustrate system pattern profiles
- A series of case notes explore history, assessment and management profiles
- The real-life story of 'Tom' traces his journey from baby through to his mid twenties
- Each chapter concludes with a succinct summary in point form that highlights the overarching concepts addressed within the chapter
- The book also includes a glossary of terms and appendices that list recommended further reading, diagnostic criteria checklists and helpful support contacts.

This blend of textual features helps to make *ADHD: Recognition, Reality and Resolution* a very readable and enlightening text and a most worthy addition to one's professional library. The book serves both to develop professional awareness in relation to the complexity of ADHD and to support clients who are living with the problems and complications associated with ADHD – whether the client be the one suffering with the disorder, a family member, a teacher or school administrator or an associate.

Published by ACER Press, *ADHD: Recognition, Reality and Resolution* is available directly from ACER (telephone 03 9277 5555, fax 03 9835 7499, mail order address ACER, Private Bag 55, CAMBERWELL, Victoria, 3124 or website www.acerpress.com.au). Price is $39.95 plus postage and handling charge of $5.50. Purchase price and P&H charges are GST inclusive.

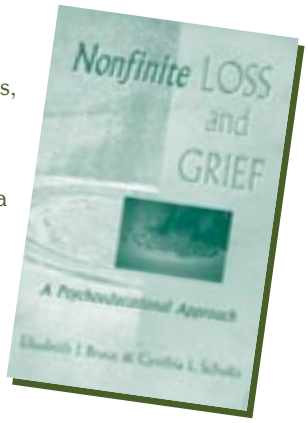
Reviewed by Judy Boylan,
an ex school principal who is now in private practice as a counsellor.

Nonfinite Loss & Grief: A Psychoeducational Approach

By Elizabeth Bruce & Cynthia Schultz

This book was written to assist counselling professionals with clients who are dealing with the complexity of nonfinite loss. Nonfinite loss is defined by the authors as : *losses that are contingent on development; the passage of time; and a lack of synchronicity with hopes, wishes, ideals and expectations.* Examples of non-finite loss cover a large spectrum ranging from loss of significant relationship through divorce or separation to receiving the diagnoses of a degenerative disease for oneself or a loved one.

The authors experience encompasses research, teaching and clinical practice in the area of loss, grief and trauma. This inspirational book draws together current theories and research to produce a framework for intervention with clients who are dealing with the insidious nature and ongoing trauma of non-finite loss.



The authors have endeavoured to bridge the gap between scientific theory and clinical practice. This is not an easy book to read for professionals unfamiliar with theoretical psychological discourse. However, a practitioner prepared to make the effort required to learn the theories and principles associated with developmental, cognitive and emotional focused psychology will be rewarded with a solid understanding of the theoretical issues and clinical applications associated with nonfinite loss. A number of case studies serve to demonstrate clinical application of the therapeutic approach preferred by the authors.

The authors adopt a psychoeducational approach to treatment. They undertake treatment as a coaching process based on providing clients with a supportive and encouraging environment. They encourage the fostering of an empowering relationship between counsellor and client with the aim of safely exploring cognitive and emotional aspects of the individual's adjustment tasks, while assisting clients to develop the ability to adequately manage their emotions. The primary aims of this approach is to assist clients to increase their sense of self-efficacy and to manage ongoing readjustment to the emerging reality of their changing world.

Published McLennan & Petty, Nonfinite Loss and Grief is available at MacLennan & Petty by ringing 02 9349 5811. Price: $69.30 ISBN: 0-86433-164-9

Book Review by Miguel Barreiro,
Chair of the Victorian Chapter of the ACA and practicing psychologist and director of Combined Community Counselling.

ADHD: Recognition, Reality and Resolution

By Geoffrey KEWLEY

Reviewed by Judy Boylan,
an ex school principal who is now in private practice as a counsellor.

Nonfinite Loss & Grief: A Psychoeducational Approach

By Elizabeth Bruce & Cynthia Schultz

Book Review by Miguel Barreiro,
Chair of the Victorian Chapter of the ACA and practicing psychologist and director of Combined Community Counselling.

Book Reviews – (Continued)

Abnormal Psychology 3rd Edition

By Barlow & Durand

Reviewed by Philip Armstrong, National workshop presenter and editor of Counselling Australia.

Abnormal Psychology 3rd Edition

By Barlow & Durand

Barlow and Durand have done an excellent job with this latest edition. One of the books main attractions being that it is one of the first of its kind to be published this year which ensures it is up to date with the latest research, prevention techniques, diagnosis and treatment in this field. The inclusion of an interactive CD with this book helps those of us who are more visual than auditory in relation to learning. The CD features real clients talking about their disorders and what it is like to live with these disorders. This adjunct to the book gives the reader an understanding that could never be reached by simple written words. The book also incorporates a study guide at the end of each chapter to ensure the reader has understood what they have read and heard. This addition to the chapters helps to challenge your own knowledge base and even if you are not a student, it gives you the opportunity to test yourself. Abnormal psychology blends sophisticated research (including new prevention coverage) and an easy writing style to enable all the information to be digested by the reader. Barlow and Durand also incorporate a great deal of information on prevention as well as treatment and diagnosis.

The book is not just another volume of disorders and symptoms with some guidelines on treatment. Barlow and Durand start by examining the historical context of abnormal behaviour continuing on to a discussion on integrative approaches to psychology to clinical assessment and diagnosis before going into detail on different types of disorders. Each disorder includes the appropriate DSM table and diagnostic criteria. The disorders, are examined in a logical manner that is uncomplicated to read and understand as well as being well referenced. Each disorder is well presented with case material. To help break up the mass of information the book has many graphs, photo's and drawings which all help to maintain the readers interest and to further visually explain issues relevant to abnormal behaviour. With each edition of Abnormal Psychology you also receive a free four month subscription to InfoTrac which is an online library which has the latest information on news and research.

I found this edition of Abnormal Psychology to be the best of several others that I have read. I recommend this book to all those either studying psychology/counselling or for those who have an interest in this subject.

Published Thompson Learning, Abnormal Psychology 3rd Edition (ISBN 0-534-58149-8) is available at Thompson Learning by ringing Melissa Zarafa on 03 9685 4201. Mention this review to receive a significant discount.

Reviewed by Philip Armstrong,
National workshop presenter and editor of Counselling Australia.

Raising Real People – Creating a Resilient Family, 2nd edition.

By Andrew Fuller

Book review by Adrian Hellwig, a Pastoral Careworker at Villanova College and Clinical member of ACA.

Raising Real People – Creating a Resilient Family, 2nd edition.

By Andrew Fuller

Andrew Fuller, who also wrote *"From Surviving to Thriving: Promoting Mental Health in Young People"*, has once again come up trumps with a book that is insightful, informative and with that touch of humour that makes one want to keep reading.

The book has not been written just to satisfy the on-going professional development needs of the counsellor/health-care professional, nor to introduce said professional to a whole range of new strategies to give to long-suffering parents at the end of their tether, and yet it serves both these needs wonderfully well. It is a book that anyone who has a family can not only identify with, but also find new insights into how that family interrelates and what to do when our less than perfect parenting skills let us down.

As a resource it is well laid out, having a newspaper feel about it with big headlines, text breaks, illustrations, and quotable quotes. As well as that it has a comprehensive table of contents, a section devoted to chapter notes and a good further reading list. One more thing, don't be fooled by the light-hearted approach or the "popular" nature of this bestseller. The scholarship is sound and based upon well-respected authors and books. The appeal of Fuller's work lies in the fact that it is also supported by and interlaced with, the stories and anecdotes of real people facing real situations; people who are both innovative and inventive in the way they approach the difficulties that raising a family can give rise to.

As someone who works as a school counsellor I can highly recommend this book both as a resource and as a very practical and helpful tool in dealing with the young people of this generation and their oft over-worked, over-stressed and under-resourced parents.

Published by ACER Press, Raising Real People – Creating a Resilient Family, 2nd edition, is available directly from ACER (telephone 03 9277 5555, fax 03 9835 7499, mail order address ACER, Private Bag 55, CAMBERWELL, Victoria, 3124 or website www.acerpress.com.au).

Book review by Adrian Hellwig,
a Pastoral Careworker at Villanova College and Clinical member of ACA.

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