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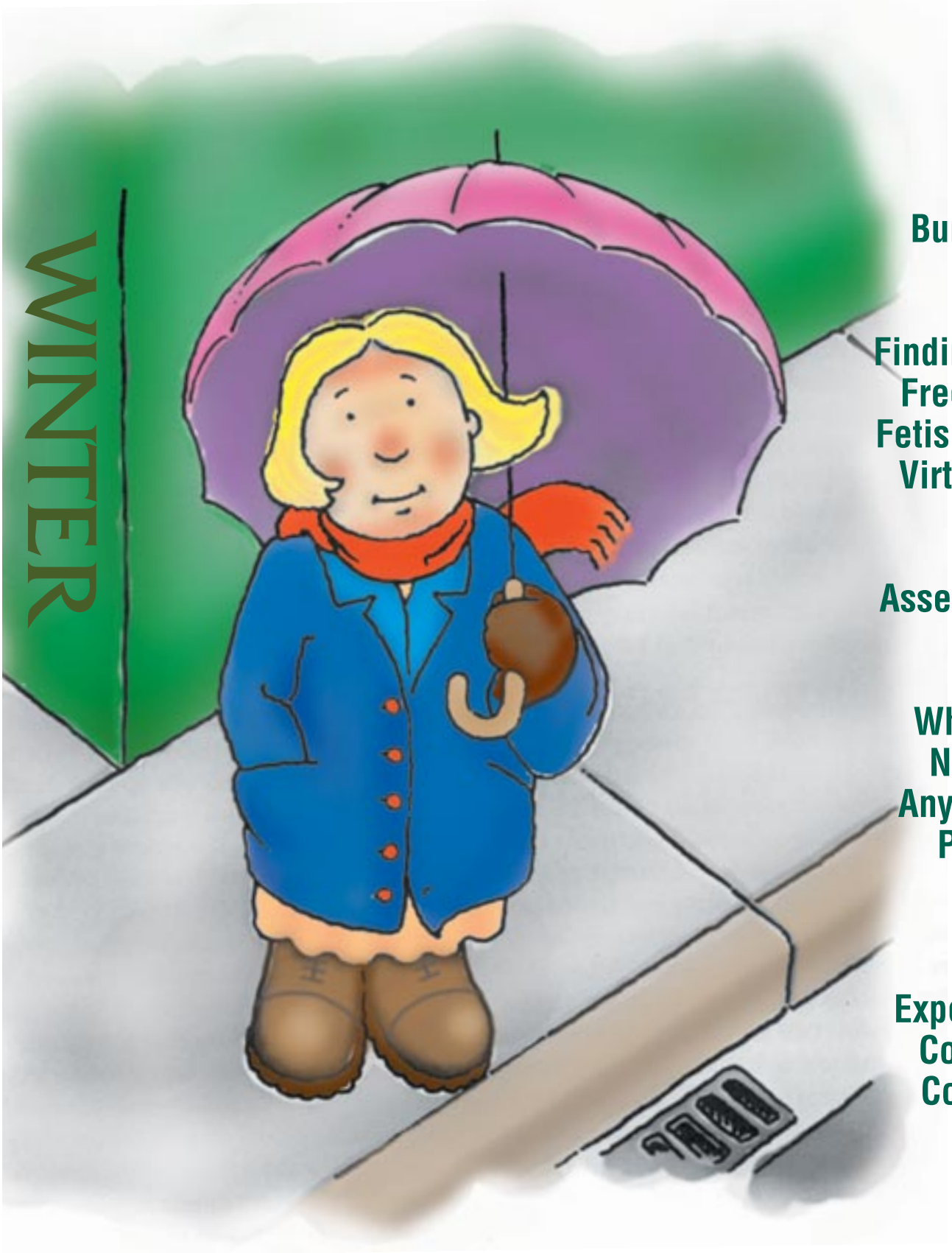

Bouncing Babies– Bowlby, Burdens and Brains

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The following counselling organisations are full members of the Australian Counselling Association:

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Editorial By Philip Armstrong

The first half of this year has flown by, with continued growth in membership and activities. We already have had three successful state conferences, in Victoria, South Australia and Queensland. We also have had a significant increase in Clinical members this year, which reflects ACA's attraction as a professional peak body. I have asked many of our new clinical members what drew them towards ACA. The most common answer is "first impressions". The top three impressions were: to talk to someone who was friendly and could answer their questions on the spot when they phoned (many actually were surprised that a human answered their phone call in the first instance); quick responses to emails; and the informative, up-to-date web page. All three impressions are only possible due to our committed and professional staff.

I also asked them why they joined ACA and the answers generally were based around their first impressions being fortified by the follow up of information. They found our standards to reflect the profession as they believe it should be; the administration of applications was simple, quick and efficient without losing the important information required for membership, and the costs of membership were realistic.

It was only due to my background in having served in the Army and not being employed by DVA that they were candid and honest with me.

A secondary general comment was in regard to ACA's continued effort to keep members informed through our journal, email of the month, web site, emails, mail-outs and Chapters. A sudden surge in attempts by other associations to copy ACA is also a good indication that we are getting it right. We are not happy, however, to rest on our laurels; it is important that members and prospective members communicate their needs and expectations of their representative body to us.

The results of the "members' survey" are now out and can be read on page 66, with the name of the winner of the book. There is also an interesting article by Professor Diego De Leo, who is the director of the Australian Institute for Suicide Research and Prevention at Griffith University (ASRAP). I was honoured to be invited to the inaugural opening of the Community Action for the Prevention of Suicide Inc (CAPS), which was founded by ASRAP. Professor Leo spoke at the opening and reiterated the high incidence of suicide in Australia. More people in Australia die of suicide than of any other one factor, including heart disease and car accidents. Although you would think that funding and knowledge would be comparable in relation to issues such as vehicle accidents and heart disease, this is nowhere near the case. It would seem that, as a society, we ignorantly still believe that, if we pretend it doesn't exist, it will go away.

Professor Leo touched a nerve with me when he went on to say that, according to the latest international research, only 20% of people who commit suicide actually suffer from depression. This figure only supports what most counsellors already know - psychological conditions, as opposed to personal conflicts, are over diagnosed. This also brings into contention the issue of medication. How many of the 80% are unnecessarily on medication that is only interfering with their ability to function rather than treating their issues? I came away from the CAPS meeting believing even more fervently what I learned in private practice and whilst working for the Returned and Services League (RSL) Queensland Branch - that many veterans and others are not suffering from psychological issues but personal issues such as shame, which is not a psychological condition but a human one.

I will never forget the first time I interviewed Vietnam Veterans who were attending the Veterans PTSD clinic at Greenslopes Private Hospital after attending CBT sessions and further anger-management programs. It was only due to my background in having served in the Army and not being employed by DVA that they were candid and honest with me. They admitted they were only playing the game to ensure they received their pensions and that the treatment was a game and totally non productive in regard to their issues. They were concerned, however, that if they did not attend treatment they may compromise their pensions. In my four years of formally working as a counsellor with veterans and 20 years of interacting with thousands of veterans, I found this to be the case more often than not. These veterans did have issues but no amount of psychiatric treatment or medication was going to help them. They had been labelled and processed but they continued to suffer and commit suicide in spite of this. Their real issues were more to do with personal issues surrounding the politics of the war and the shame they were made to feel after being ostracised by their country on their return.

The issue of suicide is a complicated one and I don't want to come across as simplifying it. Shame is simply one of many issues, however I did feel that Professor Leo had made a significant statement that supported my thoughts that counselling, as opposed to other modalities and medication, may be a positive alternative for many of the 80% who are not suffering from depression or such conditions. Or is it just that we may find it too challenging to believe that sane people commit suicide.

I am not insinuating that veterans do not suffer from PTSD, as many do, and I am not saying that suicide can be prevented by counselling. Research has shown that 80% of people who commit suicide did not suffer from a depressive condition, there is a possibility of over diagnosing depression, again for the want of a better description. I am suggesting that if we could convince more people who are in a personal crisis, particularly men to attend counselling, suicide rates may start to drop.

ACA

Bouncing Babies – Bowlby, Burdens and Brains

By Ian Hay — (Part 2)

Stress and Neurobiology

Recent research, with our capacity to look inside the living brain, provides neurobiological evidence that stressors have an impact on the brain itself. It is now known that stressors, such as abuse and neglect, have an influence on the size of brain structures involved with emotion, learning and memory.

Schore (2001,2002) and others have emphasised the effect of the stress response (particularly in terms of abuse and neglect) on the developing right brain during the first three years of life.

The right brain is referred to as the "emotional brain". It seems that our future coping capacities are a function of the development of this side of the brain during these early years. Our ability today as adults to cope with stress may have been established so long ago.

Other researchers, such as Heim and Nemeroff (2001) and Nemeroff (1998) have claimed that their research shows how patterns of depression can be linked back to events that have occurred in these very early years. The research here refers to repeated stimulation of certain pathways within the brain - the stress hormone pathways. The idea is that the more these pathways are stimulated in these very early years the greater the probability of depression in later life.

The capacity to deal with the world in a thinking and controlled way is limited through impulsivity. It is now known that neurochemicals, such as the transmitters serotonin and noradrenaline, have a marked impact on emotions, such as anxiety, depression and anger. It is also known that exposure to early child abuse and neglect can have marked impacts on these transmitter systems leading to increased risk of a whole raft of maladaptive behaviour, including several different types of violence (Virkkunen et al 1995).

It seems that low noradrenaline levels are associated with cold blooded acts of violence, while high noradrenaline levels are more associated with violence associated with extreme anger.

By way of contrast, low serotonin levels are associated with explosive rage and impulsive aggression. High levels of serotonin are more associated with repressed aggression. These same high levels of serotonin are also linked to anxiety-based problems, such as obsessive compulsive disorder and shyness. Low serotonin is also associated with suicide and depression.

One of the most repeated findings across research studying this area, has been the low levels of one of the breakdown products of serotonin found in the spinal fluid of successful suicide victims (Alvarez et al. 1999; Lidberg et al, 2000)

The probability is that there are higher or lower levels of various brain transmitters, such as serotonin and noradrenaline, as a result of varying genetic patterns across populations. Given that this may be the case it still does not detract from the research showing that early childhood abuse and neglect can have marked effects on the development of these transmitter systems.

The question is no longer if neglect and abuse cause damage to these pathways. Rather, it is how much of the damage can be corrected through later effort.

Risk Factors

Some of these are obvious.

Inadequate parenting skills, particularly those involving insensitive and inconsistent care provision, are the most obvious. Insensitivity involves misreading or ignoring the babies signals for care, comfort, and protection.

When does the damage occur? The answer to this question does not surround the occasional misunderstanding or misreading of babies signals. Indeed some experts believe these little misattunements to be quite adaptive. In this sense baby learns that these temporary unhappinesses can be made right.

No, the answer lies in persistent insensitivities, abuses and neglect. In my mind, looking for specifics is like looking back to which cigarette or packet of cigarettes was responsible for causing someone's lung cancer.

There are other factors that make insensitivity and inconsistency more probable. These are things like delayed biological maturity that interferes with the baby's capacity to signal. Parents or caregivers who are themselves in an unstable relationship can be a factor. The more parents and caregivers need to focus on themselves the greater the distraction away from the baby's needs onto their own.

One of the most repeated findings across research studying this area, has been the low levels of one of the breakdown products of serotonin found in the spinal fluid of successful suicide victims.

Poor quality childcare is also an issue with more studies showing increased salivery cortisol (a measure of stress) in children exposed to poor care and even good quality extended care. Indeed the concept of "multiple mothering" has been associated with poor developmental outcomes since studies of orphanage children were conducted in post war Britain. It seems that individualised and personalised care that is continuously provided across time is an important protective factor.

It was mentioned earlier that securely attached children are better able to express needs. There have been a number of studies that have looked at the amount and quality of verbal interaction that mothers have with their babies in the first year of life. Significant differences have been found across socioeconomic groups. It is heartbreaking that some babies are really disadvantaged here.

Studies show that mothers in higher socio economic groups talk to their babies up to three times as much compared to mothers in lower socioeconomic groups (DiPietro, 2000). Absence of reciprocal conversation and play are significant risk factors.

Protective Factors

There are some factors that are associated with the best possible outcomes. Simply stated these are things like a nurturing, secure and affectionate relationship with at least one parent and a happy supportive relationship with one other adult. Involvement in pro-social peer groups, the development of a sense of personal positive achievements followed by positive and rewarding school environments.

Bouncing Babies – Bowlby, Burdens and Brains (continued)

What represents a "good outcome" is summaried well by Teicher:

We hypothesize that adequate nurturing and the absence of early intense stress permits our brains to develop in a manner that is less aggressive and more emotionally stable, social, empathic, and hemispherically integrated. We believe that this process enhances the ability of social animals to build more complex interpersonal structures and enables humans to better realise their creative potential.

(Teicher, Scientific American, 2002, p61)

Outcomes

Teicher's statement fairly represents the better outcome. Unfortunately many children do not develop those more complex interpersonal structures to enable them to better realise their creative potential. For these children the brain has had to develop in a different way.

From an evolutionary perspective it makes no sense that development should be inconsistent with the best outcome for survival. If the world has been found to be a threatening place then development must prepare the child for survival in this hostile place. For these children depression, anxiety, suspicion, aggression, anger and violence permit such survival.

We need to undergo a change in thinking as a result of what we have learned about child development. A complete change in focus.

It appears that the psychodynamic theorists were right. The first year of life up to the third year of life may be incredibly significant in terms of individual life courses. It is up to us in terms of what resources we are prepared to commit to making individual lives happy and assisting in the realisation of human potential.

The political message must be that we reap what we sow. Teicher (2002) warns that we need to realise that stress brought about through abuse and neglect may set off hormonal changes that permanently wire a child's brain to cope with a threatening and malevolent world. And it could be, just as Teicher suggested, that once the damage has occurred there is no "going back".

We need to undergo a change in thinking as a result of what we have learned about child development. A complete change in focus.

The required change involves a focus on social and emotional development and away from cognitive development in these precious first three years. Let's not be concerned about how smart baby is, let's be concerned about how emotionally secure baby is. Let's have mums complementing each other on markers in their children, signifying levels of positive social and emotional achievement.

This is going to take some time until the popular press picks up on newer research in child social and emotional development.

As well, marketing departments are already set up to exploit parental guilt if they do not purchase some product designed to increase their baby and child's cognitive development. There are not the same manipulative minds convincing parents to engage in activities that further their baby and child's social and emotional development.

We need to encourage parents of the lifelong benefit of focusing on their children's social and emotional health through sensitive and consistent parenting. At the end of the day it is the difference between great expectations (listening and responding to baby and infant needs) and limited expectations or even worse, no expectations.

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ACA

Is that a mask you are wearing …or are you just glad to see me?

Finding sexual freedom and fetishes in the Virtual world

By Angela Lewis MA.Ed

Last issue my feature article was on the Internet personals and how people used them to find mates and relationships. This month I present an overview of the darker side of the Internet Personals – websites dedicated to finding sex and 'adult play' partners.

I have chosen to look at www.alt.com and www.adultfriendfinder.com. Let me say up front I have found this exercise most confronting, as it's outside of the bounds of what I personally find acceptable; however there are thousands of people who don't share my views on this, and I really feel it is another aspect of human endeavour that counsellors et al need to be aware of.

Firstly Adultfriendfinder.com. Much like all the personals, you need to organise a name for your cyber personality and then fill in a profile of yourself plus what you are looking for in a man/woman. There are various memberships available that require payment; however the basic membership allows you to contact others via email or via a chat room on the site. When you search for members you are presented with a 10 per page screen of pictures and profiles…however the pictures are not your average head shot of someone smiling engagingly at the camera, they are pictures of naked bodies, bodies clothed in erotic underwear and full pictures of bottoms, breasts and penises. If readers wish to have a look at this site, you are allowed one screen of member pictures and then you are asked to set up a membership for yourself, but please remember that this site can be categorised as fairly pornographic in content.

As I draw the line at putting a naked picture up of myself, I joined the site incognito; however I still received a great deal of email. Apparently male members of this site are not that fussy about viewing a potential sex partner's picture – as opposed to the genuine dating sites where people will virtually never make contact unless there is a photo posted. Basically this is a sanctioned online swinger's party, where you can make arrangements to have couple sex, same sex sex, threesomes, or simply 'talk dirty'. There are a large number of female members, who apparently do not seem to have huge safety concerns about making dates to have sex with unknown men. The people who are members appear to be ordinary members of society, from all different walks of life and those that are married are quite open about making this known.

It is fairly common for members on this site to also simply have online sex, which can follow a script somewhat like below, however evidently a surprising number of people will actually meet in real life:

Woman: did you feel my breasts pressed up against your back while you were showering…I had that image…
Man: I felt you all over me…the first time I came I was thinking about being inside your velvetiness…

Man: the second time…I was tasting you until you had orgasmed; you were sweet like summer fruits…

Woman: Oh God…..

So dear readers you get the picture - and for those of us who have wondered what constitutes cyber-sex – the above fulfils those criteria! The idea is to paint a vivid picture for each other; and my observation is that this type of website really does, by virtue of the written word, tend to appeal and cater to a slightly more educated slice of society. Let's face it, if you can't describe the female genitalia with some finesse, it may be a little difficult to get your cyber lady's attention! The more experienced members say that the idea is to keep it direct and moving along, without turning the experiences into a virtual 'wham bam thank you ma'am' exercise.

So….if I found the Adultfriendfinder website confronting, you can imagine my face when I logged into www.alt.com, a website dedicated to the fetishist /alternate lifestyler, who wishes to meet other likeminded individuals or couples. This website provides a forum and meeting opportunity for those who have alternative tastes and who wish to either exchange erotic emails, watch others (via webcam) or meet with the intention of active participation. I would not have known of its existence, but for a friend confiding that she used it. I personally found this website to be more sophisticated and less 'brothel-like' than adultfriendfinder, as it deals with the subject matter is a non-voyeuristic and respectful way. While this may seem a strange comment to make, the reader is given the impression that there are standards and manners in place here, and there appears to be an ethic of caring. The core principals of BDSM and D/S which they support are: Safe – Sane - Consensual. Aside from allowing a person to meet Doms, Subs and BDSM masters, the site also has excellent articles on safety, sexual health and information on the most common fetishes.

It is fairly common for members on this site to also simply have online sex, which can follow a script somewhat like below, however evidently a surprising number of people will actually meet in real life.

However that said, several of the profiles contain some truly bizarre pictures, with leather, whips, masks, bindings, bruised bodies, stilettos and erect penises being the fodder of the day. Obviously some of these picture profiles will not be to everyone's taste, and will extend some people's comfort zones. Interestingly there are far more men showing their faces along with their genitalia, than there are women exhibiting photos. Basic membership to chat to others and search for likeminded individuals is free. I learned a lot from visiting here, but you must set up a login and User id to utilise the site - there is no opportunity for casual voyeurism on this site.

ALT.com appeared to me to be socially responsible, with an ethic of care towards its members. There appears to be a real spirit of community on this website, with a discussion board for members to post questions and for other members to answer those questions. For people who are uncertain of their predilections or need a safe environment to learn and discover more, this site seems to provide that service; and as well as contributing a lot of information ranging from discussion of health issues, dating, relationships and specialist issues such as how to say no in sex play, handling toys (whips, canes, candles etc) how to handle first dates with other fetishist, e.g. a submissive on a first date with a dominant, plus a teen advice area.

Finding sexual freedom and fetishes in the Virtual world
(continued)

It also appears that alt.com members are very protective and supportive of each other – for example they also organise monthly get-togethers so that members can get to know each other in a social (non-sexual way), and some go regularly to fetish clubs - it offers the sense of a real 'community' if members want it to be. This would seem to be a welcoming and accepting environment for people whose sexual needs are outside of the socially accepted mainstream.

My conversations with ALT.com members highlight the difference between a site such as Adultfriendfinder where members are looking for sex and rarely a relationship and the needs of those who join ALT.com. Members of ALT appear to mostly be looking for a relationship, but built around their sexual proclivity - although of course there are those who are looking for casual encounters too - but most are looking for an ongoing arrangement. While this arrangement does not necessarily fit the norms of the conventional boyfriend/girlfriend, hold hands have conventional sex relationship, the members are still looking for partnerships and relationships with one compatible partner – however the basis for compatibility may be that a subordinate person is seeking a dominant person, a person who likes to be tied up is looking for someone who like to tie up others, etc.

The breath of the membership is huge, with members in virtually every country in the world, the scope of which seems to rival ordinary dating sites.

The breath of the membership is huge, with members in virtually every country in the world, the scope of which seems to rival ordinary dating sites. In Australia for example there are 42,000 members and in America there are 960,000 members. Not surprisingly in both Australia and the USA, the numbers of men to women were wildly disparate, with approximately 31,000 men seeking women and 2,500 women seeking men listed on the day that I visited the site. The second highest numbers are couples seeking another woman.

The chatrooms on ALT.com would appear to provide a good opportunity to experience an aspect of sexuality a person may be curious about or drawn to, as well as taking advantage of reading the questions other members have posted and reading the various magazine articles. Very basic questions are addressed, such as 'is it safe to have oral sex without a condom' up to discussions of the rights of a submissive person when their slave-master decides to sell them off to another Dominant/trix.

Some of the fetishes the ALT.com website caters for are: 24/7 power play, domination, submission, age play, knife play, pain, high heels, blindfolds, blood, Asphyxiaphila, Coprophilia, caging, collar and lead, diaper fetishes, feathers, hair-pulling, latex, leather, Klismaphilia, religious (nun-play, priest-play), Retifism, voyeurism, Urolagnia and cross-dressing. And believe me – this is not the entire list! For those of you who require some up-to-date information on any of these aspects of sexuality to supplement the knowledge base of your own practice or if you require alternate lifestyle information to direct to a client, I suggest this may be a helpful site to visit. Just be aware you cannot casually surf here, you must set up a membership for yourself.

Any prices and website addresses were correct at time of printing.

Angela Lewis (MAEd) is a registered counsellor as well as a commentator on issues related to the societal impact of technology and a lecturer in IT education.

ACA

Register of ACA Approved Supervisors

Name	Contact number	Qualifications	Cost hr	Medium
Philip Armstrong	Qld 07 3356 7262	B. Couns, Dip Psych Supervisor Trg (Relat Aust)	$88.00	Phone & Face-to-face
Nora Huppert	NSW 02 9181 3918	Family Therapy	$120.00	Face to face
Dawn Spinks	Qld 0417 633 977	BA (Psych) M. Pub. Hlth	$100.00	Phone & Face-to-face
Martin Hunter-Jones	NSW 02 99734997	MA Ad. Ed BA Psych. Philos	$90.00	Phone & Face-to-face
Kaye Laemmle	Qld 07 55911299	Dip Prof Couns Supervisor Trg (Relat Aust)	$80.00	Phone, Group Face-to-face
Miguel Barreiro	Vic 03 8801 4966	B.B.Sc (Hons)	$100.00	Group, Phone Face-to-face
Anne Warren	Vic 03 9431 4922	R.N. Dip Prof Couns.	$80.00	Phone & Face-to-face
Kerry Cavanagh	SA 08 8221 6066	BA (Hons) A.App. Psych	$100.00	Phone Face-to-face & Small Group
Beverley Howarth	Qld 07 3876 2100	Dip of Prof Healing Science CIL Practitioner	$120.00	Phone Face-to-face or Group
Brian Johnson	Qld 07 3806 9338	Psychotherapist	$90.00	Face-to-face
Mary Hogan RSM	Vic 03 9510 7888	Psychotherapy SOA Supervision	$80.00	Face-to-face
Dr Simone Jameson	Vic 03 9759 7423	PhD	$90.00	Face-to-face & Phone
Gerard Koe	Vic 0403 214 465	BA Pyschology MA Pastoral Counselling	$70.00	Face-to-face & Phone
Kevin Franklin	WA 08 9328 6684	PhD Clinical Pyschology	$100.00	Face-to-face & Group
Nerida Wellard	NSW 02 4294 3070	Bachelor of Counselling, Dip of Psychtherapy	$93.50	Phone Face-to-face
Michelle Earley	QLD 07 5446 4546	Dip Prof Counselling, Supervisor Trg (AIPC)	$88.00	Phone, Group, Face-to-face
Gary Green	NSW 02 9597 7779	Dip Prof Counselling, Supervisor (ACAP)	$176 1.25hr	Face-to-face & Phone
Gayle Higgins	VIC 03 9499 9312	Dip Prof Counselling, SOA Supervisor Trg (AIPC)	$60.00	Phone, Group, Face-to-face
Yvonne Howlett	SA 0414 432 078	Dip Prof Counselling, Supervisor Trg (AIPC)	$100.00	Phone, Group, Face-to-face
Servaas Van Beekam drs	NSW 02 9300 9907	Drs in Psych Post Doc Counselling	$120.00	Face-to-face & Phone
John Murray	NSW 02 9363 0720	MA Pastoral Ministry, Master Practitioner NLP	$85.00	Face-to-face & Phone
Jacqueline Segal	NSW 02 4566 4614	MA Applied Science Supervisor Trg (AIPC)	$80.00	Phone, Group, Face-to-face
David Hayden	TAS 0417 581 699	Dip Prof Counselling Supervisor Trg (AIPC)	$66.00	Phone, Group, Face-to-face
Catherine Clark	NSW 02 6056 5803	RN, Grad Dip Health Science Clinical Supervisor	$80.00	By negotiation
Lyndall Briggs	NSW 02 9554 3350	Mast. Prac NLP, Dip Clinical Hypnotherapy, Clinacal Sup[.	$66.00	Phone, Group, Face-to-face
Christine Ockenfels	WA 08 9312 1738	MA Arts HS (Counselling) Grad Dip Counselling Supervisor Trg (Wasley Inst.)	$66.00	Phone, Group, Face-to-face
Nirada Van der Burg	WA 08 9382 1772	MA Counselling Psychology	$100.00	Face-to-face

When you consider the coverage given through the journal, application kits and phone enquiries, you will not get a better return for an investment in marketing than by registering your name with ACA.

REGISTER AS A SUPERVISOR

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

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

ACA

Counselling Australia is distributed to every state within Australia and all major regional areas.

Registration Request Form

Name _____

Address _____ Post Code_____

Phone number w:( )_____ h:( ) _____

Mobile_____ email_____ fax_____

Clinical member of ACA Yes/No ACA membership number_____

Online Assessment of Learners Of English: a literature review

By Nickolas Gromik

Abstract

This research investigates the feasibility of using school counsellors to provide online psychometric assessment to learners of English as a Second Language (ESL).

The objective is to review the literature pertaining to ESL learner's assessment and the possibility of using the Internet to achieve such a task. This research contrasts the review with two potential websites suitable for online assessment. The present work suggests that online assessment as an asset to counsellors located in remote areas. The literature asserts however that due to the infancy of the Internet and the recently formulated complexity of evaluating learning abilities of ESL learners, research-based guidelines are still needed to improve such services.

Recent studies indicate that greater care in assessing learners who have English as their second language require further development (USA Today, 2002). The issue is that historically, assessment resources were designed for and normed on native English speakers (Schwarz, 2000; Wall, 2000). Consequently, ESL learners were more likely to be assessed as possessing learning disabilities than their peers. (Pena and Guteirrez-Clellen, 2000). New findings indicate that this may not necessarily be the case. "A language difference is not a language disorder", USA Today (2002) proclaims. Evidence supports such a claim. Numerous researchers (Christensen (1995), Spear-Swerling and Steinberg (1996) (in Dean and Burns, 2001), McKay (2000), the New Mexico State Department of Education (NMED) (2000), Butler and Stevens (2001), Pena and Gutierrez-Clellen (2001), Laing and Kahmi (2003)) all agree that new guidelines in the structure of standardized tests need to be addressed to meet with the nature of educating and assessing a shifting and growing ESL population.

From the literature gathered, no research has been found to document the applicability of online assessment on ESL population.

From the literature gathered, no research has been found to document the applicability of online assessment on ESL population. Nonetheless, the Internet offers the ability to provide culture-sensitive resources to teach and assess students (Craig, 2001; National Center for ESL Language Education (NCELE), 2002; Schwarz, 2000). Consequently in order to review the feasibility of integrating psychometric assessment with online services, this research juxtaposes two potential online assessment resources against the literature. The tests under review are: The Self-Esteem Test-Revised (SET-R) which is available from http://www.queendom.com/tests/personality/self_esteem_r_access.html and the Skillscan Online: Have Skills, Will Travel (Skillscan Online) reviewed by Beckhusen (2001). This test is available from http://smccd.net/skillscan/intro/.

The Self Esteem Test-Revised takes ten to fifteen minutes to complete. The presentation is plain. There are 30 sample questions written in easy English. The preference-based answers are similar in format, making it easy for an ESL learner to focus on the task at hand. The test also provides a free one-paragraph report. The total report can be purchased online with a credit card for $6.20 US.

The Skillscan Online was designed for career counsellors and is free to access. It is based on "the original skillscan Professional Pack© color-coded card-sort system that was first published in 1987" (p.19). Counsellors and users interested in the reliability and validity aspects of this test must refer to the original documentation. It is connected to the Holland-based interest as well as possessing a Jungian influence (Beckhusen, 2001). A typical client, Beckhusen (2001) informs, is an adult who is planning his/her first career. The Skillscan Online contains 64 skills that group into 7 color-coded skill categories (Beckhusen, 2001). The examinee is required to choose and classify the skills provided into preference categories. It is a self-administered test, which can take thirty to fifty minutes to complete. A counsellor does not require training, but Beckhusen (2001) suggests that experience with this test is beneficial. The advantage of this test is that it uses an inventory of interest to assess an ESL learner's ability.

Whether a counsellor uses a pencil and paper standardized test or an online assessment to evaluate the ability of an ESL student, the test specification requirements appear to be similar. Sampson (2000) and Finn and Banach's (2000) research about online services and Laing and Kahmi (2003) and Schwarz (2000) documentation about ESL assessments agree that norm structure is the paramount indicator of the purposefulness of a test, and should be periodically reviewed.

Laing and Kahmi (2003) demonstrated the need to periodically restructure standardized test by using the Peabody as a case example:

> "… the Peabody Picture Vocabulary Test – Revised (PPVT-R; (Dunn and Dunn 1981) which contained a normative sample that was 14% African American. … The most recent version of this measure, the PPVT – III (Dunn and Dunn, 1997) includes more African American children than PPVT-R (34%)." (p.45)

Their conclusion within the same paragraph states that since the norm changes were introduced African American children "performed within normal limits" (Laing and Kahmi, 2003: p.45). Hence their prognosis:

> "… what was once a language disorder (PPVT–R) is now a language difference on the (PPVT-III)." (p.45).

The literature informs us that restructuring the norm category of any standardized test is not the only problem for evaluating ESL students. Schwarz (2000) indicates that most standardized tests are normed on young learners making these tests even more inappropriate for adult ESL learners. In addition, Butler and Stevens (2001) explain that standardized assessments are designed with the assumption that all students have access to the same educational resources. This does not appear to be the case, because ESL students' English level begins at a different stage than their peers.

Studies of the type done by Laing and Kahmi and others, appear to provide some evidence which may be applicable for improving online assessment. For

example a "seriously entertaining" website at http://www.queendom.com provides a Self-Esteem Test-Revised (SET-R). The validation study has a sample size of 119,000. This figure does not identify the ethnicity or gender of that sample size. Furthermore, the "Statistic Performed" indicates:

> "Descriptive stats and reference values/norms; correlations with various factors; reliability (Spearman-Brown split-half, Guttman split-half, Cronbach alpha), criterion-related validity (concurrent validity, method of contrasted groups); construct-related validity (internal consistency, inter-correlations of subtest, facto analysis convergent and discriminant validity). (http://www.queendom.com/tests/personality/self_esteem_r_access.html in "find out more")

What does this all mean? Sampson (2000) suggests that counsellors train their clients to understand the reliability of a targeted test, but how can a counsellor train a client to be aware of reliable online assessment if they themselves are vulnerable to misunderstanding the information provided?

Apart from counsellor training, qualifications, reliability and validity issues concerning online assessments, other difficulties relevant to ESL assessment exist. Structural discrepancies in standardized tests are also apparent in the design of websites. Canning-Wilson (2000) explains that websites are structured by native speakers to appeal and depend on a particular designer's preference. Sampson (2000) indicates that online assessments are text intensive assessments that may discriminate against clients "with limited literacy skills" (p.5). This may not be through deliberate attempts to do so, rather it may reflect either the limitation of what is technically possible over the Internet or the attempt to reach what is defined as a "normal" majority and its needs. For example one of the problems encountered with the Skillscan online website is its design. The colors make it sometimes difficult to read the vignettes. As well it takes 30 to 50 minutes to complete the test with more time required to sift through the test results and the information provided for further research. This makes it quite difficult and the ability of an ESL student to concentrate while using a second language to maintain an appropriate level of comprehension sufficient enough to complete a defined task is called into question.

How that information is displayed may also affect the user. Cunning-Wilson (2000) suggests that images may offend or affect the examinee in a negative manner due to their culturally-sensitive disregard to religion or family background or dynamics (see also Sampson, 2000 and Finn and Banach, 2000). This may jeopardize not only the test environment but also the relationship between client and counsellor (Benick, 2002; Finn and Banach, 2000).

Culturally diverse learners, the literature asserts, bring with them an array of learning skills and strategies that may differ from their peers (Craig, 2001; Gutierez-Clullen and Pena, 2001; Limbos, 2001; NMED, 2000) and these new skills differences need to be examined closely in order to better assess ESL students' progress (McKay 2000; Schwarz 2000). Notwithstanding those learning differences, Butler and Stevens (2001) and Schwarz (2000) caution that ESL students may be able to absorb the information provided but may not be able to retrieve it. Butler and Stevens (2001) provide further proof by pointing out that prior knowledge possessed in the first language may not be easily expressed in the second language and vice versa.

In order to assess ESL students the literature provides a wide range of strategies from standardized test (McKay, 2000) to Dynamic Assessments based on Vygotsky's 1978 research (Gutierez-Clullen and Pena, 2001), or by using formative assessments to attend to the instructional needs of the students (Christensen, 1995). Some rely on performance assessment to capitalize on the ESL student's prior knowledge and experiences (National Center for ESL Language Education (NCELE, 2002)), whilst others prefer to use either Criterion-Referenced measures "which make it possible to consider the social context in which communication occurs and how language is used by the culture" (Laing and Kahmi, 2003: p.46). Another method is to use the processing-dependent method measures "which place more emphasis on processing abilities and less emphasis on prior language knowledge and experience (Laing and Kahmi, 2003: p.46). Finally, test accommodation is also suggested (Butler and Stevens, 2001). The SET-R appears to be well suited to assess the processing abilities of ESL learners, whereas the Skillscan Online seems more appropriate as an instructional device for adult ESL learners.

Nevertheless, given all these possible approaches to assessing and evaluating the language ability of ESL learners, the literature agrees that certain factors remain constant. Slow learning progress, may be partially due to a number of factors. These include the learner's interest in the learning and/or testing material given (Craig, 2001; Schwarz, 2000). A possible mismatch between instructor's background and competency to work with ESL students (Limbos, 2001; NCELE, 2002; NMED 2000; Benick 2002; Schwarz, 2000); the client's stress or trauma, socio-cultural factors (Craig, 2001; NCELE, 2002; Schwarz, 2000); and the limited academic skills or study habits the learner possesses may also be factors(Butler and Stevens, 2001; Schwarz 2000). Finn and Banach (2000) mention that the lack of technological exposure and knowledge of the Internet may affect the participation of the learner. Sampson (2000) also warns that over-worked counsellors may rely inappropriately on online assessments to facilitate their work performance.

In order to improve learning outcome of ESL students, the literature offers some recommendations regarding suitable practices.

Recommendations

In order to improve learning outcome of ESL students, the literature offers some recommendations regarding suitable practices. Relating to instructional methods, the literature suggests that teachers and or assessors need to: be highly structured and predictable, simplify the language but not the content; and build on learner's strength and prior knowledge (NMED, 2000; Schwarz, 2000). It is also suggested that teachers incorporate the use of sensory learning strategies, such as the use of pictures, charts and maps. Assessors need to use both academic and non-academic language in order to give the ESL learner better exposure to potential testing texts (Butler and

Online Assessment of Learners Of English: a literature review (Continued)

Stevens, 2001; NCELE, 2002; Schwarz 2000). Buckhusen (2001), Finn and Banach (2000) and Sampson (2000) add that online assessment allows users and counsellors in remote areas to access preliminary information and testing in order to prepare themselves better for their future or further testing. Craig (2001) also mentions that assessment must be continuous to project a more accurate conceptualization of the learning progress of ESL students.

Consequently, attempting to assess ESL learners may prove a difficult task not only because psychometric tests are not necessarily valid for that group, but contradictory evidence about the learning process and needs of ESL learners exist. Due to this revelation the possibility of introducing Internet services within the realm of ESL assessment by counsellors is even more difficult than before. Another concern relates to the professional and ethical matters such as: The assessors' bias or questionable reporting and interpretation towards the ESL candidate in regards to: gender, racial, ethnic and literacy ability discrimination must be taken into account. The counsellor/assessor may also be an inadequate or incompetent counsellor, or form inappropriate online relationships with the candidate. Other issues more confined to Internet usage are: test security, test reliability and validity, information about quality of the test; identification of theft and online security in regards to confidentiality. Another concern is the assessor's familiarity with the technology used and with the test or tests and understanding of how they are to be interpreted. Finally a lack of financial independence to access the Internet may prove a problem (Finn and Banach, 2000; Fouladi, 2001; McCarthy and Moller, 2001; Sampson, 2000; Wall, 2000).

Not only do clients need to be warned and trained into using reliable online testing services, but also Sampson (2000) promotes the idea that providing pre and post service training of online assessing and counselling resources would be of vital importance to counsellors.

Over the last 40 years computer scoring has been a facility and asset for both testing and assessing in a wide range of subjects (Sampson, 2000). Wall (2000) stresses the point, which is most visible in the evidence collected;

> "Technology used with good testing practices offers some capabilities that add value to educational assessment" (Wall, 2000: p.1).

The literature warns counsellors to educate and train their clients on the issue of educational assessments (Finn and Banach, 2000), because:

> "It can be mistakenly assumed that any test made available on computer via the Internet meets professional testing standards. … It can be mistakenly assumed that test developers have produced parallel forms that provide the same scores regardless of administration format." (Wall, 2000: p.3).

Wall's (2000) warning above is well founded. The brief report provided by the SET-R for the results achieved by this author concluded that the author had a score of "40 on the feelings of inadequacy" (queendom.com, February 19, 2003). Websites may appear to lure non-conscientious users to purchase full reports. These "full report" may not provide any further comprehensible evidence to the user.

Not only do clients need to be warned and trained into using reliable online testing services, but also Sampson (2000) promotes the idea that providing pre and post service training of online assessing and counselling resources would be of vital importance to counsellors. Sampson (2000) reports a proposed draft by the Association for Counsellors Education and Supervision, which urges for:

> "… (a) to develop Web pages, (b) use listservs, (c) use e-mail, (d) help clients search for counselling-related information, (e) apply legal and ethical codes to Intern-based counselling services, (f) understand the strength and weaknesses of Internet based counselling services, (g) use the Internet to identify and access continuing education in counselling, and (h) evaluate information quality on the Internet." (Sampson, 2000: 9)

Whilst Sampson (2000) stresses the importance of counsellor training, Finn and Banach's (2000) research question the legitimacy of counsellor credibility. They remark that the Internet may not always be used to add value, by observing that anyone can provide online services. One recommendation relating to this matter is to set up some form of online credibility check of online counsellors via an online recognized affiliation, thus introducing safety measures for the benefit of the users (Finn and Banach, 2000; Sampson, 2000).

Finn and Banach (2000), Sampson (2000) and Wall (2000) put forward compelling evidence that potential risks exist for inappropriate interpretation of a test by a user, whether it is a client or a counsellor. Not only can tests be misinterpreted, they can also be accessed indefinitely. Examinees are able independently to access the answers to a test, preview the assessment prior to the testing date or change their answers once the test has been completed (Sampson, 2000; Wall, 2000).

In contrast, Sampson (2000) and Beckhusen (2001) attest that online assessments are more effective than hardcopy standardized testing, as the test can be updated on a continual basis. Hard copy information, Sampson (2000) mentions, can become outdated or irrelevant by the time it becomes available in print. Online assessments are also more cost effective for distribution (Sampson, 2000).

Summary

The World Wide Web has the potential to offer interesting and unique methods to evaluate ESL students. However, problems consistent with the lack of site information, test validity and reliability and research renders this borderless service questionable. The literature reviewed, exposed a cautious view of online assessments. Contrasting the literature evidence with available online testing offered a more realistic observation about the documented literature.

This review highlighted the complexities, which still exist amongst researchers on the issue of ESL assessment; mainly the need to restructure the norm factors of psychometric test to better reflect

population changes. It also exposed the difficulties of providing assessments via the Internet. Until issues such as reliability provision and security are addressed, further research and development of reliable Internet assessments are required. Nonetheless, in light of constant technological developments and research about assessments of ESL learners, this review has provided evidence that ESL testing and the Internet can be combined by adopting the recommendations suggested for the improvement of standardized tests. This would accelerate the development of online testing and offer more improved services to both counsellors and clients. To analyse its hypothesis, this review has compared and contrasted two online assessment websites with the literature.

Overall the literature reviewed, provided a seemingly balanced exposition of the positive and negative aspects of using online assessments. This research however raised some questions. Does modifying the norm actually provide information about the nature of the difference that is supposed to exist? How efficient is counsellor training in interpreting reliability and validity of test? And how can they best be trained to do so with online assessment services? Thus this research confirms Finn and Banach's (2000) view that more empirical evidence regarding the effectiveness or harm related to online assessment is required.

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QueenDom: personality tests, intelligence tests, aptitude tests, attitude tests: http://www.queendom.com/test/personality/self_esteem_r_access.html

Quintessential Careers: Online Career Assessment Review: http://www.quintcareers.com/career_resources.html

SkillScan Online:: http://www.smccd.net/skillscan/intro/

Overall the literature reviewed, provided a seemingly balanced exposition of the positive and negatives aspects of using online assessments.

ACA

Why are we not getting any closer to preventing suicide? by Prof Diego De Leo

In humanistic domains such as ethics, philosophy and anthropology the debate on the legitimacy of preventing suicide seems to have proceeded in parallel with the history of human development (Minois, 1999). Even in the medical world, where suicide has been acknowledged as a primary public health problem within the past century, and where the World Health Organization declared the fight against suicide as a priority for the first time in the year 2000, there is disagreement about the effectiveness of preventive efforts (Wilkinson, 1994). There are many reasons for such scepticism, all of them more or less centred on the extreme complexity of the suicide phenomenon and its relative rarity. A recent *World Health Report* (World Health Organization, 2001) calculated the number of recorded suicide deaths to be 815,000 worldwide (0.0135% of the global population), a burden slightly lower than the estimate of 1 million published in an earlier technical report dedicated to suicide (World Health Organization, 1999).

TRADITIONAL DIFFICULTIES

Despite the huge amount of literature and research on the topic, prevention of suicidal behaviours, both fatal and non-fatal, remains an imperfect art based on scant scientific evidence (Hawton et al, 1998). The most commonly cited reasons for this are inadequate sample sizes for randomised, controlled studies (Gunnell & Frankel, 1994), and programmes of insufficient duration (Goldney, 2000). Moreover, there are numerous biases inherent in suicide research, notably the use of people who have attempted suicide as research participants; such people only minimally overlap suicide completers, and their use implies the hypothesis of a continuum between non-fatal and fatal suicidal behaviour. Other sources of bias are difficulties in creating clusters of participants with similar problems (e.g. problems within similar dyadic relationships), the use of retrospective evaluations, the lack or inadequacy of control groups, and the design of psychological investigations performed on proxies of the deceased (psychological autopsies) (Hawthorn et al, 1998). On the other hand, little is known (because they are poorly investigated) about factors that are likely to protect against suicide, such as coping skills, problem-solving capabilities, social support and connectedness. Indeed, the multi-determined dimension of suicide poses per se enormous difficulties, even at the level of conceptual models of development of the suicidal process. Clearly, it would be much easier to investigate the prevention of a phenomenon provoked by just one or two possible causes.

Understandably, the controllability of social events remains hypothetical and their relevance to suicide prevention largely speculative.

Less traditional (more neglected) difficulties

Multi-disciplinary approaches to the prevention and investigation of suicide are often flagged up but virtually never practised. Research teams have difficulties in achieving a balanced composition between biologically and psychologically oriented investigators (both equally important in the study of suicide). This is further complicated by the need to evaluate also other important concomitant factors, such as socio-economic, cultural and religious aspects. A classic example of the impact of non-biological or psychological/psychiatric factors on suicide rates is provided by the observation of epidemiological data on a century of suicide morality in Western countries. Socio-economic events (wars, major economic fluctuations) produce tremendous fluctuations in suicide morality, particularly in men. The intrinsically large-scale nature of those events provoked effects that, if applied deliberately, would be incomparably bigger than any well-targeted anti-suicide initiative (World Health Organization, 1998)

Understandably, the controllability of social events remains hypothetical and their relevance to suicide prevention largely speculative. However, the impact of socio-cultural phenomena should be considered when evaluating suicide prevention programmes, although their interference might render interpretation of outcomes virtually impossible. Categorisation and quantitative/qualitative analysis of these contributory characteristics represent a considerable challenge for every researcher, a process that commonly ends by provoking a rather limiting prioritisation of the many variables involved. Apart from the field of competence of researchers, other factors such as personal attitudes and ideologies, means and funding availability play a major part in hindering the development of meaningful research and prevention on suicide.

Lessons can be learned from approaches to the prevention of life-threatening conditions such as ischaemic heart disease. A significant reduction in mortality from ischaemic heart disease has been achieved only be addressing a wide range of factors: knowledge of family predisposition, exercise, dieting, smoking cessation, cholesterol level control, sophisticated diagnostic techniques that allow early intervention, treatment in highly specialised intensive care units, by-pass and angioplastic surgery, and personalised rehabilitation programmes have all contributed to substantial improvements in survival rates and mortality reduction. Suicide is a much more complex phenomenon than myocardial infarction, so it seems illogical that strategies to fight suicide have to be similar or less integrated than the struggle against coronary artery disease.

TRENDS IN SUICIDE RATES

Western countries are facing a general decline in suicide rates that seems reasonably unrelated to the existence of any national plan. Reductions in suicide rates have occurred not only in Finland, Sweden, Norway and Denmark (which had or have a structured strategy), but also in nations such as Hungary and The Netherlands which, like most Western countries, do not posses a national prevention programme. The presence of a 'cohort effect' (the ensemble of environmental factors that connote a certain generation) and of its relative size has been postulated several times in suicidology (see, for example, Cantor et al, 1999), although a clear description of the relevant environment factors (or a hierarchy of their importance) has never been provided. In any case, the fundamental influence of cultural differences means that cohort effects are unlikely to be universally applicable. For example, the American example of the generation born after the Second World War (the

'baby boomers', characterised also by increased suicidality) has not proved fully valid in the European context (Bille-Brahe & Andersen, 2001). Moreover, the marked decline of suicide rates in the elderly over the past 30 years recorded in predominantly Ango-Saxon countries has not been paralleled by a similar trend in Latin nations for the same generations (De Leo, 1999).

After many years of worrying increases in rates of youth suicide in nearly all Western countries, a remarkable decline is now occurring. The motives for such trends are puzzling researchers to the point that the International Association for Suicide Prevention has created a task force, headed by David Shaffer in New York and Annette Beautrais in Christchurch, New Zealand, to study the phenomenon from a trans-cultural perspective. In addition, the World Health Organization headquarters is promoting a new study, the Suicide Prevention Multi-site Intervention Study on Suicide (SUPRE-MISS), with centres on the five continents, which includes a randomised clinical intervention for people attempting suicide, a biological investigation (into DNA and stress-related hormones), and the comparison of a number of socio-cultural indicators (World Health Organization, 2002).

INSIDE THE LABYRINTH OF ANTI-SUICIDE STRATEGIES

The conflict between political convenience and scientific adequacy in suicide prevention is usually resolved in favour of the former. Thus, strategies targeting the general population instead of high-risk groups (psychiatric patients recently discharged from hospital, suicide attempters, etc.) may be chosen not on the basis of rigorous calculations (Lewis et al, 1997) but just because they might affect a much larger number of individuals and institutions, especially if the desired outcomes also include a number of conditions frequently associated with suicidal behaviours (such as poor quality of life, social isolation, unemployment and substance misuse). Indeed, although a reduction in suicide mortality should be the primary outcome of suicide prevention, interventions that target associated conditions appear more rewarding from a political perspective, especially in the light of the limited duration (3 – 5 years) that normally characterises the funding government. Many governments do not even fix targets in terms of reduced mortality, nor encourage stringent evaluative practices, because when the time comes for evaluation the term of that government is likely to be over.

Thus, for the above mentioned reasons and many others not commented on but for which review articles are available (e.g. Gunnell & Frankel, 1994), suicide prevention remains essentially a land of hopes and promises but not of certainties. This should not induce discouragement, but must be interpreted as a stimulus to do more and do it better, while endeavouring to avoid past mistakes such as the uni-dimensional interpretation of suicide, the previous abundance of 'epidemiological safari tours' in developing countries – there is a growing awareness of the sterility of many epidemiological investigations (Eagles *et al*, 2001) – and the use of popular but largely empty slogans such as 'community capacity building', which lack concrete application.

Moreover, countries should not rely on epidemiological surveys and prevention strategies developed elsewhere. Cultural factors have a major role in suicidal behaviour (Vijayakumar & Rajkumar, 1999) and there are huge differences in the dimension and characteristics of this problem around the world. As an example, the average ratios between the lowest and the highest suicide rates internationally are a large as 1:102.4 for men and 1:35.8 for women (Schmidtke *et al*, 1999). Cross-cultural comparisons, such as the World Health Organization/EURO Multicentre Study of Suicidal Behaviour (Platt *et al*, 1992) and the more recent SUPRE-MISSS, should be encouraged. They may Improve our understanding of causative and protective factors, and consequently help to reorient prevention strategies. Detailed discussion of supposed 'best practices' in the prevention of suicide are beyond the scope of this editorial but are offered, for example, by the World Health Organization (1998) and De Leo *et al* (2002).

CONCLUSION

Despite the strong association between mental disorders and *mors voluntaris*, suicidal behaviour attracts little interest among contemporary psychiatrists, as witnessed by the low number of contributions to suicidology journals. As a consequence, little is new in suicide prevention, and the current recommendations and traditional wisdom are hardly supported by an acceptable level of evidence. Greater use of antidepressant drugs to prevent mood disorders, functional neuroimaging, and genetic and psychometric screening for early detection of impulsive behaviour and suicide proneness seem to hold promise for future prevention strategies. A more rigorous use of available knowledge now seems to be a legitimate expectation.

Many governments do not even fix targets in terms of reduced mortality, nor encourage stringent evaluative practices, because when the time comes for evaluation the term of that government is likely to be over.

Suicide research requires major investment, using multi-disciplinary teams to set up more integrated approaches for large scale, long-term and thoroughly evaluated projects. 'Think Big' – to paraphrase the World Health Organization's motto with a famous entrepreneurial slogan of the 1980's – really seems to capture today's priority in suicide prevention. If lack of substantial scientific evidence continues to characterise this area, loss of interest and progressive withdrawal of investment are inevitable. Cooperation between scientists, administrators and politicians is needed more than ever, with a higher level of planning and organisation. Only in this way can we come closer to preventing suicide.

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DECLARATION OF INTEREST

None.

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ACA

Men's experience of considering counselling: 'entering the unknown' By Anthea Millar (Part 1)

Agency statistics in the UK and North America reveal that fewer men than women attend counselling, at ratio of about 1:2. This study investigated men's experience of considering counselling, with the aim of gaining further understanding of factors that might contribute to the existing gender discrepancy in utilisation of counselling. Following responses by 476 men to written questionnaires, 10 men who had considered and ultimately attended counselling were interviewed, and a grounded theory method of analysis was used to generate and analyse the participants' experiences. Three interconnected categories emerged: societal perceptions of counselling and gender roles; change of experience over time; and knowledge – 'knowing' and 'not knowing' the protocols of counselling. The implications of these findings are discussed. It is recommended that prospective male clients should be provided with information bout the counselling process, and that there needs to be increased awareness by counsellors and referring agents of male gender issues.

Key words: counselling, gender, grounded theory, help seeking, referral

Men are less likely to seek psychological help than women, at a ratio of about 1:2 (Good et al, 1989; Robertson, 1988). This ratio contrasts markedly, however, with that for men committing suicide in Europe and North America. In Britain the ratio is more than four male completed suicides to one female completed suicide (NHS Health Advisory Service, 1999). When there is such clear evidence of men's distress, why is it that men do not seek help from counselling at the same, or increased rate, as women? What does the idea of seeking help from counselling mean to men?

These questions led me to focus specifically on the period of time when men first consider counselling as an option, before they experience the first counselling session. It would seem that when men are experiencing distress, this is a crucial period in terms of the actions that they decide to take. A preliminary search of the literature demonstrated a dearth of research in the whole area of men and counselling, and I could find no studies that had investigated men's experience of considering counselling. Women's mental health issues are well represented – an important area of scholarship – encouraged by the women's movement. However, it would seem that a deeply embedded cultural bias has positioned white heterosexual men as the taken-for-granted 'norm' against which others are measured (Fassinger and Richie, 1997).

In the last few years, however, there has been a new wave of concern regarding men and boy's distress. Recent popular and research-based publications such as Biddulph's Raising Boys (1998) and Clare's On *Men: masculinity in Crisis* (2000) are examples of this increased awareness of a need to understand the specific challenges facing men.

Nearly 100 years earlier, Adler (1910), using the term 'masculine protest', noted that social pressures on men to be superior and powerful induced stress and malaise in both men and women, with women resistant to a subordinate role and men under stress from the pressure to live up to this mythical masculine ideal. Adler's understanding is echoed in the more recent work of Eisler and Blalock (1991), Levant (1998) and Pollack (1998). Eisler and Blalock (1991) identified a range of stress-inducing masculine beliefs, including reliance on aggression, power, and emotional inexpressiveness, as ways of coping. They proposed that the more rigidly these beliefs were held, the greater was the vulnerability of men to health problems.

Pilgrim and Rogers (1999), in their review of gender issues and mental health, have challenged the long held view of higher rates of depression in women (Dohrendwend and Dohrendwend, 1977), hypothesising that the identification of women as an object of study could have unwittingly accentuated the 'female character' of mental ill health. This process, in turn, may have contributed to the under-diagnosis and under-treatment of depression in men. Pollack (1998) has proposed that men manifest depression through moods and behaviours and self reports that are different from women, and has suggested that standard diagnostic tools do not understand this difference. In one study, men were found to report fewer symptoms of depression than equally impaired women, and tended to 'forget' their depressions after one year and beyond, while women continued to remember all their symptoms (Real, 1997).

It would seem that when men are experiencing distress, this is a crucial period in terms of the actions that they decide to take.

If restrictive emotionally, toughness and self reliance are culturally defined aspects of masculinity and male health, it has been argued that all those involved in the counselling context will also be involved in adapting to these constructs. General practitioners (GPs) have been observed to be less likely to identify a psychological problem if the patient is a man (Goldberg and Huxley, 1980). Similarly, men identified as having depression or anxiety are more likely to normalise or attribute somatic causes to their symptoms, missing detection by the GPs of their psychological distress (Kessler et al, 1999).

Many of the disorders commonly ascribed to men, such as violence and substance abuse, would seem to echo extremes of what is deemed 'masculine'. Lewis (1976) suggests that our society demands that men 'get over' their childhood affectionateness, and expects men to be aggressive, while at the same time challenging this same aggression: "… no wonder they often try and solve their problems by turning off their feelings altogether" (Lewis, 1976:267).

This difficulty in putting emotion into words has been described as alexithymia, first noted by Sifneos (1967) with patients who demonstrated severe emotional constriction. Levant (1998) has also identified this in mild to moderate forms, termed 'normative male alexithymia', which he notes is very common and widespread among men. Levant proposes that it can make it less likely: "… that such men will be able to benefit from psychotherapy as traditionally practised" (Levant, 1998:36-7).

The Samaritans study of depressed and suicidal young men's attitudes identified a paradox in relation to

Men's experience of considering counselling: 'entering the unknown' (continued)

emotional expression: their deep wish to be heard, alongside a great fear of revealing any vulnerability. Many interviewed said, "Nobody asks me how I feel", whilst also stating that they "would smash something up rather than talk about feelings" (Samaritans, 1999).

As well as fear of being seen as vulnerable, Heppner and Gonzales (1987) have argued that a man will not seek counselling "…because it is very difficult for him to *admit to himself* that he has a problem" (p31). They emphasise that, in Western culture, asking for help often leads men to feel inadequate, as not only is it unacceptable to have problems, but it is also 'unmanly' to seek help from anyone, especially from other men.

Whilst it appears that men do not easily seek psychological help, they may more readily present to a professional with tangible issues such as alcohol abuse, work stress and sexual difficulties (Eisler and Blalock, 1991). Rogers et al (1993) in their study of users' views of psychiatric services also concluded that men may consider it 'unmanly' to share their vulnerability with friends and lay people, and a professional consultation with a stranger may come more easily.

The studies carried out by Mayer and Timms (1970) and by Rogers et al (1993) are important in the history of psychological service research in that they offer the patient's subjective perspective and emphasise that clients know a great deal more about their thoughts, beliefs, feelings, experiences and reactions to treatment than those who are trying to help them. This view was at the heart of the present more modest study. I wanted to hear directly from men about what hindered or helped them when considering counselling, and hopefully gain new insights that would inform and have applicability to my own and other counsellors' practice.

The audio-taped interviews were the main source of data from which the findings were taken, with the written questionnaire responses providing the basic profile of each participant and also some background information.

METHOD

Participants

This study examines the experiences of men aged 16 and above, who had actually taken the step to attend counselling. I made personal contact with 43 experienced counsellors, working in a variety of settings including GP surgeries, independent practice and local counselling agencies. Of these, 37 agreed to participate by passing out prepared research packs to their male clients. It was then up to the men whether they chose to respond to me directly. My initial sample included 47 men, aged 16 to 64, who returned preliminary questionnaires. Ten men were then chosen to attend face-to-face audio-taped interviews from 35 who had volunteered to be interviewed. The 10 men who were interviewed were all white, between 27 and 61 years of age, representing as broad a range as possible with reference to relationship status and employment background. One participant was in a same sex relationship; the others were in heterosexual relationships or single. They had entered counselling to address a variety of issues; depression, anxiety, stress, addiction and sexual problems. Six were in ongoing therapy, while the others had recently completed. The duration of counselling they had undertaken varied from one session to 'long-term therapy'. Two participants had experienced only one episode of counselling; the others had all made use of counselling on more than one occasion (maximum five episodes). Time and budget limitations prevented me from gaining a broader sample – all were Cambridgeshire residents. The material presented in this paper is primarily based on interviews with these 10 men.

The researcher

My professional interest in researching men's views comes from 20 years of working as a counsellor in independent practice and in primary care. In these contexts I have seen many men come for counselling through Employee Assistance Programmes or referral by their GP, and witnessed the initial challenge many express at the idea of seeking help. At a deeper motivational level, being the only female 'blood' relation, apart from my mother, in a family of father, two uncles, three brothers, two sons and five nephews, it is perhaps not surprising that I chose to study men, an area that feels both familiar and intriguingly unknown.

Procedure

The audio-taped interviews were the main source of data from which the findings were taken, with the written questionnaire responses providing the basic profile of each participant and also some background information. The semi-structured face-to-face interviews with me lasted an hour, held at two neutral locations. Topics covered in the interview included: help-seeking patterns, the process taken in seeking counselling, communication with others about going to counselling, and thoughts, feelings and experiences regarding the idea of going for counselling.

To ensure ethical practice throughout the study, the British Association for Counselling (1995) guidelines for monitoring research were followed, with full and informed consent gained from all participants.

Data analysis

A novice to qualitative method, I decided on grounded theory analysis (Glaser and Strauss, 1967) for the main body of data, with the notion that it would provide a systematic research method that still enabled study of subjective experiences, generating a theory that was *grounded* in the data.

I listened to and transcribed the tapes, gaining a more informal feel before beginning the more structured analysis of the data. This initially involved examining each line or segment of the interviews, and identifying 'units of meaning'. Each new code, or unit of meaning, was compared with others, termed by Strauss and Corbin (1998) the 'constant comparison method'. Where possible these categories were framed in terms of activities as the ain of grounded theory is to "……uncover the basic social processes that underlie behaviour" (McLeod, 2001:72). When a new category emerged, I compared it again with other codes to identify the possibility of higher order categories. The task was then undertaken to distil the meaning carried in each category, and so produce a

"…..general statement of fact grounded in the data" (Taylor and Bogdan, 1984: 134).

I then explored connections between these categories through the technique of axial coding, putting the data back together in new ways, helped by asking the questions 'why, where, when, whom and how come?' Following this analysis, a process of selective coding was carried out, which focused on identifying the central themes and core categories emerged from this process, with a further four major categories interlinking with the central three. These seven categories provided the basis for the grounded theory model.

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Part 2 (Results) will be in the Spring Journal.

ACA

Internet and Computer Resources Compiled by Angela Lewis

Hello fellow members!

This issue is a bit of a 'grab bag' of various things: answers to some common problems people experience, news and Internet sites of interest.

Why can't I dial out to my ISP when I am using my laptop from a hotel or office building?

This happens because when your laptop dials out of the hotel, it has to be set up to dial the zero that allows an outside line. When you dial from home, you would not have that restriction. Add a zero plus a comma after that zero (to slow down the dialing) and then try it. I actually put in 2 commas to slow it down even more and ensure I get an outside line for my computer. Make sure you take the commas and zero out when you return home, if you are going to use this computer back at your own house!

Make sure you take the commas and zero out when you return home, if you are going to use this computer back at your own house!

Why do I get cutoff when I am on the Internet?

This can happen for a number of reasons. Firstly check whether you have 'call waiting' activated on the phone line you use for the Internet. If you do have it activated, and someone is trying to call you, the beep of the call waiting signal can cause your modem to disconnect. Check that the phone extension cord you are using is as short as possible and try to avoid using one at all, as this can interfere with the modem connection. Check the session limit that your ISP (Internet Service Provider) has – this could be 3, 4 or 5 hours. This means that once you have been connected for the ISP's published session limit, you will be automatically disconnected. Depending on your ISP, you not get back on immediately. Try not to have more than one device running on the phone line you are using for the modem – for example devices such as answering machines and fax machines can cause interference.

How do I block Senders?

If you don't want to receive mail from someone, you can block them; which means as soon as an email arrives from that person it is automatically put in the Deleted Items folder.

1. First click on email you wish to block from within the Outlook Inbox.
2. Then click on the **Message** Menu.
3. Click **Block Sender**.
4. A message appears saying "XXXXX' has been added to your blocked senders list. Subsequent messages from this sender will be blocked. Would you like to remove all messages from this sender from the current folder now?
5. By answering 'Yes', all subsequent messages from this person will automatically be deleted.

How to change uppercase typing to lowercase typing?

When you are using Microsoft Word and you wish to change the case of your typing, e.g. you have typed in capitals and want lower case or vice a versa, select the text and then hold down the Shift key while pressing the F3 keys enough times until you get the desired case. It moves between upper case, lower case and first letter capital.

Hotmail now has restrictions

There is now a limit to the number of emails you can send on a daily basis using your Hotmail account. This has been instigated in an effort to stop people sending lots of junk email, known as SPAM. The announcement was made on the Microsoft website (www.microsoft.com), which administers Hotmail. The limit is now 100 outgoing emails per user in a 24 hour time period.

Websites

www.togetherwedobetter.com.au is an Australian website designed to provide help, information and support for people interested in their own mental health and wellbeing and that of the community. It is run and designed by VicHealth, and contains ideas on what activities a person might participate in or organisations that can be contacted. It also provides information on mental health issues, news, case studies, and access to campaign resources.

http://folding.stanford.edu/ is the website for Folding@Home; a worldwide research project aimed at finding cures for diseases such as Alzheimer's, Mad Cow (BSE), CJD, ALS, and Parkinson's disease.

www.executiveplanet.com is a fascinating site that offers advice on how to behave with cultural sensitivity and deal with local customs and manners for a broad range of nationalities, from Russia to Samoa.

www.lastminute.com.au is an Australian site offering very good discounts on travel products such as accommodation, tours or flights, when booked at the last minute via the Internet.

Jazzing up your Mouse Pad:

Did you know that most colour copy shops will transfer your favourite photo onto a mouse pad? Check your local store for details and availability.

Jargon:

This month's jargon is taken from www.webopedia.com.

Broadcast: To simultaneously send the same message to multiple recipients. Broadcasting is a useful feature in email systems. It is also supported by some fax systems.

Broadcast Storm: a state in which a message that has been broadcast across a network results in even more responses, and each response results in still more responses resulting in a snowball effect. A severe broadcast storm can block all other network traffic, resulting in a network meltdown.

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

CHAPTER NEWS

ACA CONFERENCE – SA CHAPTER

The SA Chapter of ACA conference was a huge success. We had 35 participants made up of full members, students and a couple of non-members. Everyone had arrived by 9.00am full of excitement and expectations for the day to begin.

The day began with hot coffee and Peter Papps, the SA chairman, welcoming everyone as we had people from all over, metropolitan Adelaide and some country members had driven and even flown in to be a part of the day. The committee was introduced to the room as well as the Peer Supervision team leaders from around Adelaide. Peter went on to explain some of the activities of the A.C.A. at the national and state level which incorporated growth and strength of our Association, opening up to new opportunities in the business sectors, lobbying to the Health Funds, practitioner and student forums, practitioner directory and upcoming workshops for Lifelines, Anger Management and Building a Practice.

Our first speaker was then introduced:
Julianne Watson who was going to speak to us for the first part of the day on Anxiety, Fears and Phobias. Julianne works as a Consultant Nurse Psychotherapist at the Centre for Anxiety and Related Disorders at Flinders Medical Centre. Julianne gave a wonderful presentation where each member benefited and gained valuable learning from her vast experience in this subject. We learned about the 5 categories of anxiety, the history, diagnosis and the treatment/therapy used for each one. A special thank you to Julianne for such an informative and wonderful presentation from all SA members.

We learned about the 5 categories of anxiety, the history, diagnosis and the treatment/therapy used for each one.

Lunch was then served, then back to our conference room for an afternoon of Intimacy and Sexuality presented by Elizabeth O'Connor. Elizabeth is the Program Manager of the Education and Training unit at Centrecare and has a degree in Sociology and Politics. She also has qualifications in Parent Education and family counselling and most recently a degree in Grief, loss and Palliative care. We were asked what we would most like to learn about during our afternoon with Elizabeth.

We challenged her with the following list of what we would most like to know,

What happens when the love has gone from one partner

Minimising infidelity

Blockages – male/female perspective

Men's education in fore-play

Sexuality and the elderly/people with disabilities

Emotional vulnerability from childhood issues

Family dynamics when challenged with issues such as homosexual child coming out.

Elizabeth dealt with all questions and challenges in a very professional and informative way – she was a delight and her presentation style was warm, caring and she spoke from the heart. Again we all learnt a great deal and benefited from her knowledge in this area.

The day ended with Peter wrapping up the proceedings and everyone was invited to mingle and network over a drink or two.

Thank you to the committee for organising this fantastic event and we look forward to next year's conference.
Patawolonga Motor Inn, Adelphi Terrace Glenelg North

BRISBANE CHAPTER NEWS

The Brisbane chapter has been attracting a good turn up of members to its last two meetings. The members have been impressed and motivated by our new format of having speakers at each meeting.

The last meeting saw Adrian Hellwig, Vice President of the Clinical Counsellors Association and Head of the ACA Discipline Tribunal present an informative discussion about the processes and procedures the Tribunal followed in the event of a complaint lodged against a member of the ACA.

SERVICE PROFILE: Jan Woolmer – Survivors of Suicide Bereavement Support Association provided information about SOS and the work that the organisation is doing with those who are left behind after a loved one committed suicide.

PRESENTATION: Ellen Burton – presented a talk on the benefits of supervision and how supervision can be accessed.

The next meeting will be an Open Forum – reflection on the State Conference which was held on the 24 of May.

Dianna Dawson – will profile CREATE Foundation and the work that they do with and for children and young people in out of home care.

14 June 2003 at 10.00am
ACA, Heritage Place, Lutwyche Road, LUTWYCHE

FUTURE MEETINGS: 12 July 2003

Travis Gee – will give a presentation on the legalities of False Memory Syndrome

We hope to see you at the next meeting. For further information on the Chapter and/or its meetings you can contact Philip at ACA on 38578288.

HUNTER VALLEY

ACA Hunter sub-chapter meetings are held bi-monthly. Each meeting includes a business segment and case study or presentation by a member or guest speaker. The April meeting was for instance a presentation on Somatic Psychotherapy an enlightening event for all those who attended provoking in-depth discussion of therapeutic approaches and challenges for the counsellor. The June meeting presentation will be on Process Oriented Psychology inspired by the visit of Dr Max Schupbach to Newcastle during April. Our meetings are open to all interested counsellors, psychologists, psychotherapists and students. Meetings are followed by an informal shared supper. The **next meeting is at 5:30pm on Wednesday 18th June** at Gracegrove College, upstairs at 723 Hunter Street, Newcastle West. If you have any enquiries plese phone Ted Heaton at the college on 49 625650.

WA CHAPTER

Perth

The WA Chapter welcomes all new members to their meetings. With each new member, the Chapter and its members benefit from the valuable information and knowledge they bring. The benefits of attending our Chapter meetings are many, however the opportunities to network with other counsellors and establish contacts is invaluable.

Another important opportunity is the introduction of a regular guest speaker at our meetings which we feel provides a good opportunity for professional development. Our first guest speaker was our Chairman, Lorne Ferster who spoke on Dependency. Lorne is a counsellor and Co-ordinator for the Men's Programme at Holyoake, The Australian Institute on Alcohol and Addictions. Susan Tobiassen is a counsellor with adolescents, and will be speaking on Working with Adolescents at our meeting on 2nd June. Following we will have presentations on Codependency, Alcohol and Drug Dependency Bridge Programme by The Salvation Army.

The WA Chapter is close to becoming an Incorporated body which in itself should provide opportunities for developing a higher profile within the counselling industry representing the ACA members in WA. As a few of our regular members will be absent in July, we have decided to hold our elections for the Committee members on Monday 4th August 2003. This will also be our annual AGM, so we encourage ALL WA Chapter members to attend.

We are also looking at hosting a Conference later in the year. Details to follow.

WA Chapter members, please ensure you are subscribed to the Email of the Month News for current details on our meetings, speakers etc.

For any further details, please contact Carolyn Hage on 0403 943 042

SUNSHINE COAST CHAPTER

The next Gold Coast chapter meeting details are:

Date: 14th June 2003 **Time:** 2.30pm

Venue: All Care Counselling, 35-39 Scarborough St, Southport

Cost: FREE

For catering purposes please RSVP by 9th June to

Email: raewyn1@hotkey.net.au or ph 0414 725 142

SYDNEY SUB-CHAPTER

Schedule for 2003

Bi-monthly Meeting Dates & Presentation Topics

Saturday 14 June	Greg Stevens, "Gestalt Counselling"
Saturday 9 August	John Hunter Murray, "Neuro Linguistic Programming (NLP)"
Saturday 11 October	Ruth Bright, "Music Therapy"
Friday, Saturday & Sunday	ACA National Conference (in Sydney):
7, 8 & 9 November	(Format and topics to be confirmed)

Format of Bi-monthly Meetings

1:00pm **Case Studies Hour (optional)**
Each participant brings a difficult case study on which they wish to receive feedback from the other group members.

2:00pm **Welcome**
Presentation
An informal presentation by a Chapter member (who is a practicing counsellor) or a guest speaker, and general discussion. Your questions, ideas, case study examples, wonderings and opposing views are all very welcome.

3:00pm **Sydney Sub-Chapter meeting**

4:00pm **NSW Chapter meeting (optional)**

4:30pm **Close**

Venue **North Sydney Police & Community Youth Club**
224-230 Falcon Street
North Sydney NSW 2060

For confirmation of any meetings or events, please contact Bridget Hallam on 4294 4234 or bphallam@smartchat.net.au.

TASMANIAN CHAPTER MEETING

The Chapter is moving along well with a steady stream of new members. However we can certainly take on board more, so if you are reading this and in Tasmania please consider the benefits of attending meetings of like minded professionals. Meeting are informal with view to interaction, networking and also ongoing professional development with presenters at eat meeting.

The next meeting of the Tasmanian chapter is Tuesday 24th June. The Venue: 6 Portsea Place Howrah. Phone 03 62 478 162. It was decided that at each meeting a practicing Counsellor would present a topic so all members present could enhance their own Professional Development Level. At the meeting on 24th June 2003 our Guest Speaker will be Sharon Wilkinson and she will present " Working in Sexual Therapy " and give an overview of her work with sexually abused clients, Regards David Hayden Co-Ordinator. Tasmania Chapter. For further information on meetings you can contact David on esid@knightfranktasmania.com.au or phone 6247 8162.

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ACA

Note Taking on Law Report–ABC Radio National

Damien Carrick: Last week in Melbourne, a magistrate ordered the handing over to police of notes taken in counselling sessions with an HIV-positive man. He's currently being investigated by police; they suspect he's had unprotected sex with two women, and deliberately spread the virus.

The court heard that one of the women has already tested positive for HIV, and the other is awaiting test results.

Police say the notes are important because they will show if the man understood the risks of his alleged behaviour and if he did, that would be important evidence in any criminal prosecution.

The notes were made by employees of the Victorian Department of Community Services, known as Partner Notification Officers. They apparently contain information about the man's sexual partners, but they don't contain information that could be described as medical or therapeutic.

In court last week, the Department argued unsuccessfully that there was strong public policy reasons for preventing police from having access to the documents. The case raises a range of important issues: what's the law with respect to people who deliberately or recklessly spread the HIV virus? What are the wider public health implications of such prosecutions, and what about patient/client confidentiality? That's the one we'll focus on: what are the confidentiality obligations of counsellors, psychologists, doctors, psychiatrists, and other health care professionals? And how do those obligations mesh in with the demands of the criminal justice system?

Police say the notes are important because they will show if the man understood the risks of his alleged behaviour and if he did, that would be important evidence in any criminal prosecution.

Dr Ian Freckleton is a Melbourne barrister and academic at La Trobe University.

Ian Freckleton: The primary obligation is to keep confidential, information that they learn in the course of their professional relationships with clients or patients. However there are two major exceptions, or qualifications to that obligation. The first is that they have to obey the law, and if a search warrant is validly executed on their premises, they have to surrender whatever documentation they have to the courts. Similarly, if they are subpoenaed to attend court and are told by a judge or a tribunal member to give evidence, then they're obliged to comply with the law, just like every other citizen.

The other qualification is this: that there are certain limited circumstances in which if they learn of a specific threat to an individual, or to a class of individuals, they have an ethical and probably a legal obligation also to disclose that information in such a way as to protect the people at risk.

Damien Carrick: So they have an obligation to come forward off their own bat if they feel that there's an imminent risk to a specific or particular group of people?

Ian Freckleton: That's exactly it. And the notion lying behind that is that it would be an absurdity to maintain the sacrosanctity of confidentiality if that itself was putting people very seriously at risk.

Damien Carrick: Barrister, Ian Freckleton.

So the general principle is that a health care professional should not disclose any communications with a patient unless there's a clear risk to an identifiable person or group of serious bodily harm or death, and that danger must be imminent.

That principle was set out most clearly in the recent Canadian Supreme Court case of Smith and Jones. That case involved an accused who was sent by his lawyer to a psychiatrist to obtain an expert opinion which could be used by the defence.

Chris Hinkson, partner with Vancouver law firm, Harper Grey Easton, acted for the psychiatrist, who had grave concerns about the accused.

Chris Hinkson: He was charged actually with assault causing bodily harm. There wasn't any sexual component to the initial charge, although the victim was thought to be a prostitute.

Damien Carrick: And what did he reveal to the psychiatrist in the sessions that he had with the psychiatrist?

Chris Hinkson: Essentially he indicated that he was setting on a course to kidnap and trap a woman for a period of time and torture her in a variety of ways and then planned to kill her and dispose of the body, with a view to seeing whether if he could do it once, he could then do it a number of times thereafter. So that was his plan as he explained it.

Damien Carrick: Now I understand that the accused pleaded guilty, and the psychiatrist became concerned that the information, his report, wouldn't then be used or be available to the judge when sentencing this man.

Chris Hinkson: That's correct. What had happened was he pleaded guilty to a lesser charge of common assault, and was put over for sentencing, and the doctor phoned the lawyer who had retained him, to find out whether he was going to be required for the sentencing hearing and was told he wouldn't. And then became concerned that this fellow would be dealt with and wouldn't get any attention for his real troubles while he was incarcerated, and then would be released ultimately, and turned loose amongst the public.

Damien Carrick: So your client, the doctor, wanted that information to be put before the judge. The case went all the way to the Supreme Court of Canada; what did that court find?

Chris Hinkson: Well the court said that in circumstances where you know of someone who was at risk of seriously bodily harm or death to an identifiable group, then you have the right to make disclosure to protect those people.

Damien Carrick: So that's the general principle now as it stands in Canada?

Chris Hinkson: It is. There has been some antipathy for the judgement voiced by members of the Criminal Bar who were concerned that if they want to send their clients for psychiatric assessments and have to face the prospect of the psychiatrists turning on them and giving evidence for the Crown, they might be more reluctant to utilise that resource as defence counsel. But cases from the highest court in the country and it's binding on all the law courts.

Damien Carrick: What about the situation in the reverse? Do you ever have a situation where there are legal actions by somebody who was assaulted, or the family of somebody who was killed by a patient or a

client of a counsellor or health care professional, and they say that the counsellor or the health care professional should have come forward and warned authorities of the risk?

Chris Hinkson: We haven't had a case succeed that I'm aware of in Canada on those kind of terms. There is a decision from California called Tarasoff on the Board of Regions of the University of California where a psychologist that was seeing a fellow who was enamoured of a student and said essentially if he couldn't have her, no-one could, and he ended up killing her. And the psychologist was successfully sued for failing to protect the identified woman. As I say Tarasoff is a well-known case and has varied reception, depending which State you look at, but it hasn't been widely embraced to my knowledge.

In Canada, there's been one effort to embrace Tarasoff reasoning, in a case where a mental patient was let out on a day pass and got involved in a car accident. It was unsuccessful, perhaps the closest was a case in Toronto where the police were watching a fellow who was entering apartments and raping women and watching a particular in Toronto, where they believed he was operating, but didn't warn the women in the area. And the police were successfully sued in Ontario for failing to warn. That's as close as I'm aware that that kind of case has gone.

Damien Carrick: Chris Hinkson, partner with Vancouver law firm, Harper Gray Easton.

But how do health professionals go about applying the test laid down in Smith and Jones? What, for example, should a psychologist or psychiatrist do if a client walks in and starts talking about having sexual feelings for children? Is that enough for them to go on, to cause them to notify authorities? Ian Freckleton again.

Ian Freckleton: No, it's nowhere near enough, and that's why one needs to see the kind of reasoning in Smith and Jones within context. The fundamental principle is that confidentiality must not be breached by health care professionals, and this is a very limited exception, designed only to legitimise breach of that kind of therapeutic privacy where stringent and specific conditions are fulfilled. And they wouldn't be there, simply because someone has aberrant sexual attractions, is nowhere near enough. Nor is it enough if they say that they simply have thoughts of doing something untoward, or that they have been thinking or fantasising about committing a generalised crime. Nor is it enough if they say that they think that they might at some time, do something very nasty. It has to be specific, identifiable and close at hand to legitimise this kind of a breach of a relationship which is otherwise very important, and in the community's best interest.

Damien Carrick: So taking the paedophilia example a bit further, if the patient or the client identified a particular child, or talked about going to a particular playground and observing children there, that might create in the mind of the health care professional, the idea that there is an imminent danger?

Ian Freckleton: That's getting a lot closer, and of course there are certain categories of health care professionals in different parts of Australia who have mandatory obligations to report risks of sexual, emotional, physical risk to children. So these two issues cross over in terms of legislation, and also general common law responsibilities and entitlements. But it does have to be specific, close at hand and identifiable. And that's why it is only where the health care practitioner has reasonable cause, based on their own clinical experience, to believe that there is this major risk just about straight away to a particular individual or category of persons, for instance within a family unit, that they're entitled to take so bold a step. If they do otherwise, they will be in trouble with their professional disciplinary tribunal and they can also face civil action from the person whose confidence they've breached.

Damien Carrick: Presumably these issues of confidentiality and criminal action must be particularly at the front of the minds of people who work in prisons; have there been any cases in that area?

Ian Freckleton: Yes, that's right. That's a fraught area, and there have been circumstances in which persons who are either on remand or are serving sentences for other matters, have disclosed information which suggests that they're guilty of previous criminal offences, to a psychologists and others within the criminal system. And there was a well-known case in Victoria in 1997 where the Court of Appeal was required to look at the issue of whether evidence of a conversation between a psychotherapist and a person who ended up being accused, was admissible, or whether the confidentiality that would normally attach to health service providers, should render such information confidential and not admissible in the public interest.

He says counsellors have informed spouses or partners of HIV-positive clients who are exposing them to the risk of infection through unsafe sex.

Damien Carrick: Do you remember the facts in that case? What was the prisoner accused of?

Ian Freckleton: The prisoner was accused of murder of a six-year-old child, and the information that was elicited by the psychotherapist related to what he was alleged to have done. And so it was crucial information at the trial of this accused person.

Damien Carrick: What did the court fin d?

Ian Freckleton: The court found quite robustly that the public interest in effectively prosecuting a person for a serious offence was superior to, and trumped, the entitlement otherwise existing, of a patient to confidentiality in their communications with their psychotherapist.

Damien Carrick: In that low case, presumably the prosecution was aware that these records existed and it tried to get its hands on them. It wasn't a case of the psychotherapist volunteering the information?

Ian Freckleton: Yes, that's right.

Damien Carrick: Dr Ian Freckleton, Melbourne barrister and La Trobe University academic.

Dr David List is the President of the Victorian Psychologists' Registration Board. He says on very rare occasions, health care professionals have felt the need to breach confidentiality. He says counsellors have informed spouses or partners of HIV-positive clients who are exposing them to the risk of infection through unsafe sex. Now I should point out there's no consensus amongst health care professionals on how

Note Taking on Law Report–ABC Radio National (Continued)

to deal with the complex and specific issues surrounding the transmission of HIV.

The Victorian AIDS Council maintains it's never had the need to breach the confidence of a client. It says with proper counselling and in one extreme case, a threat, 'If you don't tell, we'll have to', it's always been able to convince clients to inform partners with whom they're having unprotected sex.

Moving away from disease transmission, Dr David List says psychologists have also reported clients to authorities to prevent a number of serious crimes. He says a psychologist would never take such a decision lightly. He explains what a psychologist would do if a client admitted to a past crime.

David List: Well the first thing would be to determine whether there was in fact a risk of something similar happening again, because once it crosses that threshold, then you're saying 'Look, someone's at risk here', and that needs some kind of affirmative, proactive decision on the part of a psychologist, which would then be communicated to the client. Other than that, it can be something of a difficult ethical conundrum for somebody. You take as a starting point, the idea that let's say someone named Joe comes in and he wants to talk about his sexual behaviour; it is very frightening to talk about, and if he's someone with AIDS, and he would be placing people at risk, it's really something that troubles him too, that he wants to give help with. And so the idea that he's not protected from his statements, and what happens in that therapy room aren't going to be confidential, would dissuade people from coming forward to discuss things. And that might place other people at risk in the nature of sexual contact.

You take as a starting point, the idea that let's say someone named Joe comes in and he wants to talk about his sexual behaviour.

But having said that, the psychologist would then be in the position of dealing with it, firstly at the level of risk, but then secondarily what if there wasn't an issue of risk, then how to proceed from there. And sometimes that question of risk is not so easy to determine.

Damien Carrick: It must be a very fine line judgement to make.

David List: As a case in point, I was consulted the other day by someone who was treating an adolescent, and the adolescent informed the psychologist about her relationship with an adult, that the adolescent was having.

Damien Carrick: The adolescent was a minor?

David List: That's right. And the psychologist had to determine whether the child was at risk, the child said that the relationship was consensual, but the psychologist had to decide whether that could be the case or couldn't be the case, and what he should do about managing that. And that was an ethical problem and he really wanted some help to figure that out. And oftentimes that's what psychologists will do; they will go and get a second opinion or they'll consult someone when those kinds of situations become as complex as that.

Damien Carrick: And what did you advise in that case?

David List: Well as a starting point, I think one of the questions that I'd be asking is why the adolescent disclosed the relationship. I mean it isn't just the fact of having one, but the fact of disclosing it to a psychologist with some kind of expectation about what the psychologist would do with it. So the adolescent might have wanted the psychologist to act in a way that he didn't feel he himself could do, or he might have wanted to just work through some of the issues, he might have thought that he was at risk, or he might have felt that he was in fact in a relationship which was with as much informed consent as he could have, but that he couldn't quite sort out what to do about, and so he was just seeking advice.

So one of the things that the psychologist should do in that situation I would say, would be to really investigate why the information was disclosed in the first place with the expectation that it might create an obligation on the part of a psychologist to act.

Damien Carrick: We're talking about though a minor and an adult, so we're talking about ongoing criminal behaviour.

David List: Well potentially, absolutely. And that's where the question of risk becomes do you say that using entirely hypothetical numbers here, if you say someone who is 18 and someone who is technically a minor are in a relationship, is that something which is paedophilia or is that just within the realm of informed consent of the maturity of the people involved. But if you say someone is 25 and someone is 15, then that obviously looks a whole lot more like something in which a situation of risk is absolutely there.

Damien Carrick: Do you know what your colleague did?

David List: No.

Damien Carrick: Have there been cases where the psychologist has reported their patient or their client to authorities or to the police expressing their concerns about what they might be doing?

David List: Yes. Yes, absolutely. there's an absolute, not an absolute but there is a clear guideline that that's acceptable where there's an absolute sense that there is genuine risk and that's where it really gets complicated. And for someone to make a notification to the Department of Human Services in Victoria for example, when they feel that a child might be at risk, would in many cases be entirely appropriate. It's only in some specific ones where it might be viewed as the wrong thing to do, or inappropriate.

Damien Carrick: Can you tell me about any other situations where you've been approached for advice about whether somebody should hand over their notes to the police or to authorities?

David List: I was involved in one case quite a number of years ago in which I was supervising someone who had seen a woman for one session and had another appointment with her, and between the first and the second sessions, the woman was murdered. And the police approached the psychologist asking for her notes of the interview, and she didn't really know what to do, because she wasn't sure how much confidentiality was really owned by

someone who had died. And eventually the way it sorted out was that the questions that she addressed was what the woman would have wanted had she been alive, and it was on that basis that she made her decision.

Damien Carrick: And what was her decision?

David List: To communicate to the police enough to know that she really had nothing of relevance to say in terms of who might have killed her.

Damien Carrick: Dr David List, President of the Victorian Psychologists' Registration Board.

That's it for this week. Thanks to producer, Maria Tickle, and technical producer this week, Carey Dell.

Guests on this program:

Stephen Bourke
lawyer, Supersplitting

Nabil Wahhab
lawyer, the Argyle Partnership

Dr Ian Freckleton
barrister and La Trobe University academic

Chris Hinkson
partner, Harper Grey Easton, Vancouver, Canada

Dr David List
President of the Victorian Psychologists Registration Board

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Eventually the way it sorted out was that the questions that she addressed was what the woman would have wanted had she been alive.

On-line Counselling – The Questions That Need to Be Answered

By Sarah Mackay

Counselling on-line is a field that is experiencing rapid growth, with some excellent articles written on 'how to' counsel using this medium. The following article will focus on the considerations that counsellors need to be aware of before choosing to counsel people via the Internet.

What is counselling on-line?

Counselling on-line is simply conducting counselling via a different medium. This could be counselling via email with a designated response time or via real time in a chat-room type set-up. Recently there was an article published in 'Counselling', the journal of the British Association for Counselling and Psychotherapy, by Steven Page, titled 'Counselling by e-mail'. This was an excellent article, focusing on the contract that is required when counselling via email. He included topics for inclusion such as availability, length of messages, frequency of messages, safeguards, storing messages and ending counselling.

It was after reading this and other articles on counselling on-line that Philip Armstrong, from the ACA, and I discussed some of the legal considerations that may impact on counselling via the Internet. I sought some legal advice regarding the issue and, as a result, decided to write this article. I would like to thank Richard Harris, who is a Solicitor of the Supreme Courts of New South Wales and Queensland, for his assistance in researching the material for this article. I will try not to be the 'Voice of Doom' regarding the legal implications of counselling on-line, however there are many issues to consider before embarking on counselling in this area. That is not to say that it shouldn't be done, it is simply to say that you need to make sure it is what you want to do and put the safeguards in place to ensure that you and your client are protected.

One of the issues with on-line counselling is that both you and your client have an exact transcript of the previous sessions. This can be a useful tool to refer back to and look at the progress of the client, to check what was covered or to clarify something from a previous session.

A disadvantage to having an exact transcript is that, as with counselling notes, the transcript can be subpoenaed by a court of law. Whist your case notes can be subpoenaed, they are not as detailed as your email transcripts will be. Therefore, when a transcript

A disadvantage to having an exact transcript is that, as with counselling notes, the transcript can be subpoenaed by a court of law.

is subpoenaed, the court will have the exact session to scrutinise and potentially misinterpret. One safeguard is to make sure that you keep a copy of the transcripts so that if a client does take action you have a copy and can ensure that nothing has been changed on the transcript. You should be aware that the Court's right to subpoena documents differs from state to state (and also for the territories).
Furthermore, for those counsellors who are members of counselling associations, such as the Australian Counselling Association, then the Complaints Tribunal of the Association can also request the transcript if a complaint has been received against you. Again, this means that the Complaints Tribunal will have an exact copy of your session to examine.

Duty of Care is another issue that you need to consider. My specific question to the lawyer was "What would happen if you got an email from a client and, in line with your contract agreement (which says you will reply within 5 days), you go to reply in 4 days. When you read the email you read that your client was feeling very low and is thinking of taking his own life. You then find out that he actually committed suicide two days earlier. Could you be negligent even though you have clearly stated in your contract that you will reply within 5 days? The lawyer's response to this is "yes you can". You have a duty of care with your client. It could be argued that you were negligent for not checking the email when it came in to ensure there were no immediate concerns. Just because you say you won't reply doesn't negate the duty of care you have towards your client.

My next concern was that of reporting of crimes. If a client admits to a crime in your counselling rooms and you inform them that you have to report it then they may just deny it if questioned by the police. But what happens if this admission is written? Does this make a difference with regard to your responsibility to report? One of the difficulties with legal questions in counselling is that state laws cover counselling so, in New South Wales the Crimes Act makes it mandatory to report serious crimes but in Queensland there is specific legislation dealing with children. Again, the different jurisdictions have different requirements. This is the legal requirement, but there is also a moral question.

My advice is to be very clear and careful with clients using your services (regardless of if it is on-line or face-to-face) about the limits of confidentiality. When taking on a new client, you should have a clear contract that includes the limits of confidentiality and get a client to sign it, if face-to-face counselling, or acknowledge via email. Also, you need to seek legal advice regarding the exact requirements for mandatory reporting in the state that you are practising from.

My next question was regarding abbreviations. There are a lot of abbreviations that are appropriate for chat rooms and emails with friends but, if counselling via email, I would recommend that you do not use abbreviations. I have concerns about misinterpretation when using email for counselling. If you use abbreviations then the chance of misinterpretation is higher. Many people are not familiar with 'computer speak', so it is best not to use abbreviations.
International boundaries are another issue that needs to be discussed. The first issue is that of qualifications. In some countries the requirements to become a counsellor are very high and in others, such as Australia, there are no regulations. You need to make sure that you clearly inform clients what your qualifications are and that you are a counsellor in Australia.

The next issue is law. Whose laws should you abide by when counselling? The legal advice was that if you are counselling from a base in Australia then you need to abide by Australian laws. This can be made clear by stating this at the start of the counselling session.

My final concern was "What if you, as an Australian counsellor, get sued by an American client. Where do you go to court?" It is most likely you would go to court in Australia but you also need to check your professional indemnity insurance policy to see what you are covered for. For example, Aon Insurance policies do not cover action taken by residents in North America. There are some policies that cover you with regard to legal action taken by North American clients but they are several thousands of dollars each. Other insurance policies only cover Australia and New Zealand so be aware of what you are covered for. There also appears to be an increase in Americans using American courts for such action. This is a major concern. Complications can arise from this. For example, if you fail to attend a court action against you in America, you may experience difficulties when travelling overseas with a court order against you.

Counselling on-line is an emerging field that shows a lot of potential. Before setting yourself up in this manner it is important to look into all aspects of the practice.

Counselling on-line is an emerging field that shows a lot of potential. Before setting yourself up in this manner it is important to look into all aspects of the practice. There are many great articles around about 'how to use on-line counselling'. This article has hopefully made you consider some of the potential legal ramifications regarding on-line services. If you are going to provide on-line counselling, think about the repercussions, make a list of questions and then seek some legal advice before deciding to head into this area. This would be my advice to anyone setting up any practice, regardless of the medium.

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Book Review

Cognitive Behaviour Therapy – an A-Z of Persuasive Arguments

By Michael Neenan and Windy Dryden

This is an A-Z dictionary of ideas and arguments that therapists can use to present to, and build on discussions, with their clients.

It is an excellent reference book, for therapists who want to help their clients develop alternative and more constructive viewpoints to tackle their problems. The content is descriptive with an easy read layout style. The material offered in this dictionary style book, is relevant to the counselling profession and would be an asset on anyone's shelf.

The descriptive answers give the cognitive behaviour therapist, the ability to offer rational or balanced responses to clients' often self defeating thoughts or beliefs.

An excellent book, which will benefit both the client and the counsellor.

Book review by Mary Gehrmann MACA, chairperson of the Brisbane Chapter of the ACA and semi-retired counsellor.

Publishers – Whurr Publishers – $75.90

Available through Maclennan & Petty
ISBN 1-86156-326-4. Phone: 02 9349 5811.

Fathering at risk: Helping nonresidential fathers.

By James R. Dudley & Glenn Stone. New York: Springer. 2001. Springer series: Focus on men.

A thought provoking book, raising and discussing what is for many, the culturally uncomfortable area of men's issues.

This is a thought provoking book, raising and discussing what is for many, the culturally uncomfortable area of men's issues. The publication is a powerful tool for mental health professionals and trainees practicing with nonresidential fathers. Whilst giving an overview of fathering the book also spotlights three groups of nonresidential biological fathers, that is, divorced, never married, and teenager. The issues of the latter two groups have rarely, if ever, received this focus of attention in general literature.

There are four major parts to the book. Part 1 incorporates chapters 1-3 and is lucid in describing the historical and current context of why fathering, in general, is at risk. Chapter 1 gives an informative introduction to the history and reasoning of the men's movements and the motivations driving the current interest in fatherhood / grand-fatherhood issues. Included are definitions of social problems. Chapter 2 insightfully profiles the three groups, their needs and the current societal stereotyping of the groups. Chapter three utilizes the research to summarize what we know about developmental outcomes of the presence or absence of fathering and the optimum goals to aspire.

Part 2 is titled 'What can we do?' Interestingly, this part only contains Chapter 4, 'Principles and strategies for promoting effective fathering". This does not appear to be due to information scarcity; rather the technique highlights the importance of the perspectives and strategies presented. These are wide ranging, inclusive, approaches to assist practitioners to deal effectively and sensitively with clients with issues in this arena.

Part 3 'Professional practice considerations in work with fathers at risk' contains chapters 5 & 6 which filled with comprehensive and powerful dot point checklists, models, and programs for working with nonresidential fathers in varied settings, that is, individually, in family systems and in group work.

Part 4 'Policies and programs to assist fathers at risk' includes chapters 7-12, each individually focused on a process to prepare for, prevent, or enhance negative situations whilst promoting positive outcomes individually, family-wise and societally.

The statistical data is provided by the U. S. Bureau of the Census. However, the book, being a forerunner in its field, can be considered as providing a 'rule of thumb' for the processes happening or likely to happen within the Australian context. One of the strengths of the book is the inclusion of regular and relevant reflection questions. These challenge the reader to process covered information, social issues, belief systems and synthesize the information into a deeper view of the issues that face fathering in general and nonresidential fathers in particular. I believe this book is a valued addition for any professional library.

Available from Maclennan & Petty. Ph 02 9439 5811 or fax 02 9439 5911 ISBN 0-8261-1418-0. Hardback. 326 pages. Price $126.50

Reviewed by Malcolm McEnery
BA (Psych) MACA. Malcolm is a Clinical member of the ACA working in private and community practice.

How to Say No and Keep Your Friends

By Sharon Scott

I as a teenager thought this book was an excellent book to read. I could understand everything in the book because it had familiar words that I could relate to. Sharon Scott has made this book easy and enjoyable to read by including pictures in this book which make it easier to understand. I would recommend that not only should teenagers read this book but adults as well, even parents/carers so they know what their children are going through and how they can help their child get through teenage issues. Particularly those that include peer roup pressure to join in activities they know are wrong. There is one chapter that really impressed me in relation to saying "no" and that was chapter five (Tobacco, Alcohol, other drugs, sex and violence).

Chapter five was really good as it had a whole heap of facts and information in it that makes you as the

reader aware of what the consequences are of our actions if pressured into any of those subjects. That is what this book is about, not having to suffer the consequences and keeping your friends if you do as you are taught in the book.

I myself tried some of the techniques written in this book and the results worked, I kept my friend as well as staying out of trouble. This book has had an impact on me and I'm thankful that I read it. Another good thing about the book is that Sharon used her friends life experiences in this book without disclosure of names and telling the outcome of their stories when they did not use what Sharon Scott suggests in her book, then telling us what to do if we were in the same position. This made the book interesting, knowing what to do if stuck in a sticky position.

Overall I recommend this book to anyone and everyone because its not just the teens and preteens who get pressured it's adults as well.

Reviewed by Phillip Armstrong Jnr,
13 years old and a student at Kedron High School, Queensland.

Available from Living Solutions Bookshop.
Price $29.65. Phone: 03 5977 6366.

The Mystical Power of Person-Centred Therapy. Hope Beyond Despair.

By Brian Thorne.

Brian Thorne's latest book continues acknowledging spirituality in human experiencing and counselling, showing an overlap between person-centred work and a commitment to spiritual living. The author builds on Carl Rogers' later view that he had underestimated the mystical quality of the person-centred approach to provide access to the spiritual dimension.

Thorne addresses the human condition alongside key person-centred beliefs. Chapter 8 shines because of Thorne's work with client, Emma. Both the healing power of the encounter and the transparent vulnerability of the counsellor are keenly felt in the human to human excerpt. The author's giving of his whole self to the client is no light offering. The exchange of love is vital in human relationships. Boundaries, though important in counselling, may need to be challenged if they prevent the client's tentative yearning for or desire to offer love. The risk in this is acknowledged in our increasingly litigious society where some clients may interpret any offering of love as an abuse of power. Person-centred therapists are nevertheless required to become more fully themselves because it enables them to be more effective companions. The counsellor's own self-love is imperative, for from this, love is shown and received by others. Personal growth and professional effectiveness are linked. Clients often sense this development from the start. Thorne writes: "It is the existential encounter which reveals whether the therapist is enough of a person to be able to assume the professional responsibility which the therapeutic relationship requires." (p.22) No ontracting or technique can compensate for the counsellor's lack of personal resourcefulness or inability to humanly engage. Of the relationship, the author writes: "There is a trust in the power of encounter to bring about transformation once energy can flow between people without defensiveness." (p.59)

Reviewed by Ann Maree Billings
a clinical member of ACA in private practice.

Available through Maclennan & Petty
ISBN 1-86156-328-0. Price $69.30.
Phone: 02 9349 5811.

Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner (3rd ed)

By J. William Worden (232 pages)

As the title suggests, this publication addrresses the subject of grief and bereavement. Its target audience is that of mental workers as well as other practitioners working with grief and loss. Ots aim is to heop such professionals understand better the complex phenomenon of bereavement as they strive to help those who mourn to accommodate their grief in a healthy manner.

Bereavement is a complex issue and people experience grief in many and varied ways. Although the main focus of this publication is on losses resulting from death, the principles can be readily fransferred to mourning various types of losses such as divorce, amutation, job loss, victims of violence etc.

The book offers current thinking on areas such as what people experience following loss, why they experience what they do, the four main tasks of mourning, identifying complicated grief and how to maximise one's effectiveness as a grief counsellor.

Of particular note are chapters 6 through 8 where the book deals with specials types of losses including sudden death, SIDS, abortion and AIDS. Chapter seven examines grief and family systems and chapter eight addresses the issues surrounding the counsellor's own grief.

While there is nothing new in the pages of te publication, it presents as a succinct resource and is both informative and pragmatic. It presents practical suggestions, useful summaries of approaches, as well as case studies allowing the reader to reflect upon te theories explored. The bibliography is extensive and valuable for further research and study.

Reviewed by Peter Monaghan,
BTh, BSc (Psych), MCL, MACA. Peter is a qualified member of ACA and an active member of the Brisbane Chapter.

Available through Maclennan & Petty
ISBN 0-8261-4162-5. Price $93.50
Phone: 02 9349 5811.

Although the main focus of this publication is on losses resulting from death, the principles can be readily fransferred to mourning various types of losses such as divorce, amutation, job loss, victims of violence etc.

Survey Results

The following are the results of the surveys that were returned:

Is there anything that ACA is not doing that you would like to see done?

98% of respondants felt ACA was doing everything possible with a few suggesting ACA provide more help with business building.

Are you happy with the service you have received from ACA to date? Yes / No

If not, why?

96% responded yes. The major issue with those who chose no was in relation to support for private practitioners.

What industry matters do you feel should be our priority?

The large majority nominated health fund rebates with others referring to issues within their own specialties. Regulation was also mentioned.

Are there any further services that you feel ACA should offer its members?

The majority felt ACA was already meeting their needs. The most common issue mentioned was further training at low cost to help with OPD.

Do you believe that ACA is showing the type of leadership you expect? Yes / No

If not, what should we do?

96% responded that they were satisfied with the current leadership. Comments from 4% who were dissatisfied were in regards to a lack of support for private practitioners.

Would you like an interactive ACA Chat Room on the Web? Yes / No

62% said yes and 32% said no. ACA will start to investigate the viability of a chat room.

JOURNAL "COUNSELLING AUSTRALIA"

Are you happy with the content and style of the journal? Yes / No

98% responded that they were happy with the journals content and style. 2% responded the journal needed more professional articles.

What, if any, changes would you like made?

Most common answer more professional articles and articles on modalities.

CHAPTERS

Are you a member of your local Chapter? Yes / No Which Chapter?

60% of respondents were not members of their local chapter and 40% were.

If not, why?

Most common reason was the member lived to far from place of meetings

Are you aware of what your local Chapter does and when meetings are held? Yes / No

20% of respondents did not know where or when local chapters met.

What would the Chapter need to do to encourage you to attend meetings?

50% of respondents claimed the chapter would need to hold meetings at a different time and at different venues. Distance to travel to and from meetings was an issue.

What cost would you expect to pay for a one-day conference with full catering? $ .00

Most answered between $100 & $200, some were unrealistic stating $20 & $50.

OTHER

Would you like ACA to develop a professional badge that members can wear to identify themselves as members?

Yes / No.

89% responded yes they would like a professional badge. ACA will develop this idea.

Would you like ACA to develop a logo you can use on your marketing material such as your

Business card? Yes / No

83% responded yes. ACA will start to develop this imitative.

ACA will now undertake to work harder to ensure that we implement the new initiatives and iron out any negative issues. We thank the members for their responses and ask all members to feel free to ring our 1300 number if they would like to discuss any issue whatsoever with us. Without member input it is difficult for us to know what direction you wish us to take the association in.

Winner of the book prize is:
Member number 2018 Yvonne Howlett.

We thank the members for their responses and ask all members to feel free to ring our 1300 number if they would like to discuss any issue whatsoever with us. Without member input it is difficult for us to know what direction you wish us to take the association in.

Australian Counselling Association 2003 Annual National Conference & Awards Night

7, 8 and 9 November 2003,

Stanford Plaza, Double Bay, NSW

Day 1 Keynote speaker **Rev Bill Crews**, founder/director of the "Exodus Foundation" — Uniting Church Minister — past awarded "Father of the Year".

ACA is currently negotiating with **Gerald and Marianne Corey**, authors, trainers, international keynote speakers and presenters to present workshops on day one. Watch this space.

Day 2 Is a series of 3 hour workshops. There will be 3 strands of 4 workshops, delegates will be able to choose 2. The following are the topics and speakers: Recovered Memories, Dr Travis Gee, Relationships with Terry & Barbara Tebo, Women & Domestic Violence with Barbara Kilpatrick, Dimensia with Sharonne Pearce from Alzheimer's Australia, Men & Boys with Allen Rudner, Buddhism, Sex Therapy with Dr Lesley Yee, Parenting with Nancy Snow and Mental Illness-Early Intervention with Barbara Lifferton, International Experience in Career Planning with Dr Nancy Author.

Day 3 Is a series of 4 strands of 4 workshops, topics and speakers as follows, Gay & Lesbian Youth with Michael West, Music Therapy with Ruth Bright, Post Natal Depression with Kerry Lockhart, Children Witnessing Violence with Tjinta, Marijuana Counselling with MDECC, Impotence with Impotence Australia, Creative Psychotherapy with young People with Stephanie Hurst, 100 years of Counselling Families with Steve Tsousis, How to Parent Boys with Geoff Price, Women Power and Creativity with Sally Gillespie, Older Men New Ideas with Bill Whitting and Kids Self Esteem with Julie Coddington.

For continuing updates go to the ACA web page or subscribe to the Email of the Month (free) on aca@theaca.net.au for updates as they occur.

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

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