Volume 4 Number 3 **Spring 2004**

# COUNSELLING AUSTRALIA

Australian Counselling Association Journal
ACA AUSTRALIAN COUNSELLING ASSOCIATION


## Sociocultural Contexts and Suicide

## Draft ACA Position Repressed/ Recovered Memories

## Disease Model of Addiction

## Gender Swapping on the Internet

## Continuing Education and Critical Thinking – A Counsellor's Guide Part III

## Success, Failure and Motivation

Counselling Australia

Published by
Australian Counselling Association Pty Ltd
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Kedron QLD 4031
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Printed by
Cross & Hamilton Printers

Front Cover by
Craig Emery

ISSN 1445-5285

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## Features

# Editorial By Phillip Armstrong

It seems that some associations wish to raise the bar in relation to minimum qualifications for membership to professional bodies. The repercussions of this are significant in regards to employment and other issues. My concern is that this is being done without equitable consultation of the whole profession.

It seems that counselling associations now just go hell for leather in adopting standards and then try to influence as many employers as they can to justify their decision, misleading employers and government departments to believe that this is with the consent of the entire profession. This is quite extraordinary, especially in regard to the fact that there is no one professional body that could claim legitimately to represent the entire profession. If ACA, an independent association, represents nearly 3000 counsellors any other body would have to be misrepresenting themselves to claim they solely represent the profession without direct consultation with ACA.

I personally do not have an issue with raising the bar if that is what the profession wants. However it needs to be done with 100% consultation of the whole profession and includes strategies for bridging courses, equal access to training at the new level and a realistic period of time to retrain and implement the new standards. I believe it is only a matter of time before counsellors will be expected to have a minimum of an undergraduate degree for employment purposes anyway. This is traditionally the way most professions in Australia have evolved.

There is no one professional body that could claim legitimately to represent the entire profession

Considering that many of the individuals pushing for the changes work as educators, it astounds me that they can push to raise the bar, knowing there is no equity in regard to access to Australian public universities when it comes to counsellor training at the undergraduate level. Were we to adopt a minimum tertiary standard, what would be the training options for potential counsellors at this moment in time? To my knowledge, there are only two universities that offer undergraduate degrees in counselling - Bond on the Gold Coast (Qld) and Notre Dame in Freemantle (WA), both of these universities are not public Universities. I will reiterate that I am discussing counselling and training to be a professional counsellor, not psychology or social work.

The next best option would be Southern Cross University (SCU), which has an undergraduate degree with a major in counselling subjects. Therefore, any potential counsellor looking for training to meet standards at a tertiary level would only be able to access a public university if he or she lived on the north-eastern coast of New South Wales and could attend SCU. There are other options outside the public education sector, such as private providers and universities who offer undergraduate and graduate training. However many advocates for the raising of the bar actually come from the public education sector. How many of these advocates actually earn an income from an involvement in training graduates in counselling would be an interesting exercise. Would this pose any conflicts of interest particularly with objectivity, possibly not if the whole profession is consulted.

Access is far more equitable for graduates (generally of psychology and social work degrees) but not for those seeking undergraduate counsellor training. Is this some covert form of discrimination to protect current programs or simply a sign that public universities have not identified the demand? With the increase of undergraduate courses being offered by private universities a demand has been identified by them. If we want to raise the bar regardless, this surely is a case of putting the cart before the horse. There is a need for more public universities to produce undergraduate training courses specifically for counsellors, before we raise the bar, simply for equity in relation to access if for no other reason.

Raising the bar needs to be more than simply self-promotion (or, dare I say, protectionism) of a few. We are in danger of limiting our choices only to becoming counselling psychologists or counselling social workers if we do not address the lack of access and choices for undergraduate training of counsellors.

ACA

# Letters to the Editor

Dear Editor

The FPCQ Student Night is a fabulous idea and I would love to be involved with more of them. A combination of studying externally and not having many "like minded" souls around me makes it frustrating at times when I want to bounce my ideas and thoughts around or even just listen to another's perspective. The fact that there are professional people willing to dedicate quality time to students when they have such large committments is a credit to them individually, the profession in general and the Federation itself. I found it refreshing to enjoy communication at such an open and honest level and it really strengthened my resolve to make a difference, that I am on the right track for me.

*Melissa Foot,* Student Counsellor

Editor

I would like to offer you my sincere congratulations for your contribution to the counselling article in Vogue magazine July issue. I have received some 'stylish' clients from it. Philip, you are doing a wonderful job in continuing to promote counselling for everyone in the ACA. It certainly is worthwhile belonging to an association who is out there in the field working for their members.

Sincere thanks. *Gayle Higgins*

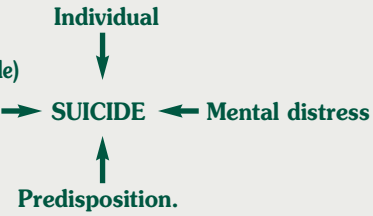
ACA

# Sociocultural contexts and Suicide By Gordon Ray

> So much of *the course of human society is found in human social arrangements, not in individual pathologies. (Straus,cited in Strickland, 1997:262).*
>
> *Eckersley refers to …the growing opinion in public health circles that we need to place more emphasis on the broad social, economic and cultural determinants.(1998:51)*
>
> *Suicide is a complex issue which, while tragic, confronts families, friends and wider communities. It results most often from an accumulation of social risk factors, and it intersects with problems and concerns across society: mental, drugs and alcohol, family issues, employment, cultural identity, law enforcement, and criminal justice, education and poverty (Wesley mission,2004:2)*

The phenomenon of suicide arises and evolves in the context of social arrangements and can be addressed through initiatives in the proximate environment and changes in the broader social, economic, and cultural determinants, as well as at the individual counselling-therapeutic level. Parsons pointed out "That Halbwachs saw that there is no antithesis, such as Durkheim posited, between the social and psychopathological explanations of suicide, but that they are complementary."(1937:326). So, this is not to deny that the individual exercises a choice but rather to say that she/he does so within a society and its institutions. Institutions are powerful formative influences that shape the social context of the individual including her/his value formation. (See 'Hardwired to connect' (2003) an American report discussed later). Although suicide can and does occur within any age or gender range, the focus here is on people in the age range of 15-34. Not only is this where the highest rate of suicide occurs, but it also reflects a series of repeated transitional stages in psychosocial development that are marked by key changes to the sense of social identity.

**Diagram 1 (multiple social contexts of suicide)**




A complex range of social variables is involved in the suicide of youth and young adults, so it follows that attempts at prevention and reduction are challenging.

A consideration of Emile Durkheim's pioneering research helps explain the contextual setting for suicide in this age group. Durkheim argued that suicide occurred when social ties that create bonds or connectedness are either too weak or too strong. If they are too weak people have less ability to anchor themselves in sound, normative values. If social ties are too strong then there is less chance of the individual being able to be sufficiently flexible to adapt well to change, challenge and uncertainty. In modern terms we can say that the latter person is over-socialized, which may reduce willingness/ability to be resourceful and adaptive. This makes an interesting connection with present day pampering and over-protection of children and also with the concept of paranoid parenting (Furedi, 2001). An example illustrates the role of overly strong social bonds.

Durkheim (1951/1897) identified altruism as one of the three forms of suicide. This occurs when the individual is strongly integrated into the social group. This type of suicide used to occur in some North American Indian and Eskimo societies. Older people who could no longer contribute usefully to the group would seek solitude and, no longer eating or drinking, would await death. Some years ago in India the cultural practice of suttee was carried out. Suttee literally means 'good woman.' Hindu wives were expected to throw themselves upon their dead husbands funeral byre and be incinerated. Severe social ostracism would follow if they did not do this. Recent news regarding American military personnel in Iraq offers further information. Another example of strong social integration but aimed at survival not altruism is that of the military. Simpson in his introduction to Durkheim notes that:

> *Durkheim's thesis is that in great crises the suicide-rate falls because then society is more strongly integrated and the individual participates actively in social life. His egoism is restricted and his will to live is strengthened. (1951/1897:14).*

Beaumont, writing in The Observer, on the high mental ill health rate among the military in Iraq notes that received wisdom in military psychiatry is that levels of suicide not only do not rise in war zones but actually drop as the will to survive comes to operate. This 'will' to survive may lead to excessive use of military force if they see it as necessary to optimal security. ''Just two suicides were recorded among US personnel during the entire Gulf war in the Nineties" (2004:22). So military training seeks to strongly integrate personnel into their group and into a cohesive and socially bonded unit. However, since the President declared an end to major combat in Iraq on May 1, 2003 the rate of US service suicides is now considered "abnormally high"; at least 22 US soldiers had killed themselves by January, 2004. So far "…more than 600 US servicemen and women have been evacuated from the country for psychiatric reasons since the conflict started." The Chief of in-patient psychiatry services at the Walter Reed Army Medical Center in Washington reported ''No psychiatry cases at all were evacuated during the major combat. The chairman of psychiatric services at the Naval Medical Center in San Diego, whose staff takes care of returning marines "expects the disorder {post-traumatic stress disorder} to occur in 20 per cent of the servicemen and women in Iraq." (Captain Berg, cited in Beaumont: 2004:22).

Captain Berg went on to say that at first there was strong public support for war but since then support from home had weakened. This is similar to Durkheim's findings (also 'Hardwired's") that the degree of strength of social connection and bonding to normative values is related to suicide and mental ill-health. (here it had been weakened from a strong prior situation). So has the strong social integration of

The phenomenon of suicide arises and evolves in the context of social arrangements and can be addressed through initiatives in the proximate environment and changes in the broader social, economic, and cultural determinants, as well as at the individual counselling-therapeutic level.

# Sociocultural contexts and Suicide (Continued)

the U.S. military been weakened by reduced home support or was it also due to the Iraqi war situation itself? Of course, Berg and others cited other factors too, such as being away from home, danger, fear and sleep deprivation. There may also be other factors which may not become public. Perhaps the number and manner of deaths and maiming of Iraqi civilians; women, children, and men, and now public knowledge of torture of prisoners could stimulate shame or guilt among some of the military even if suicide's themselves were not personally involved in such practices. As Frankl, Deurzen-Smith and the US. Report "Hardwired to connect" (2003) - all discussed later- say, human beings have a need for social connectedness and for deep connections to moral and spiritual meaning. In such a military context as the one in Iraq, deep despair, depression or suicide may result among some soldiers who cannot accept some of the consequences.

If suicide was solely a function of individual agency and not cultural factors as argued by Durkheim then rates of suicide should remain relatively stable over time and among societies. Durkheim hypothesized that if some societies compared with others had considerably greater rates of suicide, other variables beside individual agency were responsible. To test this hypothesis Durkheim conducted comparative and inter-cultural research and found that people feel isolated and disconnected when community, group, and family relationships were weak. Under such circumstances people feel vulnerable to suicide and his research demonstrated this. He connected this reduction in social connectedness to significant social changes. This disconnection is particularly so if people live in a society that emphasizes individualism which can increase feelings of alienation from their group and social dislocation. Durkheim witnessed rapid social and industrial change. This created a normative vacuum resulting in what he called 'anomie' (a state of normlessness) in this situation previous cultural values held little applicability and some people became prone to suicide.

Young adults are now faced with constant pressure to change careers and re-skill. Those who cannot, may find themselves unemployable denying them the role of work that allows young adults to undertake adult life-stage consolidation tasks, and seeking purpose and meaning.

Durkheim's historical research is still relevant to researching suicide in contemporary society. If we focus solely upon the individual and consider depression, frustration or unhappiness it does not really tell us much about why there has been such dramatic rise in suicides over the last 40/50 years. To understand this increase in suicide rates we need to also consider the social and institutional factors involved in the situation. When a rapid rate of significant change takes place such as: in economic structures, employment, social values and institutions or in the environment such as wars or epidemics then disorientation and anomie can arise. Durkheim's research found this to be the most common form of suicide.

> *But there is another form of suicide for Durkheim which results from lack of regulation of the individual by society. This he called anomic suicide and is a chronic state in the modern economy. (Simpson,1951:15). Introduction to Durkheim's Suicide.*

Simpson in his introduction to Durkheim's book explains this further. The individual's needs and satisfaction have been regulated by society included the common beliefs and practices which she/he has learned. So if and when this integration is disturbed then the individual's horizon is broadened beyond endurance or restricted unduly. Perhaps many young people today in one sense have broadened horizons in that they are told how free they are; how important individualism is and they have the world at their feet. Yet in another sense they are restricted in terms of received cultural values, the precariousness and uncertainty of employment and the fragility of relationships, and what can realistically be achieved. Then, under such conditions of reduced integration, anomic suicide tends towards a maximum according to Durkheim.

Younger people today may now experience more marginalisation because of reduced options for legitimate social participation. For example, adolescence is now seen as a discrete developmental period with few community based rites of passage to full social participation such as working within a family business, apprenticeships, compulsory military service or even being given a chance of working one's way up from a low educational base. Young adults are now faced with constant pressure to change careers and re-skill. Those who cannot, may find themselves unemployable denying them the role of work that allows young adults to undertake adult life-stage consolidation tasks, and seeking purpose and meaning. Highly competitive education systems now provide the primary pathway to social participation in both Western and Eastern countries. When anomie increases people's social anxiety increases and they seek clarity regarding rules and guidelines to live by. Younger people who are unable to develop, and are not given, a set of guidelines for adapting to the harsh realities of individualistic social expectations may exhibit familiar symptoms that might increase risk of suicide such as inability to manage stress, anxiety, or depression and adapt to challenges. Some are liable to suicide, primarily through the familiar disempowerment or social disenfranchisement which presses hardest upon those among the 15-34 age range. May promotes the concept of 'modern man's' loss of significance to explain these factors (1979).

"In certain historical periods the dilemmas of life become more pronounced, more difficult to live with, and harder to resolve. Our period, the middle of the twentieth century is one such time"(May,1979:23). How much more so is this true, then, of 2004? People feel overwhelmed by the speed and impact of technology and science and its paradoxical effect of being both empowering and disempowering. What is our individual significance when we are told how imperfect and fallible we are when viewed through the lens of such advances? Medical research gives us the same message that greater numbers of people are living with health problems requiring prescribed remedies. There is increased talk that medical science needs to prevent the passing on of genetic risk to the next generation. MacFadden (2001) considers genetic medical intervention is required because: "Replication of our chromosomes introduces errors called mutations" from parents to children and without manipulation humans will become increasingly defective. Broderick says by 2030 – 2050 a technological "spike" will occur which makes the

future just unknowable. We may be transcended by the development of super- intelligent and conscious machines. He adds that such machines may not be introduced nor will we necessarily produce genetically improved super humans (1997). But the reductionism of humanity and vulnerability of the individual is still clearly implied by these sorts of pronouncement.

We increasingly relate to objects and less to people. Reality is blurred with virtual reality. Modern sociologists have referred to this as the rise of hyper-reality; i.e. creating the expectation that life has to be more intense and exciting than it can realistically be. Aimed squarely at youth and marketed through many mediums such as TV shows, magazines, internet, computer games, commodification etc, the first generation of hyper-reality people are now adults and parents themselves For many, shopping is seen the primary social activity. Identity was traditionally related to group membership in our society; today's social identity may relate to a few significant individual relationships. Internet friendships may be the ultimate form of this phenomenon. As May, said the 1950s was a search for identity when humans felt they could make a difference as individuals. In the late 1960s and 1970s he argued many now felt: "Even if I did know who I am, I couldn't make any difference as an individual anyway" (1979:26).

Many people increasingly view the world as impersonal and anonymous; feel that they are powerless in any real sense yet are still 'fed' the myth of meaningful autonomy. Lasch wrote in 1978 that the major characteristic of modern societies is a culture of narcissism. Yet by 1984 he found not so much focus on hedonism, self-seeking and indifference to the general good, but more on retreat. His argument became that we had lost confidence in the future being faced with an arms race, increases in crime, terrorism and environmental deterioration. So we did no longer believe the political system would humanize society. The focus, therefore, became on a need to survive and retain a 'minimal self.' This has much in common with May's findings. Gergen believes that with the new technologies, computer communications, TV, mobile phones, radio, junk mail, advertisements and political persuasion the individual has become a 'saturated self.'(1991). Other writers refer to the trivialization of identity. Yet in all this the young individual has to make her/his way. People need to have a sense of meaning. Yet the constant telling of young people that they must be competitive individuals in order to be socially acceptable has proved autonomy to be a two edged sword. For some, in their confusion, it is a negative liberty signalling lack of restraint and the freedom of self-expression without heed to social consequences. Yet most sincerely wish to find their place in society and finding a meaning for being.

> *Our society's crisis has produced an enormous surge of Spiritual searching. A new world view that makes a place for a reality that goes beyond the limited 'reality' of materialism is desperately needed. (Clinebell,1995:90)*

Frankl has researched and written about an "existential vacuum" in which many people are in a state of meaninglessness. Humans are meaning-seeking creatures and seek to make sense of themselves and their world. Central to this is to have a sense of meaning in their lives and also a sense of ultimate or spiritual meaning. He insisted that meaning had a survival value. When we feel meaningless we are in an existential vacuum, and prone to ill health (1997/1948). This may be avoided or reduced by strong interpersonal connections to community and culture to enable one to connect to meanings to personally live by. Kierkegaard wrote about anxiety and saw it as a fear of nothingness; this was not only the existential fear of dying and ceasing to be but of living as a nonentity; of not being truly a person (1844). Now, says May: "…such anxiety is endemic throughout our whole society" (1979, 37). If only the following amusing attribution could have been the truth about suicide then we could all drink coffee!

One 18th century man came up with a novel reason for suicide.

> *Since tea has been in fashion, even suicide has been more familiar amongst us that in times past. (Jonas Hanaway, 1712- 1786)*

Another statement of some 4000 thousand years ago speaks tellingly of suicide ideation and it is a powerful and poignant expression. It also demonstrates the importance of social connectedness and of feeling at "home" in one's world a lack of which can lead to mental illness, reduced wellbeing or suicide. Death, here, is seen as being a welcome release.

> *To whom can I speak today? Brothers are evil and the friends of today unlovable.*
>
> *To whom can I speak today? Gentleness has perished and the violent man has come down on everyone.*
>
> *To whom can I speak today? I am heavy-laden with trouble through lack of an intimate friend.*
>
> *To whom can I speak today? The wrong, which roams the earth there is no end to it.*
>
> *Death is in my sight today as when a man desires to see home when he has spent many years in captivity.*
>
> *( circa 1990 BC./BCE.) anonymous.*

We increasingly relate to objects and less to people. Reality is blurred with virtual reality.

The above statement relates suicide ideation to a lack of social bonds and to the individual's view of the world in which he felt a stranger; a world in which he could not reach out and become involved. He felt unable to carry on.

Schweitzer and others in an Australian university based study, (1995) evaluated the degree of suicidal ideation among undergraduate students. Undergraduates are considered a higher risk than high school students. 21% of student scored as having minimum ideation, that is 'life just isn't worth living,' 19% had a higher ideation, wishing 'my life would end,' 15% demonstrated suicide-related behaviour, and 7% had made attempts to 'kill myself.'

Eckersley, an Australian researcher, examined 21 developed nations and found that: "…male suicide rates were highest in the most individualistic countries. The more personal freedom and control over their lives young people felt they had, for example, the higher the suicide rate." (2001:2). He went on to say individualism might influence suicide and other problems by means of its effect on social institutions

# Sociocultural contexts and Suicide (Continued)

such as the family. (2001). A highly individualistic society places pressure on young people to be high achievers in accordance with debatable normative behaviours. This is another cultural value and imposes on people a constant message; "measure up" or be judged by society as a failure. British researchers Michael Rutter and David Smith think that more investigation is needed into the theory that changes in moral values and concepts are the causes of the increase in psychosocial disorders. In particular there has been: "…the shift towards individualistic values, the increasing emphasis on self-realisation and fulfilment and the consequent rise in expectations" (1995). Interesting as it is, this paper cannot consider connections to liberal and post-liberal theory, for example the belief in full autonomy; that people are free and rational individuals rather than being involved in and at least partly constituted by social narrative. Hochschild, a feminist, has written on global consumer capitalism and its emotional dangers. She argues that it is eroding the social fabric and that in many instances it is degrading individualism into self-referential obsession and narcissism. (2003). Yet these attitudes and behaviours are not just plucked out of the air by young people they are socially transmitted. British writer Will Hutton reports that even at expensive schools in the UK. Parents may not support the school's values as intrinsically desirable. At one such prestigious school the headmistress Mary Steel: "…deplored the values vacuum they {parents} created for their children" She went on:

> *Everyone in society now only seems to be concerned with their own achievements and ambitions; we are in danger of creating a rootless generation. (in Hutton,2003)*

"Parents routinely lied to excuse their children from speech days or sports; there is no loyalty to the school as a social institution or pleasure in the achievements of others."

Hutton explained that she also said: "Parents routinely lied to excuse their children from speech days or sports; there is no loyalty to the school as a social institution or pleasure in the achievements of others." Both the Headmaster's and the Headmistresses Conferences and the National Association of Schoolmasters and Union of Women Teachers have recently warned that the culture of self-gratification has invaded every family to a greater or lesser degree and there is ever less support from parents in attempting to instil loyalty to social norms or promotion of the social good. (Hutton,2003). This, then, is also about parents (and other agencies) a key agency of child and adolescent socialisation and cannot be glibly attributed solely to self-referential, hedonistic young people. There has been a rise in self-indulgence amongst young people as well as older generations but the contexts in which this arises is often unfairly omitted. Unfortunately young people are often the victims of media generalisations and blamed uncritically as being apathetic, pleasure-seeking drifters. Yet such critics fail to comment upon the nature of society, of the corrosive impact of job insecurity even if jobs are available, of the rising costs of tertiary education, and housing and of the lack for many of them of the power of effective freedom of life style choices.

An Australian survey by "beyond blue, the national depression initiative" found "…young people rank drug and alcohol abuse, depression and other mental problems as among the most serious health issues facing their generation." These issues included suicide (Dunn, 2003). In recent years male suicides outnumber female deaths by a ratio of 4:1. Suicide ideation among young age ranges has risen in recent years three-fold. Actual suicides account for 25 per cent of all male deaths in the 15-24 age range, and 17 per cent among females. As the Wesley Mission notes in addition to suicide in the young: "Middle- age male suicide is increasing…the rate of suicide in men over the age of 75 is also a growing concern" (2004:2). Part of the reason for the comparatively high rate for males is the choice of lethality. Males choose firearms, hanging, carbon monoxide and then poisoning. This makes the decision to suicide more likely to be final. In the last few years death by fire arms has fallen due to restrictions placed on sales. In the period 1991-2001 the number of suicides from firearms fell from 505 to 261 according to the Australian Institute of Criminology. Whereas females use hanging, poisoning, carbon monoxide and then firearms. Statistics on attempted suicides: crisis counselling and anti-depressant prescriptions suggest that females have a greater rate of depression than males: yet the actual suicide rate is far less. Females are more likely to talk about their problems than males, and, as the above suggests, seek professional help. Further the need to outwardly achieve or be successful may be more salient aspects of the male sense of identity. Maybe these rates also reflect the rate of depression – depression is the single biggest risk factor for suicide.

What of the U.S.A.? The Commission on Children at Risk in 2003 produced a report "Hardwired to connect" to investigate and recommend on: "The deteriorating mental and behavioural health of U.S. children" This included the rise in suicide ideation and in actual suicide. The report records that:

> *But during this same period {1950s-2003} homicide death rates among U.S. youth rose by more than 130 per cent. Suicide rates- the third leading cause of death among U.S. young people, and famously recognized more than a century ago by Emile Durkheim, one of the founding fathers of modern sociology, as a key indicator of social connectedness- rose by nearly 140 per cent. More and more, what is harming and killing our children today is mental illness, emotional distress, and behavioural problems. (Hardwired to connect,2003:10).*

My understanding of the report 'Hardwired' is that in order to increase prevention and to reconnect people an ecological model is required, grounded in the sociocultural context of human interactions involving desirable norms and values. It suggests this as a practical and necessary aid to easing contemporary mental, emotional and behavioural problems, and to taking back the responsibility of socializing young people. To this end it recommends that social institutions involved in nurturing children and adolescents need to reclaim a positive and ongoing role in building and maintaining connections. "In large measure, what's causing this crisis of American childhood is a lack of connectedness. We mean two kinds of connectedness- close connections to other people, and deep connections to moral and spiritual

meaning"(2003:5). It says that social institutions need to be revitalized in order to reconnect with the young. These include: the family, the extended family, civic, recreational, educational, community service, business, cultural and religious groups that serve or include persons under the age of 18.

Some commentators say that as suicide is rare it cannot be clearly related to the social context, However, suicide does not arise in a vacuum. Researchers like Durkheim and others, including the authors of "Hardwired"(2003) provide a powerful reinforcement of Lemma's answer to this critique: "In order to understand any type of behavioural response it is essential to consider the complex interaction between the person and the environment" (1996:107). Eckersley puts this very strongly:

> *"… while suicide remains rare among young people, it is the tip of the ice berg of psychological pain, with many, many more thinking about attempting suicide, or suffering depression and other mental health problems" (1998:51).*

British researchers agree, Rutter a child psychiatrist and Smith a criminologist say that research evidence suggests that the rates of suicidal behaviour, drug abuse and depression have increased in nearly all developed nations over the last fifty years (1995). So, too, 'Hardwired to connect' which, in reporting on the deteriorating mental and behavioural health of U.S. children, records that: "We are witnessing high and rising rates of depression, anxiety, attention deficit, conduct disorders, thoughts of suicide, and other serious mental emotional and behavioral problems among U.S. children and adolescents''. (2003:5). The implication is that young people today are lacking a sense of meaning and purpose and that this mainly arises because social agencies such as the family and other institutions are failing in their role of social connection to, and of social integration with young people and young adults. It is true that individuals must make their own decisions, nevertheless, given the increased disconnectedness and rampant market-driven values, the message seems to be: live in the world on our terms or else. But many young people are urged from deep within themselves to seek the "or else" for themselves; it may even be preferable. Meanwhile their turmoil remains. This can be put into a wider perspective embracing the deep concerns of older age groups as seen in American surveys.

The PEW Research Centre in a 1999 survey found that Americans had concerns regarding the moral climate. Only a minority thought life was better since the 1950s. People were uneasy with how the country had changed culturally and spiritually. In 1999 a Gallup Poll gave forty nine per cent believing there was a moral crisis in the USA with another forty one per cent citing major moral problems. This was in line with a survey carried by The Washington Post, Harvard University and the Henry. J. Kaiser Foundation in 1998. Here seventy six per cent of Americans thought the country was seriously on the wrong track. A particularly interesting Study in 1995 by the Merk Family Fund found that Americans were deeply concerned that the core values that were driving their society; those of greed, excess and materialism not only characterised how Americans lived but underlay most of their problems. The core values these surveyed adults are concerned about are those that are legitimated by and enshrined within the macro politico-economic system. So when many adult Americans express these concerns it is no wonder younger people are confused, often alienated and finding the search for connection and meaning difficult.

In light of what been said perhaps the role of counselling/therapy in helping create sociocultural reconnection to younger adults is increasingly relevant.

The case has been made that many younger people are searching to locate their "self" within their society and yet attain or regain individual significance and meaning. As radical sociocultural change that will eliminate or significantly reduce anomie is unlikely in the short term, counselling/therapy might have a unique contribution to make to assist younger people locate themselves and create meaning ultimately reducing the risk of mental ill-health. Counsellors/therapists typically seek to understand how the client's individual and broader sociocultural context define their sense of identity and social relatedness. Heidegger insisted people may understand their own situation by examining their lived experience of being human in the world |(1927|). In other words the counsellor does not consider the client abstracted from her/his world but the degree of immersion in it and what it means to them. Counselling/therapy from this perspective draws from the sociocultural argument developed in this paper.

"We are witnessing high and rising rates of depression, anxiety, attention deficit, conduct disorders, thoughts of suicide, and other serious mental emotional and behavioral problems among U.S. children and adolescents"

Binswanger (1963) identified three dimensions in which the individual lives in the world. 1.,Umwelt or the physical dimension which involves our interaction as a physical being with our natural world. 2.The Mitwelt or our social dimension and our interaction with others. 3.The Eigenwelt is the psychological or personal dimension. This involves a personal self-concept and identity. Deurzen-Smith(1988,1995 and1997), added a fourth dimension that of the Uberwelt or the spiritual dimension. Obviously all four dimensions overlap and interrelate but addressing them can produce awareness and understanding for both the counsellor and the client and allow them to proceed.

A client may find awareness of their being does not require a move from one situation to another. Sometimes she/he may essentially need to understand the situation, have it clarified and be confirmed in it. We each need to understand our individual place in the world and realize that it necessarily involves tensions, disappointment, losses and uncertainties as well as joy, pleasure, gains so we can look realistically at our being in context. In a world that no longer provides clear pathways and directions for full social participation and identity the individual must create these for her/him self. Our essential job is to help the client find and accept themselves with their limitations and possibilities and able to take up the challenge to be positively involved in life. The aim is to help clients to encounter their world responsibly, meaningfully and as authentically as possible. In order to make use of the above four dimensions human

# Sociocultural contexts and Suicide (Continued)

nature must be viewed as adaptive and open-ended allowing for growth and a range of experiences. These four dimensions have been written about extensively by Deurzen-Smith (1988,1995 and 1997), and discussed below.

In the physical dimension we interact with our environment. This involves relating to our own body, to our health, illness, to possessions, security, ageing, loss and our own eventual death. We become aware of challenges, prospects and limits. Next, in the public or social domain, we interact with others, with social events and circumstances, and with our culture and institutions. As in the physical arena, we also develop attitudes, values and beliefs. How do we belong and fit in? Do we fully join it as part of a conformity or collectively? Do we attempt some accommodation and how do we feel about it? Next is the personal or psychological dimension. This includes the process of developing our own personal world and how we view and value it. Are we able to validate it to ourselves? This also involves looking to our own internal resources, our strengths and weaknesses and our view of opportunities, challenges and limitations. The sense of possessing a worthwhile identity is important here. Fourth is the spiritual dimension is where we consciously or not come to accept an ideology, a weltanschauung or world view which we operationalise as our own perhaps without realizing it. I discussed this in an earlier ACA article (Ray,2003). This dimension may or may not include a belief in God, or membership of an institutionalised religion. It involves a search for meaning and purpose and the finding of "…values in the search of something that matters enough to live and die for, or something that may even be ultimate and universally valid." (Deurzen-Smith, 1995:5).

This dimension may or may not include a belief in God, or membership of an institutionalised religion. It involves a search for meaning and purpose and the finding of "…values in the search of something that matters enough to live and die for, or something that may even be ultimate and universally valid.

It is interesting to think of this in light of the biological and psychosocial research findings in the US. Report "Hardwired to connect" (2003), which confirms this dimension. Of course, all dimensions are interrelated and hopefully eventually integrated by the individual in life's journey. However they must also be lived out in the knowledge of polarities such as life and death, love and hate, security and insecurity, happiness and unhappiness, togetherness and aloneness, and so on. It may be that given the contextual settings we have been talking about the client and counsellor/therapist will benefit by using this approach, at least in the early stages. It can help enable both to clarify and become deeply aware of where the client is in her/his world at present. From this insight they, the client and counsellor/therapist, may then productively move forward. This can be illustrated

by an Australian therapist who studied, researched and worked with Carl Rogers.

> *One's field of perception is influenced by various factors; needs at the time, values, relationships, the groups and community of which one is part and the still broader context of culture and environment. Whatever goes into the mix from which a person's view of reality emerges it is by this view that he or she largely acts. (Barrett-Lennard, 2003:113).*

As friends or family members we can look for signs of psychological disorder such as depression or substance abuse, or of personal decline for example at school among friends or family or, of course, of behavioural problems. If suicide ideation is expressed then obviously professional help should be sought. Parents and other family members of a child or sibling who commits suicide may spend a lifetime grieving and even harbouring shame or blame. Yet one should also realize that not all suicides give a clear clue to family members sometimes more so to friends. Also, as seen above, there may be powerful socio-cultural factors outside the family involved. A climate of open communication, unobtrusive vigilance, a family culture of care and concern amongst all members and a line of communication to the friends and teachers of ones children can be helpful in feedback. Even then disturbed youngsters may still be secretive. We should be prepared to listen to the realities as expressed that underlie distress or despair and possible suicide even if they are not our realities and seek as an individual to make a difference.

Although the focus has been on suicide, it can be readily seen that the sociocultural context discussed also influences a wide range of mental, emotional and behavioural issues, some of which have been briefly mentioned. It has been made clear that this paper has looked at the social rate of suicide and the social structural setting and this context is an important complement to the approach of the individual counsellor/therapist. Counsellors/therapists have a unique role to play in assisting individuals negotiate the contemporary sociocultural context and reduce the risk of suicide and other mental and emotional problems in younger people. The helping professions work is vital and continuing but social causes are also fundamental and reconnecting children and adolescents with social institutions is vital and urgent.

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I am grateful to Dr. Matthew Bambling, Dept of Psychiatry, University of Queensland for his reading of the draft and valuable comments.

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ACA

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# Changes to the Firearms Act 1996 Section 183

I am writing to inform you of recent amendments to the Firearms Act 1996 (the Act) relating to immunity from liability for health professionals and outline how they effect the State of Victoria's Professional Counsellors.

Section 183 of the Act now includes the provision for Professional Counsellors to inform the Victorian Chief Commissioner, through the Licensing Services Division (LSD), if they believe a person whom they are providing professional services is not fit or proper to possess, carry or use a firearm.

A Professional Counsellor may also advise, if the advice is good faith, if they believe that a person for whom they are providing professional services has a licence under this the Act, has intention to apply for a licence or possesses or intends to possess a firearm.

Below is an extract of Section 183 of the Act detailing the requirements and also the legislative definition of health professional.

***Section 183. Immunity from liability***

*(1) Despite section 141 of the* ***Health Services Act 1988****, section 120A of the* ***Mental Health Act 1986****, section 16 of the* ***Intellectually Disabled Persons' Services Act 1986*** *and any other similar enactment or provision if a health profession believes -*
*(a) that a person whom he or she has been providing professional services is not a fit and proper person to possess, carry or use a firearm; and*

*(b) that that person has a licence under this Act or intends to apply for a licence under this Act or possesses or intends to possess a firearm – the health professional may so advise the Chief Commissioner, and is not subject to any civil or criminal liability for doing so, if the advice is given in good faith.*

*(4) In this section* ***"health professional"*** *means any one of the following –*

*(a) a registered medical practitioner;*
*(b) a registered psychologist;*
*(c) a registered nurse;*
*(d) a prescribed class of social worker;*
*(e) a prescribed class of professional counsellor.*

It would be of great assistance if you could inform your members of the changes to the Act and their responsibilities as outlined.

*David Pettman*
*Assistant Director Superintendant*

ACA

Section 183 of the Act now includes the provision for Professional Counsellors to inform the Victorian Chief Commissioner, through the Licensing Services Division (LSD), if they believe a person whom they are providing professional services is not fit or proper to possess, carry or use a firearm.

# Internet and Computer Resources Compiled by Angela Lewis

We can all benefit from knowing more about efficiently locating information on the Internet, so this month is devoted to getting the best out of the Google search engine, as I share below all the ways that I work with Google myself. (In order to try these things out go to the site www.google.com).

### *Search within Results*

Many times you do a search and find you receive hundreds or maybe thousands of sites to search through – a daunting prospect! You can search through the list of sites and further refine the search by going to the bottom of the listed websites and clicking *'Search Within These Results'* and then typing in a search criteria that will help you search through the listed websites.

### *Make it Local*

Think about if you want your results to come from all over the world, or just from Australia. Many times you can narrow the search significantly and make it relevant by searching only Australian sites. Click the 'pages from Australia' option under the search box in Google.

### *Cache It*

How many times have you clicked a link to find that the web address no longer works? If you can't access a website that comes up in a Google search, click the Cached link. The cache is the copy of the web page that Google found the first time it added it. It may be out of date, but it will still give you access to that website from the first time that Google found it. Cache example below.


### *Search the News*

The Google news site updates itself with headlines form around the world every 15 minutes. Click the link for '**News**' in the Google toolbar. If you want to read news from Australia, click the 'Australia' link on the left-hand side of the screen.

### *Using Talking Marks*

If you are looking for an exact phrase such as "Toyota RAV4", then type your phrase in the search box in quotation or talking marks. Based on this example, webpages that contain only Toyota or only RAV4 would not be found, only those with the words 'Toyota RAV4' would appear.

### *Use the Google Toolbar*

You can download the Google Toolbar which incorporates the Google search box in the Internet Explorer toolbar so that you can do searches from within any webpage. As an added bonus, the Google toolbar comes with a pop-up stopper (those annoying windows that pop up with advertisements).

Find it located at: http://toolbar.google.com/ .

### *Search only the Titles*

Restrict your searches to a particular word appearing in the title of the webpage as opposed to within the body by doing an 'Intitle' search. In the Google search box type intitle: what you are searching e.g. in the example below I was searching for webpages that had the word 'gender' in them.


### *Search for Similars*

Use the Tilde symbol on the keyboard (it looks like this ~ - top left above tab key, hold down the shift key at the same time) to indicate you want to search for pages that contain words that have the same meaning as the word that follow the tilde. E.g. If I type ~Gender into the Google search box, I will get webpages that contain words such as woman, women, female, culture, male etc.

### *Search Google Groups*

If you can't find what you are looking for out on webpages, try searching in the Google Groups. There many news and interest groups holding a wealth of information, which are not be default searched when you do a webpage search. Click the Group tab before commencing your search.

## WEBSITES:

### *DNA Testing*

I actually stumbled upon this one while researching for my gender identities article. This Australian site offers DNA testing kits. They are not cheap, starting at $495 for 99.9% accuracy, and up to $780 for the court approved test; however for people with paternity issues, I would imagine this is a relatively small price to pay.
http://www.dnanow.com/ausmain.htm

### *Alzheimer's Disease*

This Australian site caters for anyone who has contact with someone suffering with AD. It offers support and education as well as creating community awareness. www.alzheimers.org.au

### *Seniors*

There are a surprising number of initiatives available for senior citizens. This government website lists services, programs and initiatives currently available to Australian senior citizens. www.seniors.gov.au

Please note that all 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 (np) practices as a corporate adult educator in Melbourne (computer training) www.AngelaLewis.com.au

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# Disease Model of Addiction By Terry Gorski

My name is Terry Gorski. I'm the President of the CENAPS Corporation, a training and consultation firm that specializes in chemical dependency and related behavioral health problems. I am pleased to have this opportunity to discuss with Dr. Marlatt the issue of whether Alcoholism does or does not meet the criteria of being a disease.

The way that we conceptualize alcoholism and other drug dependencies is critical to the development of effective policy for its treatment. Effective policy is necessary to secure the adequate resources needed for its treatment.

*If alcoholism is defined as a disease*, it will be treated as a healthcare problem. As a result, alcoholics will be assured the right to receive appropriate medical treatment for this disease. The treatment of Alcoholism will be covered by health insurance and other health care financing plans in both the public and private sectors. The appropriate health care groups will be mobilized to support its treatment. And, most importantly, ongoing biomedical research which relates alcoholism to other diseases will be funded.

*If alcoholism is not defined as a disease*, we will be making the decision that it does not rightfully belong within healthcare. Alcoholics, then, will be denied access to vital healthcare services. Insurance and other health care financing plans will exclude alcoholism. Alcoholism, which is responsible for 30% of all inpatient hospital days and nearly 50% of emergency room visits, will be divorced from the medical field. As a result it will never be fully integrated into our health care system.

If alcoholism is not defined as a disease, we will be making the decision that it does not rightfully belong within healthcare.

### *If Alcoholism is not a disease, then what is it and how should society deal with it?*

The answer to this questions is vital. If alcoholism is not a disease, then it is not a healthcare problem. If it is not a healthcare problem then the healthcare system that is devoted to the prevention, early identification, and treatment of disease should not become involved with those afflicted with alcoholism. If this is the case, where should the alcoholic go to receive treatment?

To say that Alcoholism is an "addiction", an "affliction", or "an appetite habit disorder" is to avoid the key question: "Does Alcoholism meet the criteria of a disease?" If we call alcoholism by another name, we must still apply the same question. If we call it an *addiction*, we must ask the question "Does an addiction meet the criteria of a disease?" If we call it an *affliction*, we must ask the questions "Does an affliction meet the criteria of a disease?" If we call it an appetite habit disorder, we must ask the question "Does an *appetite habit disorder* meet the criteria of a disease?"

To answer the key question of whether or not alcoholism (or whatever we choose to call it, is a disease, we must look to the technical definition of "disease" and then look at the phenomena of alcoholism and see if it meets that criteria.

### *What is a "Disease"?*

To intelligently discuss the issue of whether or not alcoholism is a disease, we must first define the term "disease". To do this I turned to the 24th Edition of the Stedman's Medical Dictionary which provided the following definitions.

1. A disease is a morbus, an illness, a sickness that causes an interruption, cessation, or disorder of bodily functions, systems, or organs
2. A disease is an entity characterized by at least two of these criteria:
   (1) a recognized etiologic agent (or agents);
   (2) an identifiable group of signs and symptoms; or
   (3) consistent anatomical alterations of known body systems.

To determine if alcoholism is a disease, we must see if it meets this definition.

My position is that alcoholism is a disease. This position is shared by many prestigious organizations including the World Health Organization (WHO), the American Medical Association (AMA), and the American Psychiatric Association (APA). The Congress of the United States of America formally acknowledged that Alcoholism was a disease with the passage of the Hughes Act in 1970. The National Institute on Alcohol Abuse and Alcoholism (NIAAA) was created to promote research on the nature of this disease. A major thrust of NIAAA has been on the biomedical aspects of this disease and much progress has been made in understanding its etiology, symptoms, and treatment.

There is a good reason for taking the position that alcoholism is a disease - alcoholism meets all of the criteria of a disease as defined by any medical dictionary or text book.

Let's go back to the Stedman's Medical dictionary's definition of a disease as see if these criteria accurately describe the phenomena of alcoholism. To do this we will need to systematically answer two questions:

1. *Is alcoholism "an illness or a sickness?*
2. *Does alcoholism causes an interruption, cessation, or disorder of bodily functions, systems, or organs?"*
3. *Is alcoholism "an entity characterized by a recognized etiologic agent (or agents);*
4. *Is alcoholism "an entity characterized by an identifiable group of signs and symptoms?"*
5. *Is alcoholism "an entity characterized by consistent anatomical alterations of known body systems?"*
6. *Do all people who experience alcohol problems have the disease of alcoholism?"*

Let's systematically answer these six questions.

### *Question #1: Is alcoholism "an illness, or "a sickness"?*

The answer to this question is yes. Alcoholism is a leading cause of death in the United States. Alcoholism is a major factor in rapidly growing healthcare care costs. Nearly 30% of all inpatient hospital days and 50% of all emergency room visits are devoted to the treatment of medical problems related to alcoholism. Anyone who has known an actively drinking alcoholic will attest to the fact that they get physically sick. This is evidence by the fact that known alcoholics have significantly higher utilization of medical treatment than non-alcoholic patients.

Even Dr. Marlatt will concede that Alcoholism is "an affliction". There seems to be universal agreement that alcoholics become ill or sick in the medical sense of the word and seek treatment in large numbers that illness or sickness.

***Question #2: Does alcoholism cause an interruption, cessation, or disorder of bodily functions, systems, or organs?"***

Again the answer is yes. There is a definite profile of alcohol-related damage to body systems and organs that usually does not occur in people who do not have alcoholism. The major organ system that is affected is the brain. There is clear evidence from neuropsychological studies that alcoholics have cognitive impairments related to the organic damage caused by chronic alcohol poisoning to the brain. The DSM IV clearly identifies and differentiates "substance related organic mental disorders" and describes their direct correlation to alcoholism.

Many other organ systems are also affected. There is a specific profile of alcoholism related damage to other organ systems. The liver, the pancreas, the heart, the endocrine systems among others are all affected.

Alcoholism can be a fatal disease. Many alcoholics die from their alcoholism each year. Why? Because if the alcoholic continues to drink heavily and regularly the organ system problems will become fatal. The NIAAA informs us that alcoholism is the third most common cause of death next to cancer and heart disease among adult Americans.

***Questions #3: Is alcoholism "an entity characterized by an identifiable group of signs and symptoms?"***

Again, the answer is yes. But here we must be careful to make careful distinctions between alcohol use, alcohol-related problems, and alcoholism.

About 70% of all Americans use alcoholic beverages on a regular enough basis to be defined as "drinkers". About 60% of these drinkers (40% of all Americans) consume alcohol in moderation and experience no problems. These people experience alcohol use, which definitely is not a disease. About 40% of these drinkers (30% of all Americans) consume large amounts of alcohol and experience some problems as a result of their use. These people experience alcohol-related problems which DSM-IV defines as alcohol abuse.

Since these alcohol abusers do not develop biomedical conditions related to their alcohol abuse, this group does not technically meet our definition of disease. Alcohol abusers, however, are engaging in high risk behaviors that can lead to alcoholism.

About 10% of these drinkers (7% of all Americans) develop biomedical complications as a result of their alcohol abuse. These people definitely meet the criteria of having a disease. For the moment, let's restrict our attention to this 10% of people with alcohol-related biomedical conditions.

There are clearly described signs and symptoms that are associated with alcoholism. These signs and symptoms were originally identified at the turn of the century and have been studied and clarified since.

Many researchers and leading professional organizations including the American Medical Association and the American Psychiatric Associate recognize these signs and symptoms. With that in mind let's briefly review the history of the discovery and refinement of the signs and symptoms of alcoholism.

The IOM Report to Congress based its reasoning upon a model that describes alcoholism as existing on a continuum of alcohol-related problems. Let's look at how we can use this model to correctly reason to the conclusion that there are a large numbers of individuals that have a profile of alcohol related problems (i.e. signs and symptoms) that meet the criteria of having a disease.

***Continuum of Alcohol Problems Model***

According to the Institute of Medicine Report to Congress, alcohol problems exist on a continuum of severity from mild to severe. The following is one set of criteria that can be used to place different profile of alcohol related problems on this continuum.

1. *Mild problems* create subjective distress and interpersonal conflict but do not result in social or occupational impairments.
2. *Moderate problems* create periodic or persistent social and occupational impairments and minor health problems but do not result in incapacitation.
3. *Severe problem* result in periodic or persistent incapacitation as a result of severe physical, psychological, or social problems.

About 70% of all Americans use alcoholic beverages on a regular enough basis to be defined as "drinkers". About 60% of these drinkers (40% of all Americans) consume alcohol in moderation and experience no problems.

***Mild Alcohol Problems:***

People with mild alcohol problems (i.e. those who have experienced only subjective distress or mild interpersonal conflicts related to alcohol or drug use) do not, at that moment, meet the criteria of having the disease of alcoholism because: there is not a full and complete profile of signs and symptoms and there is not sufficient evidence of a disorder marked by structural or functional impairment.

Some individuals who experience mild problems with alcohol or other drugs will progress to more severe problems. Others will not. In those who experience a progression from mild to severe problems, the rate of progression will vary from gradual to rapid. This variance in the rate of progression, as we will see latter, can form the basis of developing subtypes of alcoholism.

There is currently no absolutely reliable way to predict which individuals will experience progression and which will not, although risk of progression increases with evidence of genetic, prenatal, and familial risk factors, an d early age onset of initial problems.

It is reasonable to assume that the mild alcohol-related problems in individuals who eventual progress to severe problems may, in fact, be the early stage symptoms of alcoholism. Since, however, reliable predictions cannot yet be made as to who will and will not experience progressive problems, definitive diagnosis based upon mild alcohol problems cannot yet be made. As a result it is best to describe such individuals as being in high risk of developing alcoholism rather than conferring the definite diagnosis of alcoholism. As can be seen,, as of this

# Disease Model of Addiction (Continued)

presentation it is not appropriate to describe the mild alcohol-related problems as a disease.

### *Severe Alcohol Problems*

People who have developed severe problems with alcohol and drugs have a consistent profile of alcohol and drug related problems that can appropriately be classified as a disease. Most individual who develop severe problems with alcohol and drugs share the following signs and symptoms:

(1) Severe subjective distress;
(2) severe interpersonal conflicts;
(3) severe social and occupational problems; and
(4) incapacitation as a result of severe physical, psychological or social problems.

The profiles of the symptoms of patients with severe alcohol problems have been well mapped and constitute the basis of many well accepted diagnostic typologies that meet the criteria of a disease. Let's review some of the most notable.

### *Moderate Alcohol Problems - The Borderline Cases*

It is clear that people with mild alcohol problems do not meet the criteria of having a disease. It is also clear that people who have severe alcohol problems do, for the most part, meet the criteria of having a disease.

DSM IV places a heavy weighting upon the pattern of compulsive use as the primary factor distinguishing between abuse and dependence.

### *Where Do We Draw The Line?*

Now we must turn to a critical issue. Where do we draw the line between having the disease of alcoholism and not having it? How do we correctly classify the people with moderate alcohol problems? As of this presentation there are no definitive answers. It is important however to point out that in clinical practice these distinction are being made on a daily basis.

Some clinicians operate according to a set of decisions rules that in essence say, if in doubt, declare the client an abuser and attempt moderation training until that approach fails.

Other clinicians operate according to a set of decision rules that say: "Since no one has ever died from abstinence, and many alcoholics who attempt controlled drinking and fail suffer serious problems up to and including death, if in doubt declare the person as having a disease and treat it accordingly.

Here we confront the link between diagnosis (Is it a disease or not) and treatment (Does recovery it require total abstinence or not). I will return to this issue latter. For now, let's simply point out that we are not addressing the issue of effective treatment (i.e. abstinence vs. controlled drinking). We are addressing the issue of whether or not alcoholism or certain of its subtypes are appropriately classified as a disease.

### *DSM IV*

Most people who have severe alcohol problems as described above meet the criteria for *Substance Dependence* as presented in the DSM-IV. These criteria include:

A. *A Pattern of Compulsive Use* marked by a loss of control over the ability to regulate use or to abstain.
B. *Tolerance* marked by both the need for larger amounts of alcohol to achieve the desired effect and a diminished perceived effect with the same amount.
C. *Withdrawal* marked by the development of a specific withdrawal syndrome upon the cessation of use or the use of the same or similar type of drug to relieve or avoid the withdrawal syndrome.
D. *Substance-induced Organic Mental Disorders* that result from the toxic effects of chronic alcohol and drug poisoning to the brain.

DSM IV places a heavy weighting upon the pattern of compulsive use as the primary factor distinguishing between abuse and dependence. This pattern of compulsive use is marked by the following signs and symptoms:

1. *Craving*: A strong desire to use the substance.
2. *Loss of control over use:* The tendency to use larger quantities of the substance than intended and to use the substance for longer periods of time than intended.
3. *Inability to abstain:* The persistent desire to cut down or control accompanied by the failure to be able to so in spite of past attempts.
4. *Addiction Centered Lifestyle:* The increased amount of time spent in seeking and using alcohol and other drugs resulting in the centering of major life activities around alcohol and drug use.
5. *Addictive Lifestyle Losses:* The tendency to give up or reduce the frequency of involvement in important life activities to accommodate the increased amount of time spent in drug seeking and using.
6. *Continued Use In spite of Problems:* The tendency to continue to use alcohol and drugs in spite of problems.

It is appropriate to describe people with severe alcohol problems that meet the DSM IV criteria of substance dependence as having a disease. In these cases there is clear evidence of a syndrome (a clearly identifiable pattern of signs and symptoms) and a disorder (clear evidence that those signs and symptoms have created both functional and structural impairment.

### *Question #4: Is alcoholism (defined as drinkers who develop biomedical complications from alcohol abuse) "an entity characterized by consistent anatomical alterations of known body systems?"*

The answer to this question is definitely yes. There is no doubt that alcoholism produces a syndrome marked by predictable signs and symptoms. There is also no doubt that these signs and symptoms frequently create functional and structural damage to the brain and other organ systems. These facts, however, do not address the question of why a person would voluntarily keep drinking and using drugs until brain and organ system damage developed.

This question can be answered, in part, by understanding the relationship of brain reward mechanisms and the behavior of using alcohol and drugs. This demonstrates that the tendency toward alcohol seeking behavior is strongly linked to

progressive alterations in the function of the brain, and in late stages to the development of structural damage to the brain and other organ systems.

Recent NIAAA Research clearly shows that there are biomedical processes that occur within the brains of alcoholics that reinforce the regular and heavy use of alcohol. These *biomedical brain reinforcement processes* are different from the classic alcohol withdrawal syndrome. Let me quote the summary of this research reported in the Alcohol Alert from NIAAA for July of 1996.

1. People will tend to repeat an action that brings pleasure or reward. The pleasure or reward provided by that action is called positive *reinforcement*.
2. Certain behaviors, especially those associated with survival needs, are linked to biochemical processes within the brain that cause powerful *biological reinforcement* for these behaviors.
3. This biological reinforcement is related to the release of specific brain chemicals when the behavior is performed. These brain chemical produces a sense of pleasure or reward.
4. Evidence suggests that Alcohol and Other Drugs of Abuse (AOD's) produce chemicals that are surrogates of these naturally occurring brain chemicals that produce biological reinforcement.
5. As a result the use of AOD's cause a rewarding mental state (euphoria) that functions as a positive reinforcer of the initial use of AOD's. This rewarding mental state is defined as euphoria. (Euphoria is a state that is separate and distinct from the symptoms of intoxication).
6. As a result individuals who receive positive reinforcement for AOD use as a result of the production of these brain chemicals are more likely to engage in drug seeking behavior and to use drugs regularly and heavily.
7. The biochemical reinforcement that results from alcohol and drug use is more powerful and persistently reinforcing than the biomedical reinforcement provided by other survival related actions.
8. As a result, people who experience this are more likely to feel that the use of alcohol and drugs is more important than engaging in other vital survival linked behaviors. As a result they will tend to use AOD's instead of actively meeting other vital needs.
9. This perception that alcohol and drug use is more important than meeting other needs results in *alcohol-seeking behavior*.
10. After *alcohol seeking behavior* has been established, the brain undergoes certain adaptive changes to continue functioning despite the presence of alcohol. This adaptation is called *tolerance*.
11. Once this tolerance is established, further abnormalities occur in the brain when alcohol is removed. In other words, the brain looses it capacity to function normally when alcohol is not present.
12. This low-grade abstinence-based brain dysfunction is distinct and different from the traditional acute withdrawal syndromes.
13. This low-grade abstinence-based brain dysfunction is marked by feelings of discomfort, cravings, and difficulty finding gratification from other behaviors.
14. This creates a desire to avoid the unpleasant sensations that occur in abstinence. This desire to avoid painful stimuli is called *negative reinforcement*.
15. People who experience biological reinforcement (both positive and negative) are more likely to use alcohol and drugs regularly and heavily.
16. People who use alcohol and drugs regularly and heavily are more likely to develop *physical dependence syndromes* marked by tolerance and classic withdrawal symptoms, and *biomedical complications* resulting from alcohol and drug use.
17. There is evidence that people who are genetically and prenatally exposed to addiction may have pathological brain reward mechanisms.
18. This pathological brain reward mechanism is marked by a below average release of packets of brain reward chemicals when not using the drug of choice. When the drug of choice is used the brain releases abnormally large amounts of brain reward chemicals. When not using, the person experiences a low grade agitated depression and a sense of anhedonia (the inability to experience pleasure or find satisfaction in any activity). This feeling creates a craving for something, anything that will relive the feeling.
19. When the person finds the drug of choice that releases large amounts of brain reward chemicals, the person experience a powerful sense of pleasure or euphoria. The experience feels so good that the client begins seeking that experienced.

After alcohol seeking behavior has been established, the brain undergoes certain adaptive changes to continue functioning despite the presence of alcohol.

### *Progressive Symptoms of Addictive Brain Reward Mechanisms*

Let's explore the progression of symptoms that may be related to this pathological brain reward mechanism.

1. *Chronic Low Grade Agitated Depression:* Due to abnormally low release of brain reward chemicals the person experience a chronic state of low grade agitated depression. This state is dysphoric and creates an urge to find something, anything that will relieve this state.
2. *Biological Reinforcement:* The person experiments with a drug of choice that activates the release of brain reward chemicals. This results in an intense feeling of euphoria and personal well being. For the first time the person's mood normalizes and they feel good. They can experience pleasure. Whatever feelings they are experiencing prior to use becomes normalized. As a result the drug of choice can be used as a psychoactive medication.
3. *Obsession, Compulsion, and Craving:* The biological reinforcement creates a positive experience. The person trains themselves in the process of euphoric recall. they remember how good the experience was and exaggerate the memory of the good feelings. This thinking about the euphoria stimulates the limbic system to develop and emotional urge to repeat the

# Disease Model of Addiction (Continued)

experience. This emotional urge, as it grows strong, can activate a primitive tissue hunger for the drug.

3. *High Tolerance:* The person is able to use large amounts of the drug of choice without becoming intoxicated or impaired. As a result they can use heavily without apparent adverse consequences
4. *Hangover Resistance:* The person experiences minimal sickness on the morning after using alcohol and drugs. This rapid recovery allows the person to resume use rapidly and to use the drug of choice frequently.
5. *Addictive Beliefs:* As a result of the experiences created by the biological reinforcement, high tolerance, and hangover resistance the person comes to believe that the drug of choice is good for them and will magically fix them or make them better. They come view people who support their alcohol and drug use as friends and people who fail to support it as their enemies.
6. *Addictive Lifestyle:* The person attracts and is attracted to other individuals who share strong positive attitudes toward the use of alcohol and other drugs. They become immersed in an addiction centered subculture.
7. *Addictive Lifestyle Losses:* The person distances people who support sobriety and surround themselves with people who support alcohol and drug use.
8. *A Pattern of Heavy and Regular Use:* The pattern of biological reinforcement has motivated the person to build a belief system and lifestyle that supports heavy and regular use. he person is now in a position where they will voluntarily use larger amounts with greater frequency until progressive addiction and physical, psychological and social degeneration occur.
9. *Progressive Neurological and Neuropsychological Impairments:* the progressive damage of alcohol and drugs to the brain create growing problems with judgment and impulse control. As a result behavior begins to spiral out of control. The cognitive capacities needed to think abstractly about the problem have also been impaired and the person is locked into a pattern marked by denial and circular systems of reasoning.
10. *Denial:* The client is unable to recognize the pattern of problems related to the use of alcohol and drugs. When problems are experienced and confronted
11. *Degeneration:* The person begins to experience physical, psychological and social deterioration. Unless the person develops an unexpected insight or is confronted by problems or people in their life the progressive problems are likely to continue until serious damage results.
12. *Inability to Abstain:* The person attempts to abstain but is plagued by acute withdrawal and the longer term withdrawal symptoms associated with chronic brain toxicity. In addiction the low grade agitated depression and symptoms of anhedonia return. The combination of problems impair judgment and and impulse control. When coupled with the addictive belief systems and the deeply ingrained pattern of obsession, compulsion, and craving the person find themselves unable to maintain abstinence and relapses.

There is a growing body of evidence that an impoverished environment during early infancy can impair neurological development and as a result prevent for genetic and prenatal tendencies.

### *Question #5: Is alcoholism "an entity characterized by a recognized etiologic agent (or agents)?"*

The answer again is yes. The etiology of alcoholism is a complex interaction between genetic and prenatal factors, impaired neurological development resulting from impoverished environment in infancy and early childhood, and psychosocial factors that support the heavy and regular use of alcohol.

**Public Health Model:** The World Health Organization Provides an excellent model for understand the role of environmental factors in the etiology of disease. According to this model etiological factors interact with environmental factors to produce disease. Distinction need to be made between three elements:

1. *The Susceptible Host:* Different people have different biochemical reactions to the ingestion of alcohol. Some of these reactions create resistance to alcohol related damage. Other people have biochemical reactions that make them more sensitive to damage and hence more vulnerable.
2. *The Toxic Agent:* In this case the toxic agent is alcohol. The exposure to alcohol is a necessary catalyst for the development of the disease in a susceptible host.
3. *A Permissive Environment:* The environment will increase or decrease the likelihood of exposure to the toxic agent (alcohol). The more a culture reinforces the use of alcohol as necessary or desirable the greater the likelihood that more members of the culture will be exposed to the toxic agent.

### *Genetic and Prenatal Predisposition*

There is convincing evidence that there is a genetic and prenatal factors can create a predisposition alcoholism. This evidence is reviewed in depth in the series of reports to congress on alcohol and health submitted by the NIAAA. The most recent reviews of the genetic research occurs in Alcohol and Health Research World, Volume 19, Number 3, 1995.

**Impaired Neurological Development in Childhood:** There is a growing body of evidence that an impoverished environment during early infancy can impair neurological development and as a result prevent for genetic and prenatal tendencies. Impoverished environments create chronic states of pathological anxiety through abuse. Impoverished environments also deprive the infant of sufficient sensory stimulation needed for adequate development of the psycho-sensory system. This psycho-sensory system is closely related to the production of reinforcing brain chemical.

**Psychosocial Predisposition:** There is also convincing evidence that psychological and social factors can increase the risk of future alcohol and abuse and alcoholism. There is an interaction between personality style, lifestyle, culture, and social system. When these psychosocial variables encourage the following behaviors related to alcohol and drug use

the prevalence of addiction increases. The factors the increase the incidence of alcoholism appear to be psychosocial factors that:

1. Promote the use of alcohol and drugs as safe, normal, and low risk behaviors
2. Support frequent use.
3. Support heavy use.
4. Promotes intoxication as normal.
5. Views intoxication a reason to exempt individuals from personal responsibility for the consequences of behaviors while intoxicated

### *Question #6: Do all people who experience alcohol problems have the disease of alcoholism?"*

The answer here is no. Not all people experience alcohol related problems have the disease of alcoholism. There are different subtypes of alcohol related problems. To assume that all subtypes of alcohol related problems are caused by the same etiology is a serious error. All alcohol problems cannot be accounted for by a single disorder. The issue of whether alcoholism is or is not a disease can only be intelligently discussed in relation to each of its known sub-types.

The judgment as to which subtypes of alcoholism are appropriately called a disease needs to be based upon the use of standard criteria which we just reviewed that allows us to distinguish a disease from a non-disease. There are specific subtypes of alcoholism that clearly and undeniable meet the criteria of a disease. There are other subtypes of alcoholism that do not meet the criteria of a disease.

All subtypes of alcoholism have known etiologies that result from a complex interaction among physical, psychological, and social predisposing factors. Not all sub-types have strong physiological predisposing factors. The etiological factors can be described in one of three broad categories:

1. **Physiologically Dominant Predisposing Factors:** These are factors related to genetic, prenatal and early childhood experiences that alter or predispose brain function to favor the development o an addiction to alcohol. Traditionally physiologically dominant predisposing factors lend weight to defining a disorder as a disease.
2. **Psychosocially Dominant Predisposing Factors:** These are factors related to psychological predisposition (as reflected in thoughts, feelings, and behavioral habits that set the stage for heavy, regular and abusive drinking) and social predisposition (as reflected in cultural practices and social systems that support the regular, heavy, and abusive use of alcohol). Traditionally psychosocially dominate predisposing factors when presenting in isolation from physiological predisposing factors lend weight to the argument that a disorder is not a disease.
3. **Mixed Etiological Features:** Most subtypes of alcoholism have mixed etiological features consistently of differently balanced profiled o physiologically dominant and psychosocially dominant predisposing factors.

### *The New Paradigm for Alcoholism*

There is clear evidence that a new diagnostic paradigm is emerging that is reframing the definition of disease from one that is physiological symptoms only to one that is biopsychosocial in nature. Therefore the clear distinction between physical and psychosocial predisposing factors may become less important in future definition of disease.

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#### *About the Author*

Terence T. Gorski is internationally recognized for his contributions to Relapse Prevention Therapy. The scope of his work, however, extends far beyond this. A skilled cognitive behavioral therapist with extensive training in experiential therapies, Gorski has broad-based experience and expertise in the chemical dependency, behavioral health, and criminal justice fields.

To make his ideas and methods more available, Gorski opened The CENAPS Corporation, a private training and consultation firm of founded in 1982. CENAPS is committed to providing the most advanced training and consultation in the chemical dependency and behavioral health fields.

Gorski has also developed *skills training workshops* and a series of *low-cost book, workbooks, pamphlets, audio and videotapes*. He also works with a *team of trainers and consultants* who can assist individuals and programs to utilize his ideas and methods.
Terry Gorski is available for *personal and program consultation, lecturing, and clinical skills training workshops*. He also routinely schedules workshops, executive briefings, and personal growth experiences for clinicians, program managers, and policymakers.

Mr. Gorski holds a B.A. degree in psychology and sociology from Northeastern Illinois University and an M.A. degree from Webster's College in St. Louis, Missouri. He is a Senior Certified Addiction Counselor In Illinois. He is a prolific author who has published numerous books, pamphlets and articles. Mr. Gorski routinely makes himself available for interviews, public presentations, and consultant. He has presented lectures and conducted workshops in the U.S., Canada, and Europe.

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# Gender Swapping on the Internet: Do boys really want to be girls and girls be boys?

By Angela Lewis (MAEd)

In the early days of the Internet there was much fascination and interest in the concept of gender swapping, gender switching, gender bending or 'passing' as it variously known. Indeed the virtual world of the Internet is able to give people unparalleled control over the construction and presentation of their identities and personas. Basically gender swapping on the Internet involves a person portraying an online gender that is different from their biological sex, so a man named Ken who is a 22 year old mechanic may enter chat rooms or game rooms and introduce himself as Kerry, a 30 year old artist

Gender swapping is perhaps the most dramatic example of how people are able to exercise control over self representation. Other examples of deliberate changes in representation occur when people mis-represent their age, their occupations, their educational level and or their marital status. However aside from the areas of the Internet where this it expected and encouraged that a person is never their true selves such as in deliberate fantasy areas known as MUDs[1], there is not a great deal of current attention paid to this practice and it would appear that the Internet population has matured enough to cease playing 'dressups' in a virtual world. Indeed Cooper et al's 1999 survey on behalf of the American broadcasting giant MSN of sexuality and the Internet noted that.

> *"...We had speculated that two out of three of the women in chat rooms are really men. What we found is that gender-bending is fairly uncommon. In our study, 5 percent of people said they engaged in gen-der-bending, which is surprisingly low" (1999:p16).*

it was found that more than half of those who currently gender-switched did so for less than 10 per cent of their time on-line

One of the 'folklore' stories of the Internet is told by Allucquere Roseanne (Sandy) Stone in one of the oft-most quoted pieces of the nineties on the virtual world, *'Will the Real Body Please Stand Up??"* It is the story of a person called Julie who was a totally disabled older woman who pushed the computer keys with a headstick. She joined chat-rooms and began long and deep friendships with other women, to whom she offered advice, friendship and succour. After several years and the dogged detective work of one determined admirer, it was finally found that Julie was a male psychiatrist who enjoyed the depth and friendship he was able to achieve as a woman speaking with other women. There are many other stories like this, told of thirteen year old boys joining chat sites and pretending to be 22 year old males looking for a girlfriend, or 50 year old men pretending to be13 year olds in an effort to attract teenagers. It could even be said that the disembodied space that the Internet offers almost invites people to try out alternative personas. There does not appear to be a deal of published research into this practice, however a recent large scale Australian study of gender swapping on the Internet (Parks and Roberts 2000) found that 40 percent of participants in online communities have engaged in some form of gender switching and of those about half have given up the practice. Furthermore it was found that more than half of those who currently gender-switched did so for less than 10 per cent of their time on-line. The authors of the study say the results show that gender switching is in fact far less popular than some social scientists had claimed.

Gender switching became a popular topic because of what academics and Internet commentators believed it said about sexuality. For some Internet anthropologists (Herring 1996, 2000), gender switching was an example of how fluid the idea of identity has become in the modern world. Some feminists (Plant 2000, Haraway, 1991) saw it as another way of breaking down gender roles and homogenising gender in line with a creation of a non-gender 'cyborg' person. At the other end of the political spectrum, some critics of the Internet regarded the practice of gender swapping the province of paedophiles and consider it a real possibility that every 13 year-old online girlfriend your child may be conversing with is really a 50 year old ex-priest newly released from prison on a home supervision order.

Judith Butler an early feminist academic writing in this area says *"...Gender ought not to be construed as a stable identity or a locus of agency from which various acts follow; rather, gender is an identity tenuously constituted in time, instituted in an exterior space through a stylized repetition of acts"* (Butler 1990:pp140). Indeed performances of "passing" as a gender different from the body would appear to succeed (when they do succeed) precisely because they are credible representations of socially accepted and recognizable roles; so a white male middle aged psychiatrist is able to don 'virtual drag' by utilising his knowledge of cultural norms and knowledge of the type of discourse in familiar use by an older white woman. However keeping up this type of charade can only last so long and then people become their true selves. While early writing around the Internet suggested this was a perfect space to try out different personas and gender to escape the inequities or tribulations of the physical world (Butler 1990, Herring, 1993, Haraway, Turkle 1995 ), researchers have fairly quickly ascertained that individuals tend to reproduce if not 'hypergender' their real world identities (O'Brien 1999, Berman and Bruckman 2001).

Those such as Sherry Turkle (often called the Margaret Mead of cyberspace) says that Internet is a

[1] Two regions in particular, known as MUDs and MOOs (multi-user dungeons and multi-user environments), require that each person participating become a character with fictionalized attributes. In a MUD (based in part on the popular role playing games inspired by Dungeons and Dragons): your screen represents the dungeon and its inhabitants are online participants writing a script of what is occurring, make up the story as it goes.

very positive place for people to try out their multiple selves (not just by being another sex), as communication in cyberspace lets people explore their personalities by creating new on-line personae (Turkle 1984). In her book, *Life on the Screen* (1995), Turkle argues that computers and the Internet are redefining human identity, as people explore the boundaries of their personalities, often adopting multiple selves, and forming online relationships that can be more intense than real ones. The World Wide Web is *"redefining our sense of community and where we find our peers,"* she says. Nearly 10 years after she made this observation, there is no doubt that cyber-relationships are enjoyed by many. For some people they provide deep or intense emotional experiences and for others fulfilling or problematic encounters or experences – as well as all the permutations in-between.; however the 'gender swap' has probably has probably not developed and grown to the same degree.

To understand the concept of how some people present themselves as 'other selves' in cyberspace, we need to also consider what exactly we mean by "in real life" and the self we perceive as existing 'there' An acceptable definition of "in real life" would be to my mind how you appear physically, and the cues that you give other people by the sets of behaviours you employ, such as he way you express yourself verbally, your intonations, your hand gestures, your body language and demeanour, the chemical fragrance you emit, the 'vibe' that you give - things that cannot even be seen in pictures, because if it were that easy a web camera would do the trick. The virtual self on the other hand is textually created by the process of typing words and symbols onto the screen.

In an effort to help Internet users understand online identity better, Berman and Bruckman designed an online game called 'The Turing Game[2]'. In this game users are allowed to 'try on' gender roles that may or may not match their offline (or real-life) identity. They argue as a result of the data gained from this project that while the Internet does increase a person's awareness of their defined social roles, it has not altered the way males and females view each other. Further it was found that when people attempted to change their physical identities, then that deception was frequently (and often immediately) apparent to others – both in this online game and in other online spaces where research has been carried out (Donath 1998, Berman and Bruckman 2000). The author (Bruckman) relates the story of how in an early test of the game, she felt confident as an urbane, sophisticated woman who was a student of gender theory, to mask herself as a man. She was immediately 'outed' as a woman because of her long descriptive sentences; which in Western culture signal a feminine style.

Suler (1999) notes that very few women gender swap to a male persona, while the vast majority of those who he researched trying out another gender where men, who were variously interested in the attention they received from others while masquerading as a female, learning about women, endeavouring to enhance their own relationships with women or because they were testing out homosexual or transvestite feelings. Suler says that when women acted on their gender curiosities and gender swapped it was often *"…in search of power and control that could not be found in real life"* (Suler 1999:p3).

Parks and Roberts say that most people swapped gender for *'benign reasons'*, and the most common reason given by respondents was that they switched genders out of curiosity, for fun, to avoid sexual harassment or as a challenge to their online acting skills. However that is not to say that gender or sexuality swapping is of no benefit to some sections of a community. It is possible that for a person who is experimenting with gender or is confused about their sexuality, being able to 'try on' another persona may be a way of helping to resolve true feelings and inclinations. An example may be a young teenage boy who is having confused feeling about being a girl trapped in a boy's body. Being able to interact with others in cyberspace as a girl may serve as a useful tool in the process of defining his sexuality.

One of the most common questions asked on the Internet meeting others in chatrooms and virtual communities is A/S/L? This is the shorthand for age, sex and location, precisely because of the importance we associate with the first two answers and a desire to interact with people as closely as if with a real life identity. Parks and Roberts found the most common reasons that respondents did not want to assume other sexual identities were that they had no interest, that they found the practice of gender switching to be deceitful, that it was difficult to keep up the ruse and that they wanted to present their real selves online. The noted response on the difficulty of keeping up the deception of being another gender is similar to that experienced in Berman and Bruckman's research (2000) and also noted by respondent's in Suler's study (1999).

As part of researching the gender swapping concept, I logged into a chat room environment pretending to be of the male gender. I found it extraordinarily difficult to maintain the deception, and despite the fact that I was in a virtual environment, I felt that 'everybody' could see that I was indeed a female. I then asked a male friend to repeat the exercise but present as a woman. He also reported feeling uncomfortable and inept in how to portray 'being a woman', as well as saying that he felt others could identify his fraudulent behavour. He says he would prefer not to undertake this activity again.

I guess what this is telling us is that cyberspace provides us with an *illusory* freedom to be someone else. Just because it is possible for a person to type on a computer screen "I am a woman', despite living their real lives up to this point as a 35 year old man, does not mean we can escape real life on-line anymore than we can escape real life by ignoring the mortgage payments or thinking that some cosmetic surgery or a new suit is going to change who we really are.



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[2] The Turing Game was released onto the Internet in July 1999 as a free downloadable application http://www.ccgatech.edu/elc/turing. Users join a virtual lobby and chat with other Turing Game users and play various games.

# Register of ACA Approved Supervisors

| Name | Contact Number | Qualifications | Cost hr | Medium |
|---|---|---|---|---|
| Philip Armstrong | Qld 07 3356 4255 | B. Couns, Dip Psych SOA Supervision (Relat Aust) | $88 ind<br>$25 pp grp | Phone, Group & Face to Face |
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| Dawn Spinks | Qld 0417 633 977 | BA (Hons) Education and Psychology, M. Pub. Health | $100 | Phone & Face to Face |
| Martin Hunter-Jones | NSW 02 9973 4997 | MA Ad. Ed BA Psych. Philos | $90 | Phone & Group, Face to Face |
| Kaye Laemmle | Qld 07 5591 1299 | Dip Prof Couns SOA Supervision (Relat Aust) | $80 | Phone, Group & Face to Face |
| Miguel Barreiro | Vic 03 9723 1441 | B.B.Sc (Hons) | $80 | Group, Phone & Face to Face |
| Kerry Cavanagh | SA 08 8221 6066 | BA (Hons) M.App.Psych | $100 | Phone, Face to Face, Small Group |
| Anne Warren | Vic 03 9458 3170 | R.N. Dip Prof Couns. | $80 | Phone & Face to Face |
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| Subhana Barzaghi | NSW 0414 605 226 | BA Soc. Sci | $90 | Face to Face |
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| Claire Sargent | VIC 0409 438 514 | BA Hons Psychologist | $110 | Face to Face, Phone & Group |
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# Continuing Education and Critical Thinking - A Counsellor's Guide Part III

By Dr. Travis Gee, SigmaX Consulting Pty Ltd

This article, the second in a series on understanding research-related issues for counsellors, focuses on some basic ideas around the notion of probability. Although this is a difficult area, even for mathematicians, some clear thinking around what is meant whenever certain words are used never goes amiss, as sometimes, even the researchers can make mistakes with the meanings that can lead the reader astray.

What is the probability that the next client through your door will be suffering from schizophrenia?

### *Some Terms*

You may see a variety of confusing terms and ways of using probability in different articles. You hear about "a 10% chance" or "a .1 probability," or "odds of 9:1." The first example, "an X% chance" refers to a percentage scale that ranges from zero to 100, and reflects the number of times out of 100 that something should occur. If, for instance, 10% of the population has a particular problem, and you were to randomly pick 100 people, then the chances of getting someone with that problem are 10%. If instead of referring to percentages, we put it on a decimal-based zero to 1 scale, it's a probability of 0.1. The percent expression is just 100 times the decimal expression. Odds are a bit different, though. If 10 people out of 100 have the problem, then 90 do not, and so the odds are 90:10 against (or 10:90 in favour). Dividing by ten we get less cumbersome odds of 9:1 (or 1:9) such as those in horse racing. However, by now, I think we can see that they all refer to the same situation, but are just different ways of expressing the same thing.

### *Types of Probability*

Broadly speaking, there are two kinds of probability. One is subjective probability, and is fairly controversial, even though everyone seems to use it in some form or another. What is the probability that the next client through your door will be suffering from schizophrenia? Absent a detailed study of the rates of schizophrenia in the population, the likelihood that they live in your area, and the rate at which such people seek help from counsellors, you are left with a gut feeling. Perhaps you thought "about 1%" or "one in a million." This will be based on your experience, and will reflect your sense of the probability that such a thing would occur. It may even be accurate, although you could be off by a rather large margin (eg., 1% is 10,000 times more likely than "one in a million": try it on your pocket calculator: .01÷ .000001=).

Subjective probability still seems to suggest the idea of some number of events out of some number of tries,

which is similar to the purer idea expressed in the second kind of probability, where we deal with counts, and counts alone: no gut feelings allowed (although allowing gut feelings to be led by objective information isn't necessarily a bad thing). The other sort of probability is based solely on frequency. If 10 cars out of 1000 on an assembly line have a particular defect, then the probability that you will buy one (assuming they aren't caught by inspectors) is 10/1000 or 1%. It is thus known as 'the frequentist model,' and depends on sample results to get estimates of probabilities (more of this shortly).

The frequentist approach is the model most widely adopted by researchers. When we find that out of fifty clients that walk through the door, five have a particular characteristic, we are tempted to say that 5/50 or 10% have it. Indeed, 10% of your sample *did* have it, but there are other things to consider when generalizing this from your sample to the world at large, which will be discussed below in the section on populations and samples.

### *Probabilistic Words*

We often encounter probabilistic terms in everyday reading; 'probably,' 'likely' 'improbable,' 'unlikely.' However, if we think about the nature of probability as an idea that gets at the frequency with which we would expect something out of some number of trials, there are a lot of related words. Think of the word 'most.' For instance, it is often said that 'most abuse victims never report it.' It's worth clarifying what might be meant by 'most' as an example.

### *Finger Statistics (if you have 100 fingers).*

Some probability statements can be analyzed by imagining a room with 100 people in it. For instance, suppose we have a random sample of 100 people, and suppose further that by some definition, 20% of the population from which they came could be expected to have an abuse history of the sort that we are researching. That means that we should have 20 people who have such a history, and 80 who don't (i.e., odds of 80:20 or 4:1 against it in a randomly-selected person). Now, if "most" don't report it, and "most" means 90%, then the 20 who have the history represent 10% of the ones who were abused (odds of 9:1 in favour of non-reporting), as for every one reporting abuse, there are 9 who did not. That would mean we have the 20 who reported it, and 9 for each of them, or 180, for a total of 200. But we only have 100 people in our imaginary sample, so "most" cannot possibly mean 90% (or more).

On the other hand, if the real rate of abuse is 30%, but 20% report such a history, then of 30 cases, 10 did not report and 20 did. It would seem that 'most' in this case would mean "one in three" which falls a bit below the 51% mark that we would normally consider "most" to mean. With a little math, we can find that if 51% fail to report, then 49% report, and if our 20 reporters are 49% of some number, that

When we find that out of fifty clients that walk through the door, five have a particular characteristic, we are tempted to say that 5/50 or 10% have it

# Continuing Education and Critical Thinking - A Counsellor's Guide Part III (Continued)

number must be 41 (20÷0.49=40.8, but we round off as there is no .2 of a person), making the rate of abuse - disclosed plus undisclosed - 41%.

If we only have 100 people, if *all* were abused, but only 20 reported it, then 80 did not. That means that if *everyone* was abused, then 80% failed to report it. That is the most that "most" can mean, but it requires a definition of abuse that is rather all-encompassing, and which raises the question of the possible pathologisation by the researchers of normal human behaviour. (That clarification points to the way in which finding one problem can lead to looking at another, and definitions are a key point which will merit an article to themselves later in this series.)

### *Symptoms, Inferences and Conditional Probability*

Sometimes you read that something is a symptom of something else. In other words, if you see "X" suspect "Y" because Y is likely if X occurred. In the controversial area of "repression" (i.e., where someone ostensibly has no memory of some trauma because they have blocked it out), some have claimed that having no memory of a trauma is a "symptom" that the trauma was there (and especially traumatic). Back to the room with 100 people in it. For simplicity, we'll grant some numbers that are often thrown out in that debate (and round them to even values so things work out nicely). Suppose that 30 cases ("1 in 3") experienced some trauma (which means that 70 did not). Suppose further that 30% of those 30 (9 cases, again "1 in 3") "repressed" the trauma (which means that 21 did not). As well, simply assume that no one in the room has come to have false memories of trauma (i.e., the probability of this is zero). Now, those 70 that did not experience trauma have no memory, because nothing happened to them, and so they look very much like the 9 who "repressed" it. So there are 79 with no memory, and 21 with a memory. The probability that someone experienced a trauma but is blocking it out is the proportion of cases with no memory who in fact experienced a trauma, or 9 out of the 79, or 11%. The probability that someone did *not* have a trauma, given that they have no memory, is therefore 70/79, or 89%. The odds of trauma, given that they have no memory, is therefore 70:9 (or 7.8:1) *against*. In short, having no memory of trauma is a symptom of *not* having experienced it, and not the other way around. As an exercise, what would the odds be if 10 of the 70 experienced false memories of trauma?

As a further thought experiment, contemplate the statement "the probability that someone is dead, given that they've been hanged, is not the same as the probability that someone was hanged, given that they are dead."

This is a simple finger-stats example of what is called "Bayes' Theorem," which looks rather scary as an equation when you google it on the Internet, but which really is just a way of writing the preceding paragraph in one equation. It addresses the critical idea of "conditional probability," which is very important in science, because it means the probability of one thing, *given that we know another*. As a silly example, consider the conditional probability of vaginisimus, given that the client is male. Did everybody get zero? As a further thought experiment, contemplate the statement "the probability that someone is dead, given that they've been hanged, is not the same as the probability that someone was hanged, given that they are dead." Two different pieces of information, two different inferences to make, and hopefully two *very* different probabilities....

### *Summary*

There are many issues around probability, but many can be worked out fairly simply, often by imagining a room with 100 people in it and doing some simple calculations. Sometimes it's worth doing a little "thought experiment" to figure out what must really be the case when evaluating a research finding.

Probabilities are very much affected by the nature of the sample that we have obtained. In other words, how those 100 people came to be in the room is very important. This is a matter for the next issue in this series.

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ACA

# Success, Failure and Motivation By Donald Marmara

### *What's driving you?*

Every action is motivated by the desire to move TOWARDS or AWAY FROM something or someone. There is an important difference in the way these two forces work.

### *Desire for Success*

When you move TOWARDS a desired result, the intensity of the drive INCREASES as you approach your goal, rather like a magnet pulling metal towards it. There is no need to push yourself in any way, as your chosen goal acts as its own motivation.

### *Fear of Failure*

When your actions are motivated by the desire to move away from something, the intensity of your drive DECREASES as you move AWAY FROM the undesired object. When you have moved far enough from the undesired object, the drive stops. You have reached your goal.

Why is this distinction important? Because it is far more effective to be motivated by choosing what you want (ie:success) than by choosing what you don't want (ie: failure).

***CONSIDER this:***

How often do we motivate ourselves, our colleagues, employees, children, - by focusing on what would happen if we failed?

I invite you to take time to reflect upon this, as the outcomes of these two approaches are qualitatively different.

When fear is your driving force, you have reached your goal and your drive stops when you are no longer afraid. Your drive does not carry you to the goal you desire, but only away from the result that you want to avoid. So if you choose this method of motivating yourself, you can only hope to attain your desired goal by keeping yourself (or colleagues, employees, etc.) under pressure.

You have to keep pushing yourself otherwise your driving force stops and you fall into a state of inertia.

Is this not the way that most people operate in our society?

Energy is required to overcome your urge to stay away from work hence less energy is available for work, and if you can find a way of reaping the reward (money) without paying the price (unpleasant work) – you will!

Advertising campaigns for safe driving, for example, tend to focus on the terrible things that happen to people who drive recklessly. They show pictures of accidents and of guilty drivers losing their licenses and being sent to prison. They attempt to create results by using the motivation of fear. No attempt is made to promote safe driving, but only to discourage reckless driving. It is hardly surprising that they do not appear to be successful.

### *The Price of Fear*

The physiology of fear is such that it makes available a vast amount of energy in a very short space of time. In emergencies, this is essential for our survival. When maintained over a long period of time, however, it breaks down the tissues of our body and causes us serious damage.

When fear is our driving force, we have to work hard and we often pay a high price for it.

Consider this seriously, as it is one of the central issues we deal with in helping people live fuller and richer lives. Once you start to understand the underlying mechanics of motivation, the direction and quality of your life – and business – changes.

As most of us are so deeply conditioned to use fear as our driving force, it can take effort and soul searching to reach the truth as, when our habitual ways of operating are challenged, we move out of our comfort zone and the driving force of fear acts to push us back in. Often, this force acts so quickly and astutely that we are not consciously aware of it, and this is where an experienced coach – one who understands this distinction and does not operate by pushing – can be helpful in guiding you through this territory.

***REFLECT upon this:***

> What drives you?

> Which aspects of your life – and business – are driven by fear and which are by your choice to create the desired result?

> Are you able to tell the difference?

> If you really want the result you've chosen, why do you need to push yourself?

I end with a quote from Billy Connolly.

" Be wary of those who say they have the answers. Seek the company of those who are trying to understand the questions! "

## REWARD AND PUNISHMENT

### *Intrinsic and Extrinsic Motivation*

When you do something because you enjoy doing it, your motivation is intrinsic. When you do something because you are rewarded for doing it – or when you don't do something because you'll be punished if you do it – your motivation is extrinsic.

### *Motivation and Performance Management*

When these two motivational forces act in the same direction – eg: you love your work and you are well paid for it – all your energy is applied to the task at hand. There is no conflict, hence no wasted energy, no harmful stress.

When the two forces are in conflict – eg: you do not like your work but you are well paid for it –an "approach-avoidance" conflict arises. You are motivated to reap the reward (money) but you are also motivated to avoid the work that you find unpleasant. Energy is required to overcome your urge to stay away from work hence less energy is available for work, and if you can find a way of reaping the reward (money) without paying the price (unpleasant work) – you will!

In any situation, various motivational forces are operating. It is important, therefore, to understand the specific forces in play and their interaction, in order to know which changes are most likely to create lasting results.

When both intrinsic and extrinsic factors are considered in relationship to each other and to the

situation as a whole, the results are likely to be beneficial and lasting.

***THINK about this:***

> Which aspects of your life – and business – are motivated intrinsically and which extrinsically?

> What are the major motivational forces – and conflicts – operating in your life?

> Does our system of reward and punishment work? Look at the evidence. Is performance improving and stress decreasing? Are we healthier? Is the crime rate decreasing?

***Where to from here?***

Understanding what motivates us enables us to use our resources more effectively. It enables us to eliminate waste and direct our efforts on target.

Intellectual understanding, however, is helpful but not enough.

Experiential understanding - understanding that comes from our own direct experiencing – is what enables us to convert information into knowledge that leads to effective action.

***REFLECT upon this:***

> How do I form my opinions, beliefs and judgements?

> On what evidence do I base my decisions?

Donald Marmara is a certified practicing counsellor and registered supervisor of the Australian Counselling Association. . He can be contacted on 02 9413 9794 or 0412 178 234(mob) and at coredevelopment@optusnet.com.au.

ACA

# Chapter News

## SOUTH AUSTRALIAN CHAPTER (ACA) STATE CONFERENCE

Our state conference this year was a resounding success. Thanks to a fine selection of speakers, over 30 ACA and non-ACA members and a wonderful location at Tiffins on the Park – a lovely place with excellent service.

People started arriving at 8.45 for a 9.00 start greeted and supported throughout the day by ACA chairperson Peter Papps and board members, Allyson Hooley and Yvonne Howlett.

Peter began the day by welcoming all with warmth and enthusiasm, which continued all day as he masterfully kept the days proceedings on track.

There were four guest speakers:

1. Dr. Michael Radermacher, chiropractor, speaking on Reflexes and Behaviour.
2. Liz Weepers – ACA clinical member, NLP International Master Trainer & Presenter speaking on NLP techniques within Counselling.
3. Robert Mittiga and Sue McPherson – directors and counselor for GATS (Gambling Addiction Therapy Services) speaking on gambling and addictions.
4. Liz Bruce – one of our own members – a Professional Counsellor who works from her own practice in Adelaide's North Eastern suburbs speaking on Anger Management.

First speaker was Dr Michael Radermacher who stimulated our minds with his presentation on how the brain works in relation to how we behave and the influence chiropractic along with the integration of other therapies such as counselling can help clients to move forward successfully.

Second speaker was Liz Weepers who talked to us about how NLP (Neuro (Brain), Linguistic (language) Programming) can be used as a therapy on its own or in addition to counselling to create an amazing tool to facilitate powerful changes for clients. Liz says that, "NLP is a model to duplicate human excellence and learn new behaviours at an accelerated pace."

We all had the chance to experience how we can learn to instantly change our emotional state to a state of choice – an amazingly, powerful and wonderful experience.

Third speaker of the day was Robert Mittiga who helped us to recognise how specialised and intense the treatment and therapy for gambling and addictions actually is. He specialises in services for individuals seeking treatment and recovery for gambling, spending/shopping, alcohol, drugs, sex and work as well as co-dependency, eating disorders and love/relationship addictions. Robert runs a 12-step program and talked to us about the 5 stages of addiction. A very insightful presentation to this growing problem.

We all had the chance to experience how we can learn to instantly change our emotional state to a state of choice – an amazingly, powerful and wonderful experience.

Our final speaker for the day was Liz Bruce. Liz offered a wonderful presentation that covered Anger within the Family of Origin, bullies, the various types of anger and how it affects children in relation to poverty and learning difficulties. Liz talked about anger being a symptom – and this is just the tip of the ice-burg – it is what is under the surface that we need to learn to become aware of.

Thank you to all the speakers, members and non-members for their willingness to learn more and constantly develop themselves further and to the SA committee members for a fabulous day. Can't wait till next year!

ACA

# Book Reviews

First Steps in Counselling: A Students' companion for basic introductory courses Third edition
Pete Saunders

***First Steps in Counselling: A Students' companion for basic introductory courses Third edition***

*Pete Saunders*

PCCS Books 2002

This book is in its third edition for very obvious reasons. As a companion for students undertaking introductory courses, it provides a valuable additional resource, and is intended by the author to be utilised as such.

The tone of the book is set in the introduction by the author, who in the initial pages exposes his personal 'underbelly' openly and honestly in order to enable the reader to make a personal connection with him as a mentor. It is endearing that Pete decided to refer to himself as Pete rather than Peter as the former numerology denotes "better star potential" and that he chooses to share this with the readers from the outset.

The interactive nature of the text mimics what should occur in the classroom environment and includes an eclectic selection of quotes from people such as Lao Tzu, Morris West, Talking Heads and The Cure.

Saunders presents the theoretical framework in a relaxed and casual fashion, though at no time does he understate the personal investment required by both the counsellor and client for a therapeutic environment to be established and maintained.

The layout of the text is unpredictable. Each turn of the page reveals a surprise in both format and content thereby enticing the reader to move to the next step of the educative process.

The basics of the counselling process are explored in an interactive fashion with an emphasis on self exploration in order to accommodate issues such as creating boundaries, defining the counselling relationship, aims and functions of counselling and counselling vrs psychotherapy. The reader is encouraged to explore the evolution of their personal value systems and identify their 'personal blind spots' in order to understand themselves before attempting to understand others.

The critique of counselling theory and models from humanism (Maslow and Rogers) to developmental eclecticism (Egan) is detailed enough for the novice to accommodate without being overpowering. Exploration of the place of counselling within the medical model is thought provoking as is the parallel exploration of counselling within the complementary modalities.

Power in the counselling relationship is identified and examined in detail as is the dynamic of the counselling relationship. Skill development exercises and vocabulary development for each stage of the process are included. In addition, the simple process of referral is explored comprehensively and incorporates a checklist to ensure appropriate and accurate identification of reasons for professional referral.

Ethics are explored and supervision emphasised, leading to a discussion of self care strategies in an effort to instil in the reader an awareness of the risk of 'burnout' in the helping professions.

Saunders ponders some challenging questions and asks the same of the reader. "Is counselling the new religion? Does counselling work? Does counselling do more harm than good?"

Saunders incorporates in this user friendly text all of the basic theoretical requirements for novice practitioners and encourages them to take the next step in their professional journey. Academic resources which are UK based, detailed analysis of UK qualifications and definition of corresponding post-nominals, have little application for the Australian reader, however this is the only aspect of this innovative book that disappoints.

*Reviewed by: Molly Carlile,* RN, BEdStud, DipProfCouns, GradDipGrief/Bereav, GradDipPallCare, M'mentCert, AICDDiploma MACA(Clinical) FAICD

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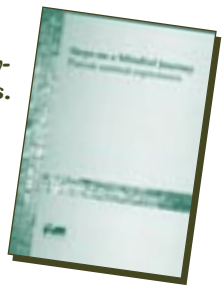
Steps on a Mindful Journey-Person Centred Expressions. Godfrey T. Barrett-Lennard



***Steps on a Mindful Journey-Person Centred Expressions.***

*Godfrey T. Barrett-Lennard,*
PCCS Books

The author is a highly experienced Australian psychologist/pyschotherapist, both as an academic and practioner. He holds a Ph.D in psychology and studied with Carl Rogers in the USA; he has practiced there, in Canada and in Australia. Although he is a person-centred therapist, this book can be used to enrich the understanding of a wide range of professionals.

It is 200 pages in length and comprises three sections. In Part One, he focuses upon how therapists may establish connection with their clients through the processes of the helping interview, listening and empathy. He includes a most informative chapter dealing with misconceptions concerning client-centred therapy – he uses this term when referring to his therapy. He declares that the whole person-centred approach is pivotal for him. He also has a chapter on the paradox of change in which he explains why he does not engage in deliberately engineering change. The author favours effects valued by the client which flow from the therapeutic process.

In Part Two, Barrett-Lennard discusses in three chapters relationship contexts covering: experiential groups that includes a participant questionnaire, family structures and the learning process of children, and measuring relationships. In this third chapter he explains the Relationship Inventory (RI).

Regarding the final Part Three, the author discusses persons, people and prospects. This involves excellent chapters on human nature and the becoming self with another on relationships and healing. It is a refreshingly jargon-free book, yet he manages to distill

and convey his undoubted skilled experiences in a most readable way, which will appeal to practioners in a range of modalities as well as to students.

The author regards the humanistic person-centred approach as an active and philosophical basis and an underpinning for leading a healthy and fulfilling life. His life experiences appear to lead him to support John Donne's poem that no man is an island, he says that he has moved away from a literally individualist mindset towards the view that individuals grow and live through relationships.

*Reviewed by Gordon Ray*, CMACA, MscEcon. MA. (Lond.) Grad Dip Ed. Dip. Psychoanalytic Psych. Dip Human Resource Mgt. (UKIPM) Chartered Member Australian Human Resource Institute.

### *Childhood Studies – An Introduction*

Wyse, D (Ed), Blackwell Publishing, Melb.
ISBN: 0-631-23396-2


Judging by the list of contributors to this text, it has its principle origins at Liverpool John Moores University and is, in part at least, a product of the British Council Research and Teaching Project. Thus, if you are looking for a text that is more practical than academic in nature, this is not for you. That said, if you are looking to expand your theoretical knowledge in regard to children and childhood, this is a well-researched, well-written and solid body of work.

The book is broken into three parts: Children and Childhood, Children and Services (though this is in the British context and particularly the law section is not relevant here there are some good basic concepts outlined and developed in this part) and Children in Society. Each part has three subsections further divided into three or four papers by individual contributors. Depending on the individual author there are useful tables and diagrams contained and even some activities!

The references at the end of each contributor's article is followed by further suggested reading and combined is quite comprehensive – as is the glossary an index at the end of the book.

The price is $69.95, about what you would expect to pay for this type of text. All in all it is worth looking at, but, personally, I'd like to see the same sort of thing set in the Australian context.

### *"Lessons from my Child"*

*by Cindy Dowling, Neil Nicoll & Bernadette Thomas*


This collection of stories by parents' of a disabled child is a valuable resource for those of us who counsel any member of a family who has a child with any form of disability. Cindy Dowling and Bernadette Thomas are parents of children with a disability and Neil Nicoll is a Psychologist working with such parents.

Neil Nicoll introduces each chapter with headings such as Grief, Denial, Anger through to Love & Joy, Spirituality, Laughter; explaining each emotion and the processes families go through in order to cope with "a life I did not ask for or expect", as they come to terms with the loss of the child they had hoped for and instead, learn to manage the child they have.

The stories describe parents struggle to deal with their own lives irreversibly changed where they feel that they have no control over the future. They are often judged harshly by their extended families and can feel isolated as a result. They talk about having no time to grieve and heal and so grief remains a constant – just below the surface – though they celebrate any 'milestone' of their disabled child, with great delight.

"Lessons from my Child" by Cindy Dowling, Neil Nicoll & Bernadette Thomas

For many parents, life becomes a series of medical or other therapy appointments as they strive to give their child every chance to grow and develop to reach their best potential – often at the cost of other 'normal' children in the family, or even their own marriage. They tell of financial strain, lack of time and sometimes lack of real support.

Many come see their disabled child as a gift and don't like to feel that as parents, they are any more heroic than other parents. Instead they often feel that they have been given an opportunity for personal growth themselves, even though they may live in a constant state of exhaustion!

I found this book humbling. We, with 'normal' children, may often feel fed up or angry over our own childs behaviour (as I certainly did when mine were growing up). Having read these stories of perseverance and devotion I found myself in awe of their ability to push through normal limits of tolerance, to find so much more of themselves to give.

Amazing people (both parents and children) with an abundance of strength, determination and love!
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Publisher: Finch Publications 02 9418 6247
$24.95

### *Adolescents Overcoming Child Sexual Abuse:*


Adolescents Overcoming Child Sexual Abuse: by Kate Ollier and Angela Hobday

"Creative Therapy" for Adolescents Overcoming Child Sexual Abuse, appears to have been auspiciously researched. Reinforcing the fundamental importance of developing a sound authentic relationship between therapist and client, which this book has the capacity to not only encourage, but also elicit a sustainable and rewarding outcome. I found this book to be an extremely applicable resource for the committed therapist working with either adult or adolescent experiencing the psychosomatic effects of sexual abuse.

# Book Reviews (Continued)

Grief & Loss Understanding the Journey By Stephen J. Freeman

Overcoming the adverse effects of childhood sexual abuse being an extremely sensitive and complex issue, requiring authentic understanding, versatility and patience on the part of the therapist. This book offers fundamental theoretical skills, supported with practical tools and activities, which are not only crucial but primary components in generating practical, realistic results that can also enhance the probability of client overcoming complex effects of their traumatic experience.

The book could benefit both therapist and client. It is detailed, easily understandable and provides activities that are effective and productive. It encompasses major therapeutic practises and insights that clearly outline a process, that is not fixed, but constantly determined by client's active participation, willingness and stage of recovery.

Creative Therapy, for Adolescents Overcoming Child sexual Abuse, is an excellently informed resource reference, which has the potential, to support client self-development throughout term of mediation process. Activity resources, meet client's needs at all stages of recovery, equipping client with practical life coping skills, creative expression and alternative rational behavioural responses.

The book provides foremost, clear functional steppingstones that have the potential to lead a client forward and toward their goal and desired outcome, in highlighting a new and clearer vision of the authentic self.

The practical activities serve as foundations that will enable therapist to authentically walk with client throughout their recovery journey, providing valuable insight for therapist and greater level of self awareness, thus empowerment for client in overcoming the complex effects of sexual abuse, which can pre-determine clients life to have been experienced as Pseudo existence.

*Book Review by Stephanie Wotzke,* B.Ed., M.Ed.Studies, M. Social Science (Counselling), ACA (Qualified)

Accepting Ourselves & Others A Journey into Recovery from Addictive & Compulsive Behaviors for Gays, Lesbians & Bisexuals Written By Sheppard B. Kominars, PhD Kathryn D. Kominars, PhD

***Grief & Loss Understanding the Journey***

*By Stephen J. Freeman*

This book provides a comprehensive and detailed account of numerous aspects of grief and loss situations including types of death, the process and experience of death, and ethical decisions pertaining to death experiences.

An informative discussion about Attachment Theory, which outlines behaviours that initially bring people together into relationships that become important mainstays during their lives is important reading for counsellors who are helping clients deal with grief. This chapter, as is the entire book, is well supported by research. Freemman not only provides information, on individual differences that exist in ways people bond during life, but explains the impact that their life bonding has on their death perspectives and separation. The author presents several different theoretical ideas on the grieving process, which he describes as reorganization after a loss. All of these aspects offer valuable reading and provide a variety of ways to understand and explain to clients the reactions of distress, emotional release, shock, anxiety, fear, guilt and hostility that they may be experiencing.

As well as reviewing the effects of unresolved grief, Freeman covers Grieving Special Types of Loss and Children and Loss. The impact of unexpected death including the shock of suicide and homicide complicate the mourning process especially as survivors frequently believe that they are left to confront the psychological issues and emotional challenges that the departed ones never had to face. Families in grief and the intellectualization, emotional survival and mourning experienced by caregivers are specific topics that give insightful information to those learning or teaching clients or classes about bereavement responses.

Throughout the book each chapter provides questions and thoughts for reflection. These are suitable for the reader's personal development or useful in grief management training sessions. An outline to grief work process based on a bereavement group model that incorporates the dynamics of attachment, loss and grieving provides counsellors with eight session outlines.

The academic verification of ideas and concepts through research that is quoted in this book, makes it an ideal reference for psychology and counselling students. Providing grief therapists and other counsellors with an extensive and informative summary of the complexities of bereavement, loss and therapeutic healing after death experiences this book is well worth your attention.

Publisher: Thomson Education 1800 654 831
$74.95

***Accepting Ourselves & Others***
***A Journey into Recovery from Addictive & Compulsive Behaviors for Gays, Lesbians & Bisexuals***


*Written By Sheppard B. Kominars, PhD*
*Kathryn D. Kominars, PhD*

Published By: Never Summer Partners, 1996

This book is the revised edition of the 1989 publication Accepting Ourselves: The 12 Step Journey of Recovery from Addiction for Gay men and Lesbians and published by Harper and Row. Written by Sheppard B. Kominars, Ph.D.its main focus was on the 12 step concept, the use of the higher power within us and the position of the homosexual in a homophobic society.

Both books have much to recommend them to friends, family and therapists of gays, lesbians and bisexuals.

The 1996 revised book is particularly sensitive, creative and thought-provoking. It is a clear and

encompassing directive for the accepting, understanding and controlling of the process of addictive/compulsive behaviour particularly in the areas of recovery from the scourges of alcohol and drugs. It also incorporates directions for self-help with depression, anxiety, learning disabilities and sexual abuse.

Current research in the US and UK tends to confirm that a third of lesbians and gay men have serious alcohol problems and that lesbians seem to have more of a problem than either heterosexual women, gay men or heterosexual men. (see www.Lesbianinformationservice.org/academic abstracts)

Written by a gay father and his lesbian daughter it incorporates many valid workshop-type sections for uncovering hidden agendas and unlikely denials. By doing so it expedites the process of discovery, personal fulfillment and self-assessment.

Both the original and revised editions have at their therapeutic core the world famous and highly effective 12 Step Behavioural Recovery Program created in 1935 in Akron Ohio by 2 enterprising alcoholics known only as Bob and Bill W.

It was Bill who summed it up best when he described alcoholism as: "The disease that tells you that you haven't got it!" Nothing much has changed over the years when it comes to the devil of addiction and its equally evil companion compulsivity.

This is NOT a book aimed at making someone gay straight. Far from it! It tends to almost worship the rights and values of homosexuality by alleviating the addictive/compulsive behaviour and therefor allowing the homosexual to maximise the joys of his or her life in our often ignorant, angry, unforgiving and bullying society.

A most important and worthwhile book that can be easily converted to powerful workshops of great and lasting value. It is recommended to all who may be concerned with the pressing issues presented, or are simply interested in self-enlightenment.

For more information on the subject for interested Counsellors and Therapists:
www.RainbowSauce.com
www.glsenco.org

*Reviewed By: Dr Ted Heaton*, Ph.D., MACA

Publisher: Living Solutions Ph: 03 5977 6366
$43.50

### *"Your Supervised Practicum and Internship".*

"Your Supervised Practicum and Internship".

This book is a useful tool in the life of any new comer to the counseling arena. The book has a flow that starts at the beginning and follows through the natural course of events that occur in a counsel context. Each section offers personal examples and real life transcripts for the reader to peruse and help them understand reasons behind some methodologies used in counseling.

A further useful addition is the inclusion of useful reference material that is among other sources, internet based. This provides quick access to web based learning and personal development. Although the book was written in an American context the ideas and concepts are applicable within most counseling setting. Of special interest was the inclusion of Multicultural issues in counseling clients. This in itself is an important aspect and perhaps an overlooked unintentionally and the book serves as a timely reminder to consider culture relevancy in all counseling interactions.

Overall, the book should be on every counselor's shelf and used regularly as the reference tool it was designed to be.
*Reviewed by Keith Lynch, B.Sc. MACA.*

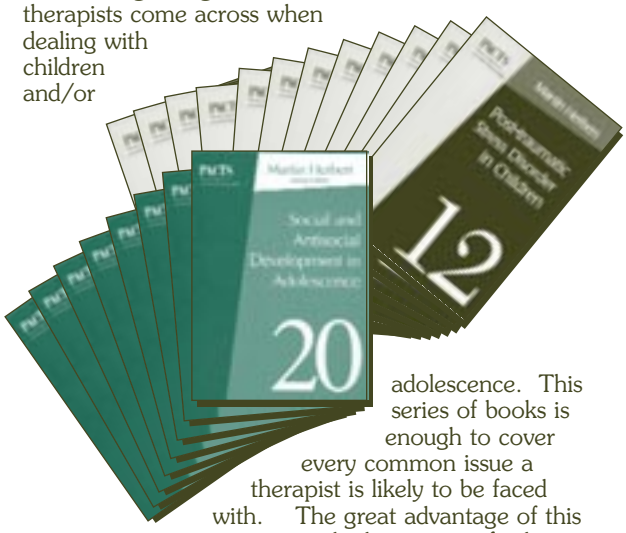
*Available through Thompson Education*
*1800 654 831 $69.95*

### *Parent, Adolescent and Child Training Skills (PACTS)*

Parent, Adolescent and Child Training Skills (PACTS) Series Editor Martin Herbert

*Series Editor Martin Herbert*

PACTS is a 20 book set of short, each being approximately of 56 pages, factual hand books that cover a large range of issues that therapists come across when dealing with children and/or adolescence. This series of books is enough to cover every common issue a therapist is likely to be faced with. The great advantage of this series is not only the variety of subjects but each book is to the point and is easily understood. The books come with questionnaires, step programmes, guides, practical interventions, activities and common sense problem solving techniques.




PACTS come in 2 series 1 to 12 and 13 to 20, and the books can be bought either one at a time or as a series. I was highly impressed not only with the easy to read content of the books but also with the quality of the content, it was relevant, up to date and easy to apply. Some of the titles are: Assessing Children in Need and Their Parents, Setting Limits, Separation and Divorce (Helping Children Cope), Social Skills Training for Children, Gambling and Addictions in Adolescence, Depression and Attempted Suicide in Adolescence, Aggression and Bullying in Adolescence and School Refusal in Adolescence.

This is a very handy set of series of books to keep in a clinic/practice and their handy size means space is not a real issue. I believe this double set of books is a necessity for any therapist who works with children and/or adolescence. I highly recommend this series

# Book Reviews (Continued)

for all teachers, therapists and anyone else who works with children and adolescence.

PACTS is available from ACER (Australian Council for Educational Research), contact number 1800 338 402, www.acer.edu.au , sales@acer.edu.au

*Review by Philip Armstrong FACA*

***Comparative Treatments for Anxiety Disorders***

Comparative Treatments for Anxiety Disorders Editors: Robert A. DiTomasso, Elizabeth A. Gosch.


*Editors: Robert A. DiTomasso, Elizabeth A. Gosch.*

This book is one of the Springer Series on Comparative Treatments for Psychological Disorders.

The first chapter provides an overview of anxiety and its disorders including its prevalence, costs, associated problems, predisposing factors, and triggering factors. A brief description of each disorder, problems in assessment and diagnosis, and cultural factors are also included.

Chapter 2 introduces the case of Sandra, a composite portrait of a woman with an anxiety disorder whose history is informed by the scores of patients treated by the authors over the past 25 years. Sandra represents the history of an anxiety-disordered patient commonly seen in practice today. A standard list of questions for contributors is also included in this chapter.

Chapters 3 through 13 present the viewpoints of a variety of seasoned clinicians practicing from a single theoretical model. These clinicians were asked to elucidate how they would approach the case of Sandra from their own theoretical viewpoint. Each chapter provides a thorough description of the model, therapist skills and attributes, assessment plans, treatment goals, therapeutic relationship issues, common pitfalls, intervention strategies, and mechanisms of change. These chapters allow the reader to "sit in and observe" the clinicians at work – what they consider important and how they weigh various factors in the conceptualization and treatment of the anxious patient.

This book is useful to those counsellors who have an interest in comparing and contrasting differing approaches to the treatment of anxiety. It is also useful for students or new counsellors to see how each approach is put into practice. The explanation of each theoretical model is very helpful for new counsellors or students. The content, layout and style is easy to read and follow, it is very well structured.

*Michele Chaseling, Bachelor of Applied Science (Information), Graduate Diploma in Counselling*

*Publisher: Elsevier 1800 263 951*
*IS08621 4832 8 $93.50*

ACA

# Draft ACA Position Statement on Repressed/Recovered Memories

The Australian Counselling Association recognises that child sexual abuse is an abhorrent crime, and that in many cases, it can precipitate problems in later life. ACA further upholds the principle that counsellors who are sufficiently trained in the complex issues of such cases can be of assistance to individuals with such issues. However, in so recognising, the ACA also acknowledges that there have existed certain disturbing trends in some therapeutic practices over the last two decades which raise concerns for the industry as a whole.

In particular, "Repressed Memory Therapy" (sometimes known as "Recovered Memory Therapy"), or RMT, has been practised in some quarters by psychologists, psychiatrists, psychotherapists and counsellors in a manner that may be damaging not only to clients but to third parties as well. In issuing the present statement, the ACA is following many other bodies that have issued statements and guidelines on the topic (e.g., American Psychiatric Association, 1993, 1994; Australian Psychological Society, 1994; American Medical Association, 1994;Canadian Psychiatric Association, 1996; Michigan Psychological Association, 1994;Royal College of Psychiatrists, 1997). The extremes to which this has been taken by some unfortunately has reflected poorly on the industry as a whole.

Numerous court cases, particularly in the United States, have led to challenges that relate to RMT. However, Canada, the UK, and Australia has not avoided these. As early as 1998, the Canadian Psychological Association urged the Minister of Justice in Ottawa to conduct a special inquiry into harm done by testimony based on such recovered memories. In Melbourne, the Victorian State Government is contemplating such an inquiry as of 2004. In Queensland, the Director of Public Prosecutions Royce Miller issued guidelines in 1994 prohibiting the use of testimony based on hypnotically "refreshed" memories (which included the use of Eye Movement Desensitization Reprocessing, or EMDR), and the Queensland State Parliament held a Forum on Justice in Sexual Abuse Allegations in Dec. 2002 where the extent of the problem in that State was identified.

### *Truths*

The ACA first acknowledges that there are two different sorts of "truth" in statements from a client. The first is "historical truth," which refers to the usual sense of having historical accuracy about events. The second is "narrative truth," in which the statements are viewed as significant and meaningful to the client, and in tune with his or her "life story," but where those statements may refer to events that have complete, partial or zero "historical truth" content. In other words, clients may find (or have suggested to them) a "truth" which refers to completely fictional events. The use of suggestive methods in the pursuit of recovery of memories of traumas that are presumed, without evidence, to exist, is viewed as a potentially dangerous path which is not good practice, and which is therefore discouraged. Counsellors are urged to be sharply aware of the distinction between historical and narrative truth, and the functions these play in the therapeutic context. Counsellors are also urged not to encourage confusion between the two in their clients, and to review cases where this may have occurred with their professional supervisor.

### *Repressed/Recovered Memories*

"Repressed" memories (which, upon identification, become "Recovered" memories) are typically of long-ago childhood sexual abuse (although not entirely limited to that category of trauma). The theory of repression (often used almost interchangeably with the term "dissociation" through widespread idiosyncratic usage of the terms in many self-help books) suggests - in its modern form - that traumatic memories somehow get stored away in an inaccessible part of the mind to protect the individual from the pain of recollection. However, allegedly pathological symptomatology follows from the repressed memory. The view, in RMT, is that such memories must be released to cure the individual of the problems. Furthermore, the view is generally taken that such memories are on the whole quite accurate representations of historical truths.

### *Symptoms and Diagnosis*

The ACA also recognises that some therapists may mistakenly believe that the presence of a particular constellation of "symptoms" allows them to infer that someone who has no memory of having been sexually abused as a child was in fact abused, but is currently "repressing" or "dissociating" the memory. The ACA concurs with other bodies that no research exists which identifies a cluster of symptoms that would permit a diagnosis of long-ago childhood sexual abuse to be made, and cautions counsellors not to do so in the absence of a memory raised by the client without suggestion.

ACA also acknowledges that there have existed certain disturbing trends in some therapeutic practices over the last two decades which raise concerns for the industry as a whole.

### *Veracity*

With regard to the historical veracity of traumatic memories that have emerged in an individual who claims previously to have been unaware of such events, the ACA concurs with other professional bodies in stating that, absent external corroboration, the "historical truth" content of a 'recovered' memory may be low or nil. This is especially the case where certain methods have been used (e.g., hypnosis, guided imagery, journaling, amytal interviews, regression therapies, so-called "body memories," literal dream interpretation, leading interview questions or abuse-focussed readings and workbooks). Such methods have been purported to improve recollection in people who have no memory for a trauma that the helping professional assumes to be present. The ACA concurs with other professional bodies that there is no solid evidence to support this assertion. Further, ACA recognises that there is a body of research evidence that suggests that such methods can create pseudomemories (i.e., memories of events that did not happen, but which are subjectively real to the client). The ACA urges counsellors to be extremely careful that leading questions and suggestive techniques not be used in this sort of case.

# Draft ACA Position Statement on Repressed/Recovered Memories (Continued)

### *Therapy*

In RMT, treatment initially focuses upon recovery of memories of trauma that the counsellor has assumed to be present based on some pattern of symptoms. Further treatment often involves cathartic methods, and often these methods involve repeated review of traumas, despite a lack of evidence of their efficacy, and suggestions that such methods may in fact make clients worse. The ACA acknowledges that there have been cases internationally of extreme damage being done to clients and their families by such practices. Therefore the ACA must look to the legal position of the counsellor, and warn counsellors of the possible legal difficulties in which they could find themselves, as they may be construed as having a duty of care to those whom they incriminate based solely upon a recovered memory that they may have affirmed to be true without adequate corroborating evidence.

The therapist who is incautious in such cases may be exposed to legal proceedings from clients first from clients who do not receive optimal treatment or who are harmed by such methods.

### *Duty of Care*

The ACA subscribes to the ancient medical principle of "do no harm." This focuses naturally upon the client, but also upon his or her social support networks, which often will involve family. Numerous methods advocated in RMT can be highly destructive of these networks, and may leave the client dependent on the therapist in a way possibly not intended by the therapist, but harmful nonetheless. Furthermore, these methods (eg., confrontations with alleged perpetrators, cutting off relationships with people who do not actively support the recovered memories) are generally unsupported by evidence of their efficacy.

The therapist who is incautious in such cases may be exposed to legal proceedings from clients first from clients who do not receive optimal treatment or who are harmed by such methods. Secondly, there may be exposure based upon a perceived duty of care to third parties who may be falsely incriminated, to whom the therapist may be viewed as owing a duty of care. Lastly, the therapist may, by using suggestive methods, taint the testimony of someone who is in fact a victim, and thereby prevent the prosecution of an actual offender.

### *Personal Issues*

The ACA recognises that many people counsel who have themselves had issues of various sorts in the past, and this extends to the issue of past sexual trauma. One the one hand, ACA recognizes that there can be a benefit to the client in terms of empathy, offering hope and useful advice from the perspective of someone who has travelled the same road. However, the ACA also acknowledges that when counselling a person whose issues are the same as those that the counsellor has had, there is serious potential for conflicting interests to be at work that can disadvantage the client. This is no less so with sexual abuse issues. Counsellors are advised to reflect seriously on their own progress in dealing with the issues when considering taking clients who share a past problem of their own. When counsellors find themselves in such a position they are advised to consider seriously whether the client should be referred to another professional, and if not, at the very least, they should raise matters routinely with their professional supervisor to ensure the protection of the client.

### *Conclusion*

The ACA follows other bodies in encouraging counsellors who work in this area to educate themselves about the issues surrounding memory and the processes by which memories may be retrieved. Counsellors are advised to acquaint themselves with the legal issues surrounding these matters in their own state. The ACA promotes the highest standards of practice in the interest of avoiding harm not only to the client, but to the individuals accused of heinous crimes, to the counsellor, and to the industry as a whole.

**ACA**

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