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COUNSELLING AUSTRALIA

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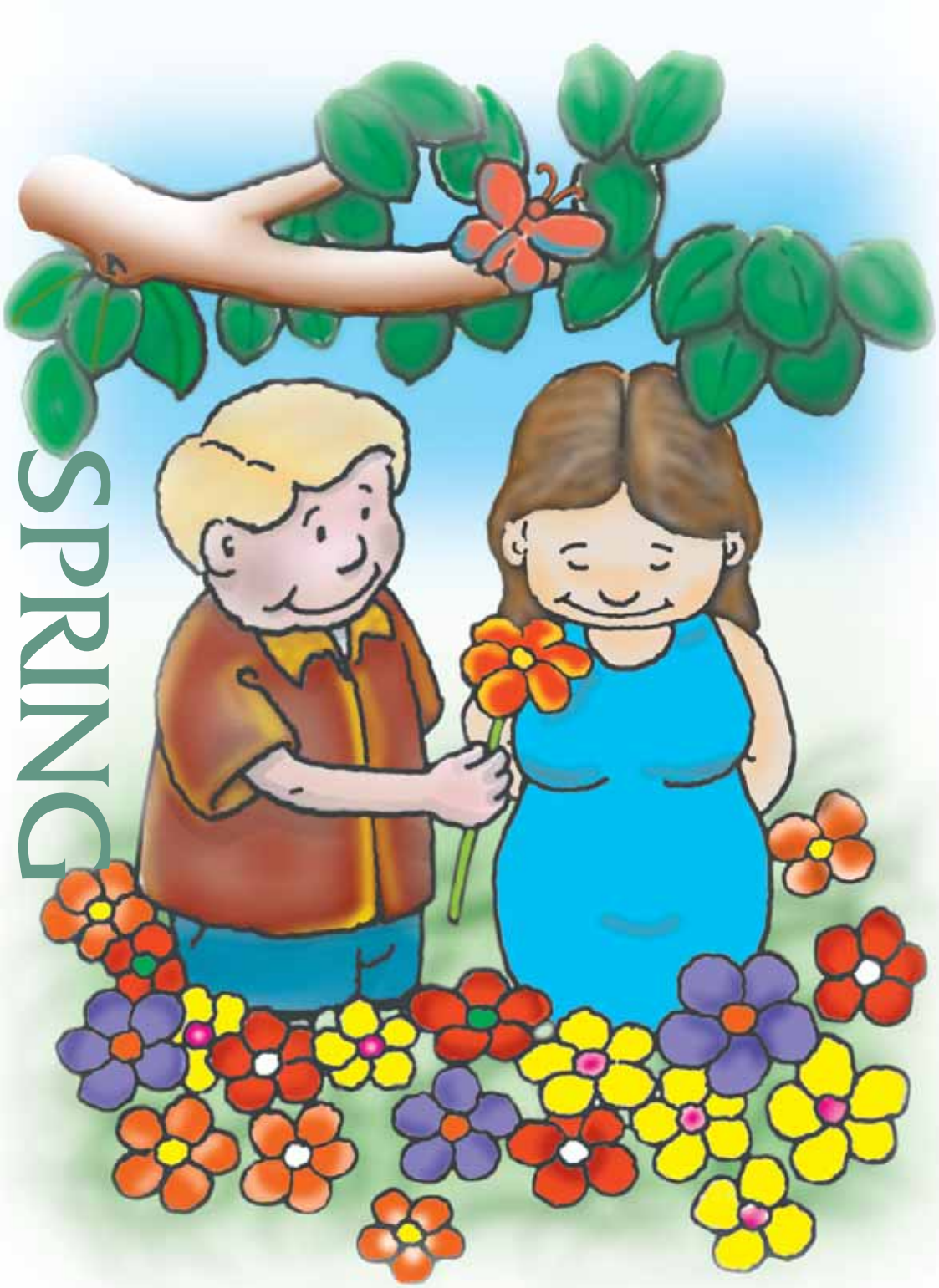

CERTIFICATE IV IN COUNSELLING SUPERVISION

(69828)

Nationally Accredited Training

Course Designer: **Veronika Basa**

In partnership with: Results Training Australia, RTO (#60098) &

The Certificate IV in Counselling Supervision is a self-directed learning program for experienced counselors interested in supervising other counselors. It embraces the methodology of learning delivery which empowers you, as the learner in the learning process. This is achieved by giving you flexibility in options as to when, where and how you can best learn to develop and demonstrate competency in this qualifications. Initially you will identify what you already know and what you need to learn to demonstrate competency in a range of different contexts/situations and within a reasonable timeframe. You are then guided to identify and undertake the required learning in the learning model that suits you the best.

THE WORKSHOP LEARNING MODEL

This model is suited to those learners who enjoy learning with their peers in an interactive learning environment where the focus is on you the learner and what you need to learn, and is delivered using adult learning principles and accelerated learning techniques.

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This model is suited to experienced counsellors who are currently working as counselling supervisors and want to gain formal qualifications in Counselling Supervision or experienced counsellors wanting to undertake the learning program within their existing workplace.

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This model is suited to those learners who are unable to attend the Workshop Learning Program or unable to undertake the Workplace Learning Program as a result of employment, distance and/or time restraints.

The Recognition of Prior Learning (RPL)

This model is suited to those who have extensive experience in counselling supervision and are able to demonstrate competency via their workplace experience.

COURSE CONTENT

1. Working within a counselling supervision framework
2. Issues in Supervision
3. Supervision Interventions
4. Self Evaluation
5. Supervision Tools/Instruments

STUDY MATERIALS

We provide the required learning materials to complete your studies. The course recourses are designed to assist your comprehension, research skills and other skills relating to counselling supervision and counselling supervision models, to enable you to confidently and competently perform counselling supervision.

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Assessments of your competency against the required Units of Competency include:

1. Demonstration
2. Observation
3. Questioning (oral/written)
4. Authenticated evidence of relevant work experience and/or formal/informal learning (e.g. testimonials, portfolios/log book or copies of completed workplace records)
5. Written assignments/projects

Assessment materials are used by assessors to gather sufficient evidence of competency to make reliable judgments about whether a person has met the required Competency Standard.

AUSTRALIAN COUNSELLING ASSOCIATION (ACA)

The Australian Counselling Association (ACA), peak body for counsellors in Australia with a membership in excess of 3000 Australia wide, has approved and accepted this course as an appropriate accredited level of training for their counselling supervisors.

Essential entry requirements - criteria set by ACA - Extensive experience as a counsellor – clinical level practitioner with a minimum of 6 yrs experience and having undertaken a minimum of 200 hrs being under supervision themselves.

RESULTS TRAINING AUSTRALIA (RTO # 60098)

Basa Education and Counselling Services (BECS), is working in partnership with Results Training Australia a Registered Training Organisation (RTO # 60098)

Results Training Australia will issue the Certificate IV in Counselling Supervision to those who demonstrate competency in this course."

ACKNOWLEDGMENT

Basa Education and Counselling Services (BECS), acknowledges the provision of some of the learning materials in this course by Philip Armstrong from the Institute of Human Development.

Philip holds a Graduate Degree in Counselling, Diploma of App Science (Counselling), Diploma of Psychology and Diploma of Child Psychology; and currently undertaking Grad Dip in Mental Health Science.

Philip is a Fellow of the Australian Counselling Association, Associate Fellow of Australian College of Health Service Executives, founding member of the University of Notre Dame School of Counselling and Behavioural Science's External Advisory Board, and President of the Federation of Psychotherapists and Counsellors of Queensland Inc. Philip is also editor of the professional journal "Counselling Australia" and co-editor of the International Research Journal cphjournal.com.

BECS STAFF

All education staff have minimum tertiary degree in their appropriate discipline; the trainers and assessors a minimum of Cert IV in TAA; all staff meet national registration requirements and have many years of experience. All counselling staff are clinical members of the Australian Counselling Association (ACA)

Course Designer – Veronika Basa

Veronika is a qualified and experienced professional educator, counsellor, counselling supervisor, VET designer, assessor and trainer, facilitator, and speaker.

She is a Clinical Member of Australian Counselling Association (ACA).

Veronika has Masters Preliminary in Linguistics and Bachelors of Arts Degree La Trobe University Melbourne, Diploma in Education Monash University Melbourne, Diploma of Professional Counselling, Australian Institute of Professional Counsellors, and Certificate IV in TAA.

In her professional career, she has worked with a number of Government and Non-government Organisations in the areas of Education: DEST – Commonwealth and State – Indigenous Unit – Monash University of Melbourne, Curtin University of Perth, Chisholm TAFE Institute, and Secondary Colleges; Counselling and Counselling Supervision (students and qualified counsellors): in Community settings and her private practice.

WORKSHOP DATES

Full Course	Bridging Course
Melbourne	
(8th – 13th Oct)	(15th -18/19th Oct)
Brisbane	
(22nd – 27th Oct)	(29th - 1/2nd Nov)
Sydney	
(5th – 10th Nov)	(12th-15/16th Nov)

BOOKINGS AND ENQUIRIES

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Editorial By Phillip Armstrong

Well we live in interesting times, in Queensland! A state senator has just been charged with a serious drink driving offence. This is significant because the same senator was only recently going around the state discussing the issue of the terrible carnage on our roads and the contribution of alcohol to this problem. She was dismayed at the problem and wondering how any reasonable and responsible person could get behind the wheel of a car after drinking alcohol, knowing they were risking not only their lives but those of others. It seems that walking the talk can be difficult. It is even worse for those who insist the media are there to broadcast their message to all and sundry. The repercussions when the walk becomes wobbly due to incongruency between what we claim to represent and how we really act can be potential professional suicide.

What does this have to do with counselling? Well, we are prone as professionals to this same problem in various ways. Unfortunately, this edition carries a complaints notice that informs you, the reader, that ACA have had to deregister a member from the association who has been found to have breached several of our ethical codes. The complaints committee have upheld a complaint made by a member of the public with regards to an ACA member and the appeals process has also upheld the decision of the complaints committee. The ACA complaints system has once again been tested and found to be fair and efficient and has maintained the trust held in it by the public. But this does once again bring about the question of competency of counsellors.

The ACA complaints system has once again been tested and found to be fair and efficient and maintained the trust held in it by the public. This does once again bring about the question of competency of counsellors.

It is unfortunate that counsellors (no we do not get automatic entry into saint hood with our qualifications) are prone to human conditions that can see them misusing their position for personal gain. This can be intentional, and at times even unintentional, but all the same a misuse of position. Whether it is for financial, ego or physical gain, the outcome remains the same: an abused client. Sometimes this is through ignorance, which is why we insist on members maintaining ongoing professional development (or education). At other times the counsellor can be personally suffering from a mental health condition which fogs their ability to be self reflective and rational. Then there is simply the ego maniac who believes their position gives them the right to sort everything out on behalf of the client, regardless of whether this is in the interest of the client or not. Self empowerment takes on a whole new meaning; a bit of the old thou (counsellor) knows best or thee (client) would not be here. Unfortunately, this is what some clients are looking for without understanding the full implications of handing over responsibility for their lives and decisions to essentially a stranger with a title.

Some clients can confuse control with direction or possibly more accurately choice, which makes sense in a way as they are in most cases confused and emotionally vulnerable in the initial session. This is possibly why they are seeking out counselling services in the first place. It can be quite relieving to have some-one else shoulder your burden rather than help you work through it; just give the counsellor a ring every now and again to see if things are sorted, cool. Regardless of how difficult the choice may be, if the final solution does not involve choice and come freely from the client have we not abused our position? Even if the client's choice involves death, such as refusing treatment for an illness, is it for us to deny this choice by taking control? If we have appropriately challenged this choice and the client is rational have we not done our job? The contract does not claim the outcome has to be subject to our endorsement. The client's final decision deserves our respect, not approval.

This can be challenging for a counsellor if this choice is in contravention of their own fundamental belief system. But rarely does a client seek out counselling to adopt a new belief system. The issue in these cases lays with the counsellor, not the client. Is it not again abuse to force our beliefs onto the client, especially if it is only that we are challenged and having difficulty accepting the final choice made by our client? Does a client not have a right to determine their own path, for example even to chose to remain a drug addict? Although this maybe not be a smart choice, it is theirs to make regardless. When challenged by such choices what can a counsellor do to ensure they remain balanced and functional? What are our choices?

Obviously there is professional supervision. This is possibly the most appropriate first option and why associations such as ACA insist on it being a mandatory component of membership. Professional supervision can also perform the function of ensuring the counsellor is adhering to good practice policies and ethics. How many times do we hear the question "who is counselling the counsellor?" Professional supervisors have a great responsibility to the public as well as to their supervisees. They are our point of quality control. In ACA's experience there is an anecdotal link between poor practice and poor supervision or no supervision.

We quite often see this during the complaints procedure: there is often a clear connection between the two, although, only future research on this issue would prove any substantial link. When a counsellor is challenged, tired or has problems of their own that impact on their ability to counsel appropriately they should take advantage of the supervisory process. Generally we are the last to know that we are engaging in questionable practices with our clients or are overstepping the counsellor-client relationship. Without realising it, we are setting ourselves up for a date with the complaints committee. Regular use of the supervisory process can be the difference between this becoming a reality or not.

ACA

Australian Counselling Association Submission to the Inquiry into Mental Health Services in Australia

INTRODUCTION

This submission highlights some of the key issues and areas of concern for the Australian Counselling Association and its members since the introduction of the Better Access to Psychiatrists, Psychologists and General Practitioners through the MBS initiative. The Australian Counselling Association (ACA) is the peak industry body representing counsellors in Australia. The ACA welcomes the opportunity to make this submission on behalf of its 3000 members to the Community Affairs Committee for its inquiry into mental health services in Australia.

The ACA is highly concerned about a number of issues and inconsistencies that have arisen under the new arrangements. The Committee's own report, *A National Approach to Mental Health – from Crisis to Community* and the recommendations it made with regards to counsellors appear to have been ignored. This is in stark contrast to the Federal Government's dependence on counsellors to deliver some of its most important mental health initiatives, including the recently launched National Pregnancy Support Helpline and Beyond Blue, as well as a number of others including the Domestic Violence Helpline. These are programs that play key roles in servicing the mental health needs of the Australian community, demonstrating a strong reliance and acknowledgement of the vital role counsellors play to help address these issues. This is in direct contradiction with the MBS treatment of this population.

The key issues and areas of concern for the ACA and its members in relation to the Inquiry are as follows:

- Significant decline in the number of referrals to Counsellors from GP's since the introduction of the Better Access initiative due to the exclusion of Counsellors from the Allied Health professionals eligible to access the rebate
- Equity of access and choice has been dramatically reduced through having to either see a GP or a Psychologist as a first option, rather than patients self-determining who they see as a first option
- The MBS is under utilised in rural and regional areas due to the low numbers of GPs and Psychologists in these areas, whilst local Counsellors are having to close their practices due to the dramatic reduction in referrals coupled with current clients leaving in order to access the rebate
- Lower socio-economic areas have not seen the introduction of any new services. Under the new arrangements, access is limited to those who can afford the gap payment to see a psychologist, which is often a substantial cost

In short, the ACA's concerns are primarily about access, exclusivity and financial incentives for referrals.

There are also concerns that the available data used in assessing the success of the initiative to date is not reflective of the reality. This may be due to the fact the MBS has not been in effect long enough, but could also be due to a lack of proper consideration given to the factors discussed above.

The ACA has put together this submission to reflect the Inquiry's Terms of Reference and is happy to assist the Committee throughout its investigations.

About the Australian Counselling Association (ACA)

The ACA was established in 1998 and is the national peak association for counsellors and psychotherapists. The Association is independent with over 3000 individual members, and is the largest and most influential organisation representing counsellors and other workers in the mental health profession. ACA is administered by professional full time staff in its own offices and is contactable during normal business hours on a national 1300 number.

The ACA was established to be a self-regulatory body providing both registration of members and a mechanism to deal with complaints about members. Being registered with the ACA ensures members practice under a uniform and clear Code of Conduct and Practitioner Standards with the provision of a National Complaints Tribunal.

An Overview of the Counselling Industry and the Role of Counsellors

Counsellors focus on the prevention of mental illness by concentrating on emotional and mental health issues, aiming to prevent an issue from becoming chronic or a full-blown psychological disorder. While counsellors may work with patients with a psychological disorder, they are not able to treat or diagnose anything from the Diagnostic and Statistical Manual of Mental Disorders (DSM IV (RV)), this is solely allocated to psychiatrists and psychologists.

Counsellors play a significant role in the provision of mental health services. Counsellors' work with patients in relation to social, cultural and developmental issues, as well as with the problems associated with physical, emotional, and mental disorders. Techniques employed are predominantly centred on the individual, encouraging self-empowerment. The most common reasons for people to visit a counsellor include: personal issues, marital/relationship issues, problems at work, anxiety, depression, grief, trauma, parenting and youth issues, as well as drug and alcohol addictions.

On average, the fees charged by counsellors are $60-100 per session in cities and $40-60 per session in regional areas. Most patients require between 6 and

These programs play key roles in servicing the mental health needs of the Australian community, demonstrating a strong reliance and acknowledgement of the vital role counsellors play to help address these issues.

Outcome of Complaints Procedure

Craig Wilmott, having been found in contravention of the ACA Code of Ethics (Sect 1) and in violation of sections 2.1.3.1 & 2 of the code of practice has been excluded from the Australian Counselling Association with the termination of any professional status, privileges or membership to take effect immediately.

Australian Counselling Association Submission to the Inquiry into Mental Health Services in Australia (Continued)

12 sessions when counselling is sought before issues escalate.

Government-recognised registration is one challenge facing the Counselling industry. This is reflective of the general community's belief that counsellors should be qualified at a minimum of tertiary level, and should be registered by an official body, at a National level. It is important to recognise that the majority of counsellor training for indigenous counsellors is at this level.

The ACA defines a 'counsellor' as a professional having completed an ACA recognised qualification or a qualification that meets ACA training standards at the level of Diploma, Degree, Graduate Diploma, Masters, Doctorate or a PhD in counselling In order to be placed on the National Register, counsellors have to not only be members of ACA, but must meet other industry requirements. This includes adhering to the Code of Conduct which stipulates that all counsellors must have not only achieved a level of competence, but that it must be maintained and developed through continuing professional development coupled with regular and ongoing professional supervision. This includes meeting the requirements of disability access legislation and good practice codes.

The median age of Counsellors is 47, with 75% of both the industry and membership of ACA comprising of women.

Personal health insurance can become more expensive when having to declare a classified mental health condition to a health insurance provider

INQUIRY'S TERMS OF REFERENCE

Part 2 (a)

- **The extent to which the action plan assists in achieving the aims and objectives of the National Mental Health Strategy (NMHS)**

The National Mental Health Strategy was designed to provide "……a framework for national reform from an institutionally based mental health system to one that is consumer focused with an emphasis on supporting the individual in their community."

The Strategy aimed to ensure people suffering from a mental illness had access to a full and effective range of services. The new *Better Access to Psychiatrists, Psychologists and General Practitioners* initiative has prevented this aim from being fully achieved, due to its exclusion of counsellors.

Increased Waiting Times

The legislation has not led to the introduction of new services, but rather an over-utilisation of psychologists. Current waiting lists range from 2-6 weeks in most metropolitan areas, and longer in regional areas, if there are any services available at all.

There is considerable anecdotal evidence that since the introduction of the legislation, referrals are being directed to overbooked psychologists rather than to previously referred-to Counsellors. This is not only crippling the small businesses of many privately practicing counsellors, but perhaps more importantly, it is delaying assistance being received by those most in need, particularly in cases where immediate help will almost certainly curtail an issue from becoming chronic.

There is further anecdotal evidence suggesting that manipulation of the system is occurring with couples using the rebate for relationship counselling. The MBS supported services are for individual counselling. However, by requiring that only one of the partners be referred under a GP Mental Health Plan, couples are able to access the rebate, effectively subsidizing their relationship counselling. This in turn increases waiting times for those genuinely in need of accessing mental health services.

Repercussions of Being Classified With a DSM IV Disorder

In order to ensure sufferers of a mental illness are able to enjoy the same opportunities as other Australians, it is important, according to the NMHS, that the following services be able to be accessed within communities:

- specialised mental health services that recognise their rights and respect their dignity
- general medical services, housing, accommodation support, social support, community and domiciliary care; and
- income security, employment and training services that can all have a significant impact on the capacity of a person with a mental illness or psychiatric disability to live in the community, free from discrimination and stigma.

Considering this, many patients are unaware of the consequences of being placed under a GP Mental Health Plan. The ACA understands that many GPs are failing to properly explain the repercussions of being classified with a DSM IV (RV) disorder.

Personal health insurance can become more expensive when having to declare a classified mental health condition to a health insurance provider. It is also considerably more difficult to get income protection insurance if one is self-employed and declaring a classified mental health issue. A person is also required to declare a mental health problem if he/she wishes to join the armed services (regular and reserve), police service, ambulance service and many other government and security agencies. In Queensland, once classified with a mental health condition, the person is required to get a letter from their doctor confirming suitability to hold a driver license.

These ramifications from a classification with a DSM IV (RV) disorder under a GP Mental Health Care Plan are significant inhibitors from allowing sufferers of a mental illness to be free from discrimination and stigma in their everyday lives.

Part 2 (b)

- **the overall contribution of the action plan to the development of a coordinated infrastructure to support community-based care**

The ACA practitioner survey did indicate that Non Government Organisations who have been offering counselling and Mental Health services for many years are in danger of closing their doors due to a significant drop in the utilisation of their services. They are also losing expert specialists to the commercial sector as they cannot compete in the wage market compared to potential earning in the

commercial sector utilising the MBS. This combination with extended waiting lists for services under the MBS would indicate infrastructure is fracturing as opposed to being further developed.

Part 2 (c)

- **progress towards implementing the recommendations of the Select Committee on Mental Health, as outlined in its report *A National Approach to Mental Health – from Crisis to Community***

When reviewing the recommendations of the Select Committee on Mental Health contained in the report, A National Approach to Mental Health – from Crisis to Community, there are a significant number of recommendations that either directly or indirectly relate to Counsellors that have been ignored or contradicted through the introduction of the new MBS supported services at the exclusion of counsellors.

Since the introduction of the GP Mental Health Care Plan in November 2006, a significant number of counsellors have seen a dramatic decline in their business. The ACA conducted a survey in May 2007, sending out 3000 questionnaires with over 760 respondents. The results of the survey clearly demonstrate that since the introduction of the new legislation, there has been a negative global impact on the counselling industry.

Results from the survey are provided in more detail below, but it is important to note the overall reduction in the size of the Counselling industry already occurring due to the omission of counsellors from the list of MBS supported services.

The Committee should also be aware of the sudden rush by psychologists to receive clinical status now there is a financial incentive, whereas historically there has not been any rush.

This submission will aim to highlight some of these inconsistencies between the Committee's recommendations and the issues currently facing the Counselling industry:

Recommendation 2

2.4 (point 5) Integrate the NMHS, National Drug Strategy, National Suicide Prevention Strategy and National Alcohol Strategy and the delivery of services under these strategies.

Associate Professor Allan Huggins of MensOwn Counselling Clinic has said that many counsellors see patients initially for relationship, stress or anxiety issues. These patients often do not disclose any drug use to their GPs for fear of this being noted on official records. Their first disclosure is often with a trained counsellor. Those patients referred to treatment, in only 5.8% of cases were referrals for help from GPs and medical specialists. In fact, 37% of drug and alcohol abusers refer themselves for treatment[1].

The types of treatment for patients vary, but according to the Alcohol and Other Drug Treatment Services in Australia 2004-05: Report on the National Minimum Data Set, the most common main treatment type nationally was counselling at 40%. This was followed by withdrawal management or detoxification at 18% and assessment only at 12%.

With regards to the principal drug of concern, counselling accounted for the highest proportion of closed treatment episodes for alcohol (44%), cannabis (36%), heroin (29%) and amphetamines (42%).

Considering that in 2006, the use of the drug Ice increased to varying extents in every State[2], and with such a high incidence of people suffering addictions seeking help from counsellors as a main treatment source, it is critical that counsellors be given access to the MBS.

Rebates to counsellors will allow the counselling industry to survive, maintaining its role as a significant source of help for those suffering drug and alcohol addictions. It will also ensure those who can't afford the gap payment for psychologists and psychiatrists will continue to have access to the help they need.

Recommendation 12

2.18 (point 1) Increase the number of funded places and financial incentives in accredited medical and allied health training courses to meet future mental health workforce demands.

The ACA survey also included responses from both students undertaking studies in counselling and from training providers, both VET/HE sectors.

137 students responded to the survey, with 132 claiming they were ceasing their courses or reconsidering to study social work or psychology rather than counselling in light of the exclusion of counsellors from the Medicare rebate.

Of the Training Providers, 18 responded to the survey. 7 of that 18 indicated that the exclusion of counselling for rebates had had a negative impact on enrolments. 15 had indicated that they had students cancel their enrolments as a direct consequence of the exclusion, with 12 providers responding their course would no longer be commercially viable if counsellors were not given access to the rebates.

2.18 (point 2) Substantially increase job support for people with mental illness, recognizing its therapeutic value and provide tax incentives for businesses employing people with mental illness.

Queensland Centre for Mental Health Research recently released findings from a study into the cost of depression and anxiety to Australian business. When looking at workforce participation, depression and anxiety are costing Australian business at least $6.5billion in lost productivity, not considering absenteeism.

By excluding Counsellors from the MBS, the opportunity for early intervention is significantly reduced. Early intervention in many of these cases can prevent conditions such as depression and anxiety from becoming chronic, and in turn, significantly reduce future financial burden on the economy.

The MBS supported services are for individual counselling. However, by requiring that only one of the partners be referred under a GP Mental Health Plan, couples are able to access the rebate, effectively subsidizing their relationship counselling.

1 *Alcohol and other drug treatment services in Australia 2004-05: report on the National Minimum Data Set*, 27th July 2006

2 AUSTRALIAN DRUG TRENDS 2006, Findings from the Illicit Drug Reporting System (IDRS), published by the National Drug and Alcohol Research Centre

Australian Counselling Association Submission to the Inquiry into Mental Health Services in Australia (Continued)

Recommendation 36

3.27 That access to effective non-pharmacological treatment options be improved across the mental health system through:

- **Better access to therapies (including 'talking therapies') provided by psychologists, psychotherapists and counsellors with particular attention to therapy for people with histories of child abuse and neglect.**

Access for all sufferers of mental illness to talking therapies is becoming increasingly limited through the closure of a number of private practices since the introduction of the MBS supported services.

Out of the 331 respondents to the ACA survey in private practice, 314 have lost current clients whom stated that they were changing services in order to access the Medicare rebate. 145 respondents indicated that they would be unable to continue practicing for more than 6 months if there was no change to current provisions, with 3 having already closed their practices, a number of which are now dependant on unemployment benefits. Of those 145, 44 are already actively looking for alternative employment.

In fact, high risk groups such as young men in rural Australia are the least likely to have access to these new MBS supported services – precisely the group with the highest suicide risk and whom are most in need of services.

Of the 134 Non-Government agencies that participated, 98 respondents indicated that they had experienced a significant decrease in client numbers since the introduction of the rebate, with 96 attributing the decline to clients being referred to similar private services that offered rebates. 90 respondents indicated that the future of their counselling service was now in jeopardy.

136 employed or employers of counsellors responded, with 105 indicating there was no future for counselling as an employer/employee without access to Medicare rebates.100 said it was not viable to hire counsellors because they cannot offer rebates.

Recommendation 84

3.75 That greater flexibility in the allocation of Medicare provider numbers for mental health service provision (for instance psychiatric nurse practitioners and counsellors), is exercised in rural and remote areas in recognition of the shortage of psychiatrists and psychologists in these areas.

And

Recommendation 86

3.77 That ongoing incentives and supports be provided to GPs and mental health professionals to promote working in rural and remote areas.

Male farm owners and managers commit suicide at around twice the rate of the national average[3]. Chairman of the Alcohol Education and Rehabilitation Foundation Emeritus Professor Ian Webster believes the rate of alcoholism and diseases like heart disease are higher in the bush due to the prevalence of mental health issues[4].

There is more access to counsellors in rural and regional areas than to other approved practitioners of MBS supported services. According to *Psychology Labour Force 2003*, almost 95% of clinical psychologists are located in metropolitan areas[5]. This is in direct conflict with the fact that people in rural and regional Australia face significantly more issues that are likely to impact on their mental well being, such as drought and isolation.

By not including counsellors in the rebate, many sufferers of mental illness in rural and regional Australia are denied help due to the shortage of eligible providers. In fact, high risk groups such as young men in rural Australia are the least likely to have access to these new MBS supported services – precisely the group with the highest suicide risk and whom are most in need of services. Research such as the FPCQ Regional Project in Queensland also shows that mature age males in rural Queensland will access counselling services as a first choice as opposed to GP and psychological services.

It is significant to also note that the uptake of the new Medicare items relating to social workers, occupational therapists and mental health nurses is negligible. Also negligible is the uptake of the Medicare items covering group therapy, services outside of consulting rooms and remote (phone) counselling.

The ACA advocates that Medicare-funded counselling rebates for registered counsellors would not only minimise the occurrence of mental illness through early intervention, but would also assist in the prevention of tragedies such as youth suicide and relationship breakdowns, both of which have a higher incidence in rural areas.

Recommendation 89

3.80 That 'Indigenous only' education venues for Indigenous health workers are adequately funded and supported to provide collaborative, culturally affirming learning environments for Indigenous people. Consideration should be directed to extending the capacity of facilities such as the Bachelor Institute Indigenous College, the Djirruwang Program at Charles Sturt University, or the introduction of scholarships for Indigenous health professionals, and incorporation of Indigenous Health curriculum in mainstream courses. .

And

3.82 That governments direct recurrent funding to Indigenous community controlled health services to administer the development, implementation and evaluation of appropriate mental health programs.

At present, there is a shortage of psychologists and

3 NSW Farmers Mental Health Network available at http://www.aghealth.org.au/blueprint/

4 ABC News "Calls for Greater Regional Mental Health Focus" 20th July 2007

5 Psychology Labour Force 2003, National Health Labour Force Series Number 33, Australian Institute of Health and Welfare, Canberra, 2006, p. 5

psychiatrists in most Indigenous communities. The large majority of actual "indigenous" counsellors are non psychologist or social work counsellors and are trained through the Vocational Education and Training (VET) sector at the Diploma level. There are VET sector training courses for qualifications as an Indigenous Counsellor in Queensland, New South Wales, South Australia, Western Australia and Northern Territory. All these courses meet ACA registration criteria. These counsellors do not have access to MBS and therefore are unable to work within their respective communities under the current rebate system. It should be recognised that currently access to Higher Education for the majority of the Indigenous community is not attainable whereas VET training is.

While there is a heightened need for mental health services within these communities, most people are unable to afford services, especially when there is a significant remaining gap payment. This is particularly concerning given there are a substantial number of counsellors available, in communities including Cairns, Alice Springs, Port Augusta, Cook Town, Mt Elisa, Pilbarra District, Townsville and many other regional areas who would have the capacity to service this population if a rebate were available to cover costs for residents.

There is also capacity within the ACA and counselling community to train Indigenous counsellors with appropriate funding. Given the fact that traditional psychological services have a limited impact due to cultural nuances, there would be particular value in focusing an effort to train Indigenous counsellors at a diploma level to offer services within their own communities.

Part 2 (d)

- **identifying any possible remaining gaps or shortfalls in funding and in the range of services available for people with a mental illness**

General Practitioner Payments

The number of referrals to Counsellors from GPs has significantly dropped since the introduction of the rebate. A key factor is that GPs are not incentivised to refer patients to counsellors as opposed to psychologists or psychiatrists.

GPs receive rebates of $150.00 to set up a Mental Health Care Plan and then $100.00 to review the plan (up to twelve per calendar year in two groups of six). A Clinical Psychologist receives a rebate of $110.00 with a Psychologist receiving $75.00[6]. Until May this year over 48,000 people accessed the rebate that hadn't previously sought or been referred for psychological treatment.

There is anecdotal evidence of a high incidence of no-shows after the initial GP referral, suggesting an overuse of the GP Mental Health Care Plan in order to access the rebate without appropriate follow-up taking place.

Gap Payment

The gap payment to see a private psychologist/psychiatrist is often more than the full-fee of an ACA-registered counsellor particularly in regional and country areas. There has been no advancement in the affordability of treatment, and many GPs are not fully explaining the gap payment to patients. The gap payment ranges from $50 -$170 as the APS recommended hourly rate for a psychologist is $192 per session.

Many sufferers of mental illness cannot afford ongoing counselling services due to the lack of a Medicare rebate. By enabling access to a rebate for early-intervention counselling services, those sufferers would be able to receive treatment for a condition before it becomes chronic.

The rebate for psychologists and psychiatrists is considerably higher than what it would be for referred-to counsellors, reducing the overall cost of the MBS. According the MHCA report, - *Mental Health and the new Medicare Services: An Analysis of the First Six Months* - there is already the likelihood of a significant cost blow-out. The initial project was funded at $538m over five years. Even if current uptake levels remain steady, the likely 12 month cost of the project will exceed the estimated $220m. Just three of the new Medicare items have cost

$78m between November 2006 and May 2007, including: Item 2710[7] at $38.8m; Item 80010[8] at $15.9m, and; Item 80110[9] at $23.3m.

The ACA believes that counsellors should be entitled to a $50 rebate per 50 minute session. This is considerably less that the current rebate payable to psychologists and psychiatrists. To enable this to occur, the Government would need to include registered counsellors as an eligible Allied Health worker, to whom GPs would be able to refer patients who are under a GP Mental Health Care Plan.

There is anecdotal evidence of a high incidence of no-shows after the initial GP referral, suggesting an overuse of the GP Mental Health Care Plan in order to access the rebate without appropriate follow-up taking place.

Providing Choice

Counsellors mainly assist people in the early stages of a mental illness or emotional distress, working to prevent a condition from becoming chronic. By excluding counsellors from MBS arrangements, the legislation is limiting the choice available to people wanting to access assistance in dealing with their mental health issues.

The ACA believes, and according to the Government's NMHS, there should be equity of access to all services that can make up a mental health care strategy. While psychiatrists and psychologists play vital roles in the management and treatment of mental illness so do counsellors. Counsellors in particular play a major role in the treatment of emotional distress, in early intervention and treatment. In many cases, counselling intervention can prevent mental illness or family breakdown from occurring. They also ensure that those dealing with life-issues as opposed to psychological disorders are able to get assistance before their condition becomes

6 New Mental Health MBS Items – Fees and Rebate Table, available at www.health.gov.au

7 Preparation of a Mental Health Care Plan by a GP

8 Psychological assessment and therapy for a mental disorder by a clinical psychologist lasting at least 50 minutes (up to 12 planned sessions a year)

9 Psychological strategies services for an assessed mental disorder by a clinical psychologist lasting at least 50 minutes (up to 12 planned sessions a year)

Australian Counselling Association Submission to the Inquiry into Mental Health Services in Australia (Continued)

chronic and without the real or perceived stigma of a DSM IV disorder.

The new legislation has distorted competition and placed service provision at risk. Choice has been limited with regards to accessing services as a preventative measure. The new MBS supported services only provide assistance as a reaction to an already established condition.

Pilot Project for Rebates for Counsellors

The Federation of Psychotherapists and Counsellors of Queensland Inc (FPCQ) is a full foundation member of the ACA. Since 2005 FPQC has been working with the ACA, the Queensland Government, and the Mental Health Association (QLD) to provide rebates for members of the public seeking counselling services in rural Queensland.

The Project includes a $20 rebate per 30 minute session with a capped gap payment of $20 per hourly session. Many counsellors charge no gap at all, making the service equivalent to Medicare bulk billing.

The Project has seen a dramatic increase in participants since its inception and has recently been given an extension, with the Queensland Government funding the Project until 2010. However, due to the increase in demand, the Project now has limits on how many sessions counsellors can offer and how many clients counsellors can see per month. One significant outcome of this service is the significant access by mature aged males to the program when the requirement for referral was removed.

Due to the increase in demand, the Project now has limits on how many sessions counsellors can offer and how many clients counsellors can see per month.

It is the ACA's view that this program clearly demonstrates a strong level of community demand, trust and potential for increased utilisation of counselling services when a rebate is provided, particularly when the rebate does not include a referral by a GP. We also believe this suggests that the new Medicare arrangements have not effectively alleviated demand on mental health services, particularly in rural and regional communities, and that high gap payments demanded by psychologists are acting as a deterrent to mental health care access.

Conclusion

The initial introduction of the initiative to place mental health care services under Medicare was lauded by the both the general community and the medical profession as a positive step in dealing with mental health as an important standalone health issue, and has made some significant progress since its introduction. There is now a need to ensure that the project is a complete success, by ensuring improved quality and access to all key mental health services, including counselling, by all people suffering from mental illness.

The ACA believes that the needs of sufferers of mental illness need to take precedence at all stages of the debate. Counsellors play a significant role in the early treatment of patients. There are proven benefits to seeing a counsellor in the early stages of a potential problem or addiction and the preventative opportunities counsellors provide. A fact that is supported by the Federal Government through its employment of counsellors as the first point of contact in dealing with mental illness and its potential causes. However the current MBS arrangements pose a significant threat to the future of the counselling industry, placing at risk the long-term availability of counsellors to deliver Government initiatives such as the National Pregnancy Support Helpline and the Violence Against Women, Australia Says No Helpline, both of which are manned by trained counsellors.

In order for counsellors to successfully move forward as a viable option in the battle against mental illness, the Australian Counselling Association would like the Committee to consider the above mentioned issues and concerns.

The ACA is hopeful it can work with the Committee to ensure that the shortfalls in the legislation are effectively addressed. The Australian Counselling Association is happy to offer its assistance in any way possible, and would welcome the opportunity to provide expert input at any future hearings over the course of the Inquiry.

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Private Practice with Ken Warren

Ken Warren runs a successful counselling practice on the Sunshine Coast (Qld). He specialises in mentoring counsellors throughout Australia to succeed in private practice. Download a copy of his free e-book on private practice through www.kenwarren.com.au

Coping with the new reality after Mental Health Case Plans

I think most Australian counsellors and psychotherapists in private practice were rather taken aback when psychologists and social workers only were given Medicare rebates for people referred under Mental Health Case Plans. Many wondered if their practice could survive with such an uneven playing field.

Has there been an impact since the introduction of MHCPs? Yes, there has. Almost all counsellors and psychotherapists have reported a significant downturn in referrals from GPs. Some of these practitioners are considering closing their private practice and others are thinking twice about going in this direction. This is contrasted against many practices of psychologists and social workers gaining increased referrals from GPs.

However, a few problems are starting to become more obvious with MHCPs. Firstly, the rebate offered does not tend to cover in full the typical fee charged by psychs and social workers, with the clients typically having to pay about half. Clients are also discovering that they are sometimes being referred to therapists who do not necessarily have expertise in the area that is needed. This is not a reflection on all Psychs and Social Workers of course.

Psychs and Social Workers in private practice are also experiencing some frustrations. Clients being referred under MHCPs tend to be more price sensitive and less likely to keep their appointments. Some of these practitioners are finding they are receiving referrals outside of their expertise or issues in which they do not enjoy working. My experience is that clients who are prepared to pay for counselling services themselves, tend to place a higher value on the therapist, work harder in their sessions, and are more likely to keep their appointments. Of course, this generalization is not true for all.

I would like to remind those counsellors in private practice that there has always been an uneven playing field. In the past, private practitioners have had to operate in an environment where there were also free counselling services, government and community agencies, and Medicare and health fund rebates for certain occupations. With low or no cost services in existence, why do people consult private practitioners and pay for counselling with them? This is often because there is a perception of value around the work done by those practitioners. Those therapists are either promoting or have a reputation for doing quality work or for having expertise in the area the client is needing. With the new reality, the need to increase people's perceptions of value in the work we do has just become even more important. Of course, there are still going to be many people who are price sensitive, but there are also many who are prepared to pay more for working with the right person.

So how can you increase people's perceptions of value in the work you do? A good place to start is by being excellent at what you do. You can also increase people's perceptions of value by promoting a viable specialty (perhaps not covered by MHCPs), by developing a profile in your community, or by speaking or writing on your areas of expertise. The private practice operated by Dawn Spinks in Brisbane, for example, has chosen to write and speak to their local GPs about the need to refer people to 'relevant, high quality counselling, not just a service that, while financially appealing, may not be meeting the client's needs.

While Dawn's practice and my own also employ social workers and psychologists, we also employ fellow counsellors who are busy doing what it takes to network with potential referrers and establish value in the work we do. I also present seminars and produce products which have helped diversify income for my practice. Some people will be thinking, "That's OK for them, they already have a profile". This is a defeatist attitude - one that will stop you doing what is needed to build your practice.

Counsellor and ACA Manager, Philip Armstrong, has told me that he has also been proactive with his practice. Philip has diversified his referral base so that he is not solely relying on referrals from GPs, but instead benefitting from his involvement in business networking groups and receiving referrals from employee assistance programs. In a similar way, I have been doing some active relationship building with Family Lawyers who are referring couples who want to develop an easier relationship even though they are separated..

Clients being referred under MHCPs tend to be more price sensitive and less likely to keep their appointments.

I would like to remind everyone that behind every obstacle there is an opportunity. Some people will be thinking that perhaps their opportunity is to retrain or go and work for someone else! I would suggest that there are also other options. The challenge is to consider what the opportunities are for your practice. Some practitioners have seen the opportunity to promote services and specialties not covered under MHCPs, to do more therapeutic group work, to network with other referrers apart from GPs, to share their expertise through writing books or conducting seminars.

Remember that worrying or complaining is a very bad use of your energy. You are better to accept what is out of your control and then move your focus to what you can do to address unmet needs, establish a greater value around your work, and build relationships with potential referrers of your ideal clients. When this is done well, you will attract more of those clients who want to work with you in particular, even if you are not the cheapest therapist in town.

For those feeling overwhelmed or unclear regarding the steps they need to take, I recommend two things. Firstly, setting priorities for what you need to do and, secondly, surrounding yourself with like-minded private practitioners. On Friday 30th November, I am bringing together a group of private practitioners and

Private Practice with Ken Warren (Continued)

those considering private practice, to workshop ideas and strategies for developing their practices. Entitled, Long Lunch with Ken: Private Practitioners' Roundtable, it will take place in a lovely restaurant overlooking Mooloolaba Beach. Only six places are available. Details can be gained by telephoning (07) 5443 7626 or through

Those who are unable to make this event are always welcome to email me at and I will do my best to be of help.

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Tips and Traps in Parenting Plans

Since the shared parenting amendments commenced in July 2006 there has been growing interest in the use of Parenting Plans. With that increased use it is timely to identify some of the tips and traps that are starting to develop both for legal practitioners as well as mediators and counsellors.

PARENTING PLANS

What are they?

Parenting Plans were first introduced to the Family Law Act in 1996, they were later removed but have now returned with the amendments to the Family Law Act on 1 July 2006.

A Plan provides a way of documenting children's arrangements other than with a Court Order.

A Parenting Plan is an agreement in writing, that is made, dated and signed by both parents and which deals with arrangements for the children.

Parenting Plans can deal with a variety of matters, such as, who a child lives with or spends time with, whether parental responsibility is shared or allocated, dispute resolution and other aspects of care for the child.

It does not take much for a Parenting Plan to be created, it is difficult for a Parenting Plan to be set aside and the effect of a Parenting Plan (particularly if there is already a Court Order in place) can be significant.

When is a Parenting Plan made?

A Parenting Plan can be made at anytime and anywhere, more importantly it should be noted that there is no standard form for a Parenting Plan so it is quite easy for a Parenting Plan to be made even though that may not actually be the intention of all parties, at the time.

A Parenting Plan can be made before or after 1 July 2006, it can be made inside or outside of Australia and it can be made with other people as parties to it other than the child's parents (including a grandparent or other relative of the child).

A Parenting Plan can be revisited and updated to reflect the changes which occur from time to time.

Family Relationship Counsellors or Family Relationship Dispute Resolution Practitioners are legally required to advise parties that they can consider entering a Parenting Plan and where they can get further assistance to develop a Parenting Plan.

Parenting Plans are not registered with the Court and are not enforceable as Court Orders.

A Parenting Plan must be made free from any threat, duress or coercion, although it is important to understand that that is a determination that a Court would ultimately make and depends upon the Courts view of the evidence. Duress is a high legal threshold to establish.

What effect does a Parenting Plan have?

If a dispute between parents arises after a Parenting Plan has been prepared, the Court is entitled to look at the Parenting Plan as a reflection of the parties intention in guiding the Court as to what Order is appropriate.

If a Parenting Plan is made after a Court Order has been made then the Parenting Plan will override the Court Order.

How do you change a Parenting Plan?

A Parenting Pan may be varied or revoked by agreement in writing between the parties to the Plan.

Obligation on Lawyer and Counsellor

A Lawyer or a Family Relationship Counsellor or Mediator must inform parties that:

- If the arrangements are "reasonably practicable" and in the "best interests" of the child then the child spending equal time with each of them may be an option for them to consider.
- If equal time is not appropriate but it is "reasonably practicable" and in the "best interests" of the child for the child to spend "substantial and significant time" with each of them then they should consider that option.
- Parenting issues should focus on the best interests of the child.
- The matters that may be dealt with in a Parenting Plan are set out in Section 63C (2) Family Law Act.
- What ways there are of resolving disputes and of changing the plan.
- The Court is able to have regard to the terms of a Parenting Plan when making a Court Order.

Tip

It does not take much for a Parenting Plan to be created, it is difficult for a Parenting Plan to be set aside and the effect of a Parenting Plan (particularly if there is already a Court Order in place) can be significant.

WHERE DO YOU START?

The legal process is complicated and careful consideration of particular circumstances is critical.

Brisbane based Family Law Specialist, Michael Lynch recommends that Specialist Family Law advice should be obtained before doing anything. To assist this process he has recently published a book "A Guide to Family Law – Everyday Answers". Michael says the book is not a substitute for legal advice but will certainly help clarify the changes to the law in an easy to read style. For a free copy of the book telephone (07) 3221 4300 or email law@mlynch.com.au.

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Patient, heal thyself: A clinical case study

Dr John Barletta Ph.D., a practicing Counselling/Clinical Psychologist (Grange, QLD), is Senior Lecturer and Clinical Practicum Supervisor, School of Psychology, Australian Catholic University (www.johnbarletta.com).

It is intriguing to learn things that aggravate me are usually those that have taught me the most or reminded me of stuff I had forgotten. These are the lessons I have seldom enjoyed at the time. I have had enough lessons in life and am a sufficiently educated and experienced therapist to know most of what I need to be a useful professional helper. I do not think I want the reminders I give my students, that the path of the therapist is a treacherous life-long one, to apply to me. In fact, I am certain of it. I have worked with a critical mass of patients, and undertaken ample supervision and consultation to know that I am able to handle many psychological issues and scores of people in distress. It is a comfortable, if not mildly deluded, state to bask in where professional confidence is my faithful companion.

Like many therapists who have struggled with their conscience to work within the milieu of managed care, I have publicly spoken unfavourably of this insidious beast that constricts therapy on the basis of the financial imperative. The dreaded limited-sessions scenario and the strict hour-therapy have been shackles on my professional wrists. This sense of restriction and control begins as I consult the appointment book to make a patient list at commencement of the day. I used to amuse myself by images of managed care patients as cattle from my childhood farm where they would soon be herded unceremoniously through the holding yard (waiting room), branded (intake forms, informed consent, administrative paperwork) and finally dehorned (the speech on session limits). However the case of Alison attests that some of these processes work well in spite of such restrictions.

I often sensed an almost chronic tiredness and defeat typically seen in people with a depressive illness.

I always enjoy receiving patients who have consulted other therapists. At times it is because of a conflict of interest or personality that renders the possibility for future sessions ethically inadvisable. In other instances it has been a problematic or intractable patient who has been referred. I rub my hands with glee at the prospect of these referred cases. I have nothing to lose and everything to gain. It tests my will and skill. It suggests I am different to the referring therapist, which I relish, with the implication that I may be superior in some way. The unique and competitive side of my nature enjoys being more and different. But alas, the referral reason for Alison was none of these. A colleague had been hit by a car which guaranteed a trickle of her patients in my direction. Alison had consulted with my colleague once before the accident and now was my professional responsibility.

Alison was a nurse whom I remember looking forward to meeting. Nurses have always held a special place in my psyche and heart. As a sick child I remember them as the people who wielded pain-inducing hypodermic syringes. As an adolescent they held the privileged position of the fantasised ultimate plaything with a starched white uniform, strapless-watch dangling from a full chest and the obligatory origami-like head-dress. As a college student they were the high-spirited life of the party. And as an adult, a nurse was my very own curative relationship, after a particularly painful and disconnected period in my life. She enabled me to regain confidence and the desire for relational commitment; a transitional relationship. My wife (not a health practitioner) may perhaps be thankful to the nursing profession for its positive impact on me, albeit vicariously.

But Alison was no run of the mill nurse. She was thirty-six and a specialist in psychiatry, a professional colleague, who would know my moves and motives, the rules of engagement. Such professionals can be superb patients; keen, insightful, personality intact, committed to therapy because they know it works, or conversely I have experienced some who are unwilling or unable to let go of their pain and ego, presenting as cynical, hyper-vigilant, demanding and testing. Initially Alison was much of the latter, primarily because of her circumstances, but she transformed through our time together to become a very willing and engaged patient.

With regards to mental health professionals as patients, I vividly remember agreeing to see a Counselling Psychologist whose anxiety compelled him to provide our session with a running commentary of what I was doing, the paradigm that had influenced my interactions and any polysyllabic term his textbook-inspired free associations delivered. He annoyed me greatly. I recall a fantasy of yelling at him **"physician, heal thyself"** but held back for fear of him labelling me a zealot! I'm glad I restrained myself. Fortunately we consulted only once. I hope he is now driving someone I do not like crazy, as he would certainly have done to me.

To say that Alison was dishevelled in our early sessions would be an exaggeration, but using the term in a figurative sense hits the mark. Although she always dressed appropriately casually given she usually came to sessions from home, I often sensed an almost chronic tiredness and defeat typically seen in people with a depressive illness. Her messiness was less about the vast mane of hair she carried, but more about how her husband abandoning her had left her life untidy. She had a sixteen-year marriage that was now over and it was our challenge to clean up. The role of therapy in this case was to guide the cleansing process and my aim was to facilitate the change required to restore faith in herself and the possibility for a hopeful future through the chaos of being deserted. Her goal was less lofty. She wanted to have someone independent who remembered how painful she felt and offload with, and get some support and insight. I stated in early sessions that I was not one of her girlfriends where we would simply chat. I had to be someone she did not have in her life to facilitate what others could not. I wanted therapy to be useful and I was in the business of change. As she said matter-of-factly several times, "I wouldn't continue to come here, given how far I have to drive, if this wasn't worthwhile for me." We both needed reassurance.

Alison was angry with herself and questioned whether she had indeed been a good wife. According to her account of husband David's perception, she had been inadequate in many roles as well as being a "manipulative controlling tyrant." She believed that her husband leaving was directly related to things she

had done or failed to do. The break-up was her fault. So enduring was her low self-assessment that she never fully enjoyed her considerable success in university studies for fear of being identified as a fraud, an impostor. Alison was pissed off at David for leaving her with three children, one of whom was a baby and she was incensed and disappointed that she had invested a decade and a half to a relationship that sank fast. Her resentment meant that she spent much of our early sessions having a "bitch and moan," an quaint expression one of my doctoral professors taught me, about anything to do with her husband, sometimes referring to him as the "weak spineless emotionless pathetic excuse for a human." It was seldom tedious to be present during her elaborate tirades and mostly I would regret I did not take more notes in sessions so that I could have justification for writing the marvellously colourful and sophisticated vocabulary used to shape descriptive utterances to deride David.

Nobody escaped Alison's antagonism, me included. Angry that occasionally I did not understand her well enough or that I could not explicate sufficiently or clearly a statement I had made to her satisfaction. I never thought she did not like me per se. I knew what she didn't like was the fact that she needed to see a professional. We hung in and trusted there would be light at the end of the therapeutic tunnel and for me it was not until our penultimate session that I realised we had stumbled into effectively using the working alliance.

There were many times Alison was certain a miserable future for her was a fait accompli and she described **"black episodes"** where she seriously considered whether life was worth living. Worryingly she discussed her new less-judgemental position on those who to chose to end their life. My duty and ability to find something to anchor her was easy; she chose her children as the reason to stay around. She discussed fantasies of either killing her husband or as she playfully explored, "I think about getting in the car and repeated running over his fucking new trendy bike!" The expensive pristine bicycle, which David recently bought for himself, was his symbol of defiance and freedom from the oppression he felt he had endured in her company. For fleeting moments I considered if my duty of care extended to his luxurious state-of-the-art bike, but I never consulted my lawyer or insurer to explore the parameters of my legal or ethical responsibility. I am, however, fully aware of my responsibilities in the presence of suicide-related conversation, although it does not petrify me as it once did. I appreciate suicide threats as a definitive marker of hopelessness and a compelling request to work intensively.

Alison was not a teary patient but when she was, it was very instructive. One episode where she touched an important issue came when she recalled a dispute in which her husband grabbed her with such force that finger-bruises remained on her upper arms. She cried for the deterioration of the marital dream and her sorrow showed the worthlessness she experienced. Alison, the competent respected professional, was distressed at the impotence she had in the relationship to which she gave so much.

In an early session I was fascinated by a nightmare she experienced. Alison was at an airport boarding an aeroplane to take an expedition to an unknown destination. The part that raised her nocturnal anxiety to the level that distressed her was the feeling that she did not have the obligatory passport to be sanctioned to travel. I did not provide an interpretation of the dream at that time, I simply noted the fact that not even in sleep was she tranquil. In hindsight the implication of the nightmare seems evident; she was embarking on a journey of therapy while retaining doubts about possessing the requisite resources to enable her progress. It was gems like this which made Alison a patient who sustained my interest, which is quite a feat given my susceptibility for inattention.

To explore marital abandonment without conversations about grieving multiple losses is irresponsible. This woman had lost her life-partner, dreams, assumptions, self-respect and control and her only acquisitions in the early stages were embarrassment, shame, guilt, sorrow and humiliation, all of which were unable to be processed initially. She later found these millstones could be endured and became that which made her determined to persist. At times like this my Sicilian family might say one needs to simply **"tira avanti"** (move ahead). But Alison's grief had to be depathologised so that she could feel somewhat normal, accept her inability to control her husband's choices and identify what she could still influence in her life. Firmly and optimistically I encouraged her to see the world was no longer as it had been but the new world which she found herself in could certainly be navigated. We interacted in ways that allowed her to experience support and compassion from someone who was not going to abandon her. At least not for ten sessions. A restorative relationship focused on empowerment is vital and Alison, or **"action girl"** as I warmly called her because of her methodical planning, had to find ways of channelling her energy into adapting and restoring equilibrium. She had to believe in a future that was worth moving towards, that there was no option to surviving. I had to represent hope and advocate faith in a blasé fashion because she was a patient who had the potential to identify and critique my every move. She seldom did.

For fleeting moments I considered if my duty of care extended to his luxurious state-of-the-art bike, but I never consulted my lawyer or insurer to explore the parameters of my legal or ethical responsibility.

Alison used her time in therapy well. She was honest, insightful and talked with a frankness of which every therapist dreams. She felt comfortable using profanities when she was angry or wanted me to know that something was important, and I in turn borrowed her expletives, or accessed my own cache of them, as a mark of solidarity. My focus was to personify the essence of acceptance, or as most know it now via the term appropriated by **Carl Rogers**, unconditional positive regard. She needed to experience our sessions as being safe, encouraging and challenging. Simultaneously my friendship with the master family therapist **Maurizio Andolfi** reminded me that in therapy, I **"don't have to be extraordinarily nice."** I wanted her to know that in spite of my own happy life I could understand and be with her in the enormous suffering she experienced. A suffering that took on dimensions of palpable physiological pain. I did not want her to think I was not present in the loneliness and desperation that isolation supplies, because I too had been there, but

Patient, heal thyself: A clinical case study (Continued)

this was not my privileged time to explore the history of my pain and fragmentation. This was the time to model the reality that people recover from anguish and authentic meaning is gained through the most torturous experiences.

I quickly became the type of sparring partner for Alison who contains the punch, holds the pain and remarks on style, intensity and adjustments. That is what she wanted and I trusted she knew what she needed. This was her first time in the ring and I was the seasoned warrior. I admire her for knowing how to start therapy the way she intended to continue. I also had to trust myself. I regularly asked Alison what she wanted from our time together. She was adamant that interpretations of what she shared and alternative ways to view and cope with her situation would be invaluable. Alison's aims were always clear and consistent; **"I want you to really hear what I'm going through and tell me how I'm doing in this process."**

My need for evaluation and peer recognition became apparent and was something I subsequently attended to so it interfered less with what had to happen for her.

In one of our last sessions she commented; "You have always given me at least one thing in a session that I think about for a while after our meetings; while I don't always agree with you at the time or instantly understand the comments or insights I later find you're exactly right, you know?" Wow this is what great therapy is all about, I was finally a truly perceptive and useful therapist. It is clear now that my ego being stroked was exceptionally satisfying and I prized it. Maybe I was omniscient after all. It was flattering comments that made me wish I had videotaped our sessions or at least have had a crowd of graduate students peering at us through the two-way mirror in my University clinic. Such brilliance on my part, the educator element of me would imagine, should not be wasted in the confines and sterility of an agency therapy room. This was the feedback and interaction novice therapists had to observe so they could trust everything else that I said in class and what experienced colleagues should witness so that they knew I was one of them. My need for evaluation and peer recognition became apparent and was something I subsequently attended to so it interfered less with what had to happen for her. Her kind comments served my need to be seen as an expert with exemplary skill in how to provide meaning, and my astute comments sustained her healing between sessions.

Alison made good improvement in therapy. The focus of her stories shifted from almost an entire attention on David with her anger and frustration, to discussions about the plight of her children, then a review of her family-of-origin (an abusive alcoholic father) and ultimately to discussions about herself and the future. This was indeed useful territory to traverse and explore. All stakeholders were discussed and the

conversation transitioned to dwell where it needed. She sought to stop treading water and move on. This progress could be facilitated with an exploration of the enduring themes and for Alison it was about not feeling worthy.

During the course of therapy Alison continued with life because there wasn't a choice, an assumption that did not go unchallenged. I informed her that I had seen many patients who have chosen not to continue with life in the sense most would understand; working, parenting, getting help, bathing, interacting with the world, planning, eating properly and communicating with family. She was doing all of these things, had started a graduate program and was moving into a new professional role. So although Alison thought she was marking time, she was moving forward in considerable steps. She was establishing clearer boundaries with her husband and was socialising with friends at the times she did not have guardianship of her children. This was a new and adventurous time because she had been with David all her adult life and had never dated anyone else. Now the possibilities were endless and she began to explore them.

After seven months of therapy there was a dramatic shift for Alison. She came to the session wanting to discuss the issue of having a fling, a casual sexual relationship, with a colleague. We delved into the issues and implications in such a way that I avoided either being seen as prudish or encouraging. This was something I did not want to be a part of but I did not want to abandon her at this juncture. I was not sure a fling was such a great idea but as I have seen before, she often knew best. Within a month she had begun a relationship with a co-worker who was visiting briefly from overseas. This man, whom I labelled and she was amused to agree, was her **"transitional object."** We had another conversation that I am sure entertains her to this day as I explained the 3-Rs of why people have sex; Relationship, Reproduction and Recreation. I learned this hokey but catchy way to view intimacy from my efforts conducting pre-marriage education courses and I thought it might be useful. The only use it really served was as a source of absolute amusement for her, which I can accept, and sounding like the stereotypical relationship educator is not something I relish.

Alison's transitional object, as it accurately did turn out, bore none of the characteristics of any of the 3-Rs, rather it became an issue of control. This was the first time in many years that Alison exercised her power. She made advances to a man which were clear in intention and descriptive of her needs. She got what she wanted, no one was hurt and it was beneficial for her development, but it did not stop there. Alison had at least a couple subsequent flings she equally enjoyed, in part, because she finally learned how to **"date like a man."** Although I initially feigned umbrage at her stereotypical view of men, I knew exactly what she meant and my ensuing silence provided tacit support. My encouragement was aimed at supporting her expressions of control and power because someone who had lost much, and whose grief was so painful, regaining a sense of mastery over her life was working out how to start the process of recovery. And she was learning what was needed to do in spite of my presence. She did not develop an habitual pattern of casual relationships, given her newfound libidinal drive, but there was little doubt sex (as an expression of control) was getting her back on track. It was pleasing to see her ultimately find a companion who had a similar intellect and personality and with whom she was interested in developing a more serious partnership.

During discussions of her flings I routinely fantasised, given that I knew where she lived and where she socialised, that there would be a time where she would be regaling her latest conquest, only for me to find out that my best friend who lived in an adjoining suburb and frequented her local pub, would be her latest play thing. There existed an ambivalence for me whether or not this would be good thing for all involved. My friend was a widower who, while well on the route to recovery, also derived immense benefit and pleasure in flings. So my fantasy played out fully, there would exist my best friend dating, or at least sleeping with, my best patient. What an image it created for me with visions of dinners or outings where everyone would be laughing heartily at some absurd remark, with Alison and I sharing intimate details to which our partners were not privy.

As Alison's time in therapy proceeded I needed to gain approval from the agency manager, also my Clinical Supervisor, to extend Alison's allocation of sessions. This is the double-edged sword of managed care. It is restrictive as it does not allow therapists to work at depth, yet sharpens therapeutic skills to see what can be achieved within a predetermined limit. In this case therapy had been too good for both of us to stop now, and I was successful in gaining additional sessions for her, but subsequently she paid independently beyond that allocation. Everyone was pleased with the generosity of the arrangement. Prior to negotiating this new agreement, we had conversations addressing termination where her abandonment anxiety was highlighted. She did not want to end therapy prematurely and I did not want to be another significant male in her life to abandon her. My supervisor agreed she needed to leave therapy with a positive experience, that she felt her aims were satisfied and that I remained for her a model of fidelity and genuineness.

She did not want to end therapy prematurely and I did not want to be another significant male in her life to abandon her.

In our thirteen session I mentioned that I thought she was sufficiently robust that we could soon terminate. She assumed I was trying to tell her that by now, given her husband had left a year ago, she should be emotionally stable. Again an honest conversation ensued to address the misunderstanding. Alison and I shared a therapeutic intimacy and honesty that couples in a committed relationship aspire for. This is not uncommon in good therapy. I am reminded of what the eminent existential psychotherapist **Irvin Yalom** embodies as he confirms therapy is not a substitute for friendship, but it shows patients what they can achieve outside of therapy in their world. I had the same expectation for Alison.

When I would consult the intake assistant to check the appointments for the following day, I was occasionally told that Alison had not called to confirm. The agency had a policy that if a patient did not confirm their appointment by noon on the day preceding their appointment, the session would be allocated to some other needy case. Uncharacteristically I would ask that

Patient, heal thyself: A clinical case study (Continued)

Alison was phoned to see if she needed the appointment. I wanted to continue our work and she invariably sought to attend. It was a case of useful therapy needing to continue toward a fitting closure. Therapists have few times where they get to work with a patient for an extended period of time and experience the joy and satisfaction of substantive changes and I did not want to be denied. I could not contemplate this case being DNF; Did Not Finish.

Early in her therapy as I was preparing to go on holidays she tentatively asked where I was going. Her hesitancy indicated she did not think it was her business where I went on my annual travels and it was not. In the second year of her seeing me, just before we terminated, I was preparing her for my holiday departure by telling her from what date I would not be available. She remarked by saying, "this is not the usual time you take holidays." This comment stopped me momentarily with the realisation I had a patient who knew my holiday schedule, a patient to whom I said I was going on holidays rather than the usual, "I will be unavailable for consultation for 5 weeks." What was different here and why give her the privilege? I use the "I will be unavailable" spiel to keep myself distant from patients, to maintain a professional façade. To disclose going on annual holidays to New Mexico with my wife means being honoured with personal information. I had been honoured to learn much about her life and this was one small announcement where the favour could be returned.

She remarked; "John, thank you so much for everything you have been to me, I will never forget that you are the best doctor I have ever seen, come here."

Although in therapy I get close to patients, I have always remained in the shallow end of the self-disclosure pool. My rationalisation for this has been a combination of self-preservation and not wanting to be one of those therapists spoken about at dinner parties, often unceremoniously described as having more problems than the patient. Alison was no different and although I did not specifically tell her of the rejection, marginalisation and pain that I had experienced, I think she knew because of my kindness. I wanted her to understand via my sage-like comments; "I know the agony of rejection seems impossible to endure at times but this is something we survive and it makes us more certain about what we are capable of and moulds our compassion." I never wanted to tell her of my heartbreaking story because she was doing so well to work through significant portions of her own, as I did before her.

Toward the end of her course of therapy, our time together, we reminisced with increasing frequency, like old friends. I would recap on how she had changed in her self-awareness, views, behaviours, dreams, plans and language. She looked different too, and I told her so. I told her I did not know how, but I knew. She became less messy with her hair, facial expressions, body movements and purpose. Now at thirty-eight she regained her attractive appearance and disposition that had been masked during her struggle with rejection. She would mention things I said that had been useful to her and how good it had been for her to have committed to therapy. It was like we were preparing for a death, the slow and regretful demise of an intensely intimate relationship and the end of some certainty. The certainty I had come to enjoy when I had a session with Alison, as I knew we would be able to work with each other's style; but how to ultimately close and celebrate therapy appropriately escaped me.

I recall a couple of years prior I had been involved in a research project in the psychiatry department of the local hospital. After a series of sessions with Gwen, a sixty-two year old patient with major depressive disorder, we decided to have coffee in the hospital cafeteria as a way of celebrating her progress. After a pleasant social chat I walked her back to the main corridor where would part ways forever. As I finished my brief parting oration wishing her luck in front of a row of elevators, one opened (filled with specialist physicians) as she remarked; **"John, thank you so much for everything you have been to me, I will never forget that you are the best doctor I have ever seen, come here."** And with that, grabbed me to bestow a gigantic bear-hug from the basement of her being. As wonderful as it was in its spontaneity, to this day I wonder what the medicos who observed such gratitude thought. I was not embarrassed. I was proud Gwen thought so highly of me to make a public declarative statement of my competence and value.

With Alison I was not sure how this course of therapy would or should end. Alison and I never touched. I do not think we shook hands at the initial meeting which is quite atypical. So how unusual would it be to offer one now? Should a hug be initiated and for what purpose? It's not my style. I knew I wanted to ask Alison and allow her to again allay my anxiety by showing me the way forward. But that was not her role.

When approaching our final session I was filled with misgivings. Termination is probably one of the most simultaneously repugnant and liberating terms used in the helping professions. It connotes a new beginning via a planned ending. How much would I miss her? Would we ever see each other again either as patient-therapist or by chance publicly? Could she continue with the gains made thus far? Would I again have a patient with whom I could spar so robustly? What would her life be like post-therapy? How wonderful were the possibilities for her…

What I decided to do for termination was uncharacteristic. I thought in preparation for Alison to reflect on our time together, it would be useful for her to write about her experience of the impact of therapy. She immediately thought that was a useful exercise adding it would be more useful if I did a similar thing. A draft of this article was my offering to her for our final session and her musings that follow are hers. So it was Alison who brought me to write this case study. Committing to paper a range of perceptions that would be checked-out by the involved party is a challenge. Sometimes, as I am retelling therapeutic tales in class, I know that I embellish my prowess or am duped by a euphoric recall.

My sessions with Alison were impressive. She reminded me much about therapy over many consultations and an extended period of time. This was not a patient from whose experience I could regale stories of the efficacy of short-term therapy. Rather this was a patient who showed good outcomes sometimes happen in their own good time. I recognise what I have learned throughout her course of therapy is simply this treatment and relationship

worked with this patient. My sessions since Alison and I finished are less cautious and more self-disclosive, liberated. **It has been a treasure to experience this patient grow as a person, as I have grown as a therapist, educator and person.**

Alison's reflection on therapy

When I was a little girl, I was quite a solitary child and reading was my main pastime. Looking back, I retreated from a world I found quite incomprehensible at times into the comfort of words. Books and words became my closest companions. It is probably not surprising that when my world once more became incomprehensible to me as an adult woman that I sought solace and meaning in words. On this occasion, however, the words didn't come from a book; they form part of several significant, ongoing conversations. The conversation we had over a long period of time was without doubt the most significant. John, you asked me to give you my feedback on our conversation and time together, so here it is.

Possibly, it is true that the human mind has a way of smoothing over some especially painful experiences so that it is possible to look back at those times with some degree of equanimity, acceptance. I think, though, that there are several moments I always remember with an involuntary sort of shudder. Much of my grief was expressed in a physical way and I can still remember the constant, dull ache just under my ribs, like some load I carried for months. I had, for the longest time, a sense that I was drowning and often my nightmares would always be me standing, looking up at a wall of water and waiting for it to crash down on me. It never did. At the beginning I would often feel like a lost child looking for her mother, father, family. In a sense, David had been all of those things to me. The worst times were when I felt as I was hanging on to my very life and it would be easy and so much less tiring to just let go and let the waters close over me. For me, it was a very long goodbye.

What I want to talk about are several of the ways in which therapy informed what I thought, then felt and finally did, over time. I think that when I first came to see you I had the need to "do something" (sound familiar?). The first conversation that truly stays with me was the one where you asked what my husband's grievances against me consisted of. I said, "well, he says I oppress him and control him," amongst other things. I may well have seen the eyebrow go up at this point and you said, "think about it for a minute, who's in control? It certainly isn't you." And for the first time I was able to see the situation in a totally different way.

You see, I always had the sense (notice I don't say feeling) that if I could survive this, it would be a way of finding a way to think about it that I could live with, that is, I could have peace. Possibly one of the valuable things you did for me was to address the issue of control; what I could and could not control. "You want satisfaction," you'd say, "you want David to do this and say that, don't you get it that you have to live your life most likely without the satisfaction of

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Patient, heal thyself: A clinical case study (Continued)

having all the answers you want. You'll have to sit with the shitty bits!" I railed against this for some time.

One of the things that you helped me accept was that I would have to go through it. There would be only one way to the other side and I might as well start walking towards it, essentially on my own. **You did not sugar-coat any of it and gave me the dignity of acknowledging my profound grief.** I can remember almost picturing myself trying to look over the horizon towards a day when the sadness would end and I could imagine a life without David. For a very long time I couldn't see any further than the horizon. But I recall late one afternoon at the beach with my son, drifting about in a shallow, warm tidal pool. Almost looking at the first stars of the evening and knowing, with a sense of wonder that the physical pain had lifted momentarily. I knew it would return, but for the first time I envisioned the day when the pain of this loss would be gone. The encouragement of hope was an important part of our relationship. I speak of genuine, tentative, hard-won hope that comes when you believe it is worth choosing life and living, whatever happens, and the kind of hope you have when you have been tested and ultimately not found wanting (with a little help from your friends).

Another little gem you delivered, never with great fanfare, almost always by-the-by, was the afternoon you suggested (conspiratorially) that perhaps the end of my marriage was not such a bad thing; heresy! "After all, it hadn't been great or even good for a long time, your husband looks like the bad guy and you win the public relations war, etcetera; just think about it okay." What a crappy thing to say, how could you? Did you not see the grief and agony I went through? "Just think about it. That's all I want you to do." Damned if I didn't think about I all the way home, with a half smile. I had already begun the work of seeing myself not as a victim, someone to whom things are done, who has to accept whatever is given, but someone who chooses how to respond, how to consider, how to feel.

For me, therapy had to be a two-way process, a conversation with a real human being who was secure enough to disagree, look irritable, argue and maybe even make some hand gestures, yet would stay with me.

The end of the beginning probably came the afternoon we had a particularly poignant conversation, "How do you know when it's truly over? How will I know? What will it feel like?" We talked around it for a while and you said, "I think you've just answered your own question," and when I left I felt an odd mixture of sorrow and acceptance and I knew the worst part of that long goodbye was over for me.

For me, therapy had to be a two-way process, a conversation with a real human being who was secure enough to disagree, look irritable, argue and maybe even make some hand gestures, yet would stay with me. John, if you had sat there saying "mmmm, ok, yes, I see," I would not have wasted my time. I needed someone to challenge me on a regular basis. I was never short of shoulders to cry on, but I required a therapist who could pick up any attempt at bullshit or self-deception and return it to me still wriggling. I found our conversation to be a bullshit free zone.

It is almost like this experience has become part of the story of my life, almost like pages of a photo album. You look through the pictures that precede it and you allow yourself to look carefully and respectfully at those special pages and then you turn the pages and go on to the next part with your whole heart. I believe our conversation has helped me make this intensely painful experience of loss a part of my life story, but not the experience that defines me as a human being.

I have often wondered what my experience of the last year or so would have been like without our conversation. You spoke more than once about sitting in the shitty bits. **I like to think that, along with those who love me and who never let go of my hand, you sat there and kept the faith until the day I found I had faith in myself.**

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Kerry Cavanagh	Adelaide	08 8221 6066	B.A. (Hons), M. App. Psych.	$120	Face to Face, Phone
Adrienne Jeffries	Erindale	0414 390 163	BA Social Work, Dip Psychosynthesis	$85	Face to Face, Phone, Group
Moira Joyce	Frewville	1300 556 892	B. App Sc (Soc Wrk), Cert Mediation, Cert Fam Ther, Cert Couple Ther, Supervisor Trng	$100	Face to Face, Phone, Group
Anne Hamilton	Gladstone	08 8662 2386	Grad Dip Mental Health, Supervisor ACCS	$66	Face to Face, Phone, Group
Yvonne Howlett	Sellicks Beach	0414 432 078	Reg Nurse, Dip Prof. Couns., Supervisor Trng (AIPC)	$100	Face to Face, Phone
Dr Nadine Pelling	Adelaide	0402 598 580	M.A. Ph.D Psychologist & Counsellor	$100	Face to Face, Phone, Group
Maurice Benfredi	Glenelg South	08 8110 1222	Grad Dip Hlth Couns, Dip Counselling and Comm, Advanced Dip Appl Soc Sc	$90	Face to Face, Phone, Group
Carol Moore	Old Reynella	08 8232 7511	Dip. Prof. Couns. B. Bus HRD, Prof Supervisor	$99 Ind, $25 Grp	Face to Face, Phone, Group
WESTERN AUSTRALIA					
Christine Ockenfels	Lemming	0438 312 173	MA. Couns., Grad Dip Couns. Dip. C. Couns. Sup Trng (Wasley)	$66	Face to Face, Phone
Dr Kevin Franklin	Mt Lawley	08 9328 6684	PhD (Clin Psych), Trainer, Educator, Practitioner	$100	Face to Face
Carolyn Midwood	Sorrento/Victoria Park	08 9448 3210	MA. Couns. NLP, Sup Trg, Dip Prof. Couns. Cert IV Sm Bus Mgt	$99	Face to Face, Phone, Group
Eva Lenz	Fremantle	08 9336 3330	Adv. Dip. Edu. Couns., M.A., Religion, Dip Teach	$75	Face to Face, Phone, Group
Lillian Wolfinger	Yokine	08 9345 0387	Professional Supervison	$60	Face to Face, Phone
Beverley Abel	Scarborough	08 9341 7981 0402 902 264	Registered Psychologist	$110	Face to Face
Deidre Nye	Gosnells	08 9490 2278 0409 901 351	Supervisor Training	$80	Face to Face, Phone, Group
John Dallimore	Fremantle	0437 087 119	COA of Supervision (CCC) B. Couns B. Appl. Psych	$90	Face to Face, Phone, Group
TASMANIA					
David Hayden	Howrah	0417 581 699	Dip. Prof. Couns. Prof. Sup (AIPC)	$80	Face to Face, Phone, Group
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Rian Rombouts	Parap	08 8981 8030	Dip Mental Health, Dip Clin Hypno, Supervisor Trg	$88	Face to Face, Phone
Margaret Lambert	Brinkin	08 8945 9588 0414 459 585	Grad Dip Psych B Bch Sc (Hons)	$80 ind $120 group	Face to Face, Phone, Group
SINGAPORE					
Hoong Wee Min	Singapore	65 9624 5885	MA Social Science, Supervisor Trng	$100	Face to Face & Group

Theory of the Second Question By Bill Jackson

Before this article goes anywhere I must admit to something: this is a definite work in progress. The theory, while hopefully clinically sound, is also built upon a number of presuppositions which will hopefully become clear as the article progresses.

I have, over a number of years developed a theory which I have named, for want of a better or more imaginative expression, the *theory of the second question*. Now let me be up front about what this theory involves lest you eagerly anticipate for too much longer only to be sorely disappointed upon its revelation.

The theory goes something like this is in what we might consider a typical dialogue:

Me: Hi
Them: Hi
Me: How are you/how are you going etc.?
Them: Good.
Me: How are you *really* going?
Them: Actually not so well (or words to that effect).

I know what you're thinking. So what? Exactly! Except for the fact (and I am aware that I am in all likelihood speaking to the converted here) that more often than not this dialogue never occurs. And the reason it doesn't occur is, I think, very much an Australian phenomenon. Let me explain.

We Australians have, over the years, developed our own wonderful yet distinctive Aussie vernacular where we implicitly and unintentionally ask after each other's welfare in our greetings.

Having lived both in Australia and overseas (specifically the United States) as well as having done my share of overseas travel, I am very much aware of what constitutes typically and distinctly Australian greetings and salutations. So much so, that in order to blend in to U.S. culture, our family gave up our Aussie greetings in favour of more familiar Americanisms. "Hey" became our standard greeting to those around us. This particular expression was particularly pragmatic at the Institution where I was studying as "hey" is so "accent free." Go on, try it out. Not an accent to be found within the expression.

The nice thing about "Hey" was that it meant little (if anything) more than just that. There was no intention other than a mere acknowledgement of another person: "I see you and acknowledge your presence." Implicit in this of course is a plethora of other non-verbal statements. What "hey" *doesn't* say is:

"How are?"
"How are you doing?"
"What's happening in your life?" etc.

Naturally, this expression is something practised frequently by strangers even (in my case) on the same campus. We were fellow students but that was the limit of our commonality. We did not know each other and (implicitly) in many cases had no intention of getting to know each other. Nothing bad in that of course, just a realisation that we were not friends, we did not care for each other's welfare in any sort of personal sense, and that was the end of it.

Australian culture, on the other hand is not so simplistic or as well defined. We Australians have, over the years, developed our own wonderful yet distinctive Aussie vernacular where we implicitly and unintentionally ask after each other's welfare in our greetings. Consider the following examples: (written in the Aussie vernacular for convenience)

"How are ya?"
"(G'day mate,) how ya goin?"
"How's it goin?"

We have all (and possibly continue to do so) used such expressions without giving any thought to what we are actually saying. This, I find is to our collective detriment. For we are, regrettably, and as I have mentioned, usually unintentionally asking how the other party is faring. Hence, the above examples could just as easily be understood as implying the following:

"How are you?"
"Good day friend, how are you going/doing?"
"How are things with you going?"
"What is happening in your life at present?" etc.

However, while the actual words may mean this, this is certainly not what is meant by the use of such words. This is not the intention of such interaction. But herein lays the dilemma. For when we do ask after someone's welfare, such a question of intent sounds not dissimilar to the above greetings. So a sincere "How are you going?" sounds no different to a simple greeting such as "How are you?" Our asking after someone's welfare is readily interpreted as nothing more than saying "Hello." It is not surprising then that such a question is more often than not met with little other than a response of "Good." For something like "good" is the recommended and socially acceptable response to such a question. As a response then, "good" is synonymous with a simple "hello." Thus a two way conversation such as the above, while containing within it the implication:

"Hi, how are you?"
"Good and you?"
"Also good" (or some such variation),

in actual fact means nothing more than:

"Hi"
"Hi"
"Hi" (reprised.)

Now, in all fairness it must be noted that in a vast number of cases, not only does this dialogue work, but it is all that is required by either party. The average person has no intention of enquiring of another's welfare so the above dialogue serves the purpose well. The (implied) meaning here takes precedence over the actual words used. Hence the problem.

Those of us in the counselling or general helping professions will have experienced frustration in such instances. A question of concern is responded to as if it were nothing more than a mere greeting. And even more frustrating it is for those who *do* care, but do not possess the vocabulary to go the next step. Too many people ask sincerely after another's welfare only to be thwarted at the first step. In answer to the "how are you?" question too many people, as we have seen, interpret this question not as a caring question at all but as nothing more than a greeting. Their reply then ("good") is more often than not, not only convenient but totally inaccurate. In short, it is not true. Hence the need for a *second question*.

My *second question* is premised on a number of assumptions which I believe to be true. In summary, they are as follows:

- Most people think that no one really cares about them
- Most people don't like to complain
- Most people don't like to genuinely express their feelings
- Many (other) people are of the opinion that if they truly ask someone how they are, the other person will tell them, and that's a problem because
- Most people aren't in fact all that interested in how other people are going, and so
- If one person asks another how they *really* are, they may end up getting more than they bargained for: in short, people may actually tell them exactly *how they are*.

The bottom line in all this is that

- Half the people don't ask how the other half are doing, and
- The other half doesn't tell how they are doing.

What we are left with is a wonderful and potentially destructive impasse.

I say *potentially destructive* on the basis of another assumption, namely:

- *We want to tell others how we are faring; or in other words:*
- *We want them to care (about us.)*

The reason I say this is on the basis of some empirical (albeit anecdotal) evidence. This evidence gathered over more than a decade has both informed me and convinced me that when I ask a second, follow up question about someone's welfare in normal *conversation they invariably tell me*. The standard answer is gone and immediately replaced with a more sincere, heartfelt response. Why is that? We may well wonder! An assumption which I have stated above provides (for me) a satisfactory answer: people both want *and* need to share.

I would love to see more training courses conducted for those with a caring heart.

I have found that when others become aware of genuine care and concern; when they become the unwitting recipients of another's concern; when they come to the stark realisation that your "how are you?" means more than a cursory "hi" and that it literally *does* mean "how are you?" then they are more than willing to offload; to speak their burden, to share their pain. For me, this is a profound privilege. It is this realisation that has led me to formulate my *second question* theory: namely that:

When people discover a genuine caring and safe environment (through the intentional use of a follow-up question), they are more than willing to share how they ***really*** *are.*

While this may not be overly profound; and while it is surely something that all counsellors would give assent to, it is nevertheless deeply significant. It may also help to explain why counselling as a profession continues to become more and more legitimate and why it continues to build in size. It is as if people have been waiting for such an opportunity: that they have been waiting for permission to actually share themselves with someone who *genuinely cares.*

Theory of the Second Question (Continued)

Six hundred persons joined the ACA in 2004 alone. Little wonder that the Australian Bureau of Statistics reportedly stated "the demand for counselling services is strong and growing."[3]

I use these words intentionally and quite deliberately. I also omit equally intentionally and equally deliberately the sentence "with someone who is qualified." While we approach and practice our profession as qualified professionals, perhaps the reason that we *are* professionals is that we were carers in the first place. Is that not why some of us have moved our way into counselling? And it is this quality, rather than any diploma hanging on a wall, that attracts people to us and it is that same quality that allows even encourages people to open themselves up before us.

I am aware that this embryonic theory, as it stands, is not something that will come as a shock to any caring allied health professional. We are, after all, in the business of asking second and third and even more subsequent questions. "Follow up" questions are the stuff of counselling. However, demand increases in our society for trained caring people to be out there in the front lines. Before any one makes a counselling appointment they come in contact with a plethora of persons: friends, family, colleagues, associates etc. Advice is sometimes sought, and sometimes given. At times, this advice is even good.

Regrettably, however, there are some who, wanting to care, but not knowing how, proffer bad, destructive advice. Some of these are bad listeners and untrained questioners. Others, without the benefit of insight (let alone empathy) ask after someone's welfare, only to be told that they are "good" and that is that. Unfortunately, as we know, that is usually, *not* that. More concern is needed; indeed, a second question is what is required. I would love to see more training courses conducted for those with a caring heart. Of course, some courses do exist but these are few. This should not surprise us for specific counselling courses are few in this country: at least at the undergraduate level. Some church organisations and community organisations at times run some type of "helping skills" or "listening skills" courses.

As one who has spent many years in the training and education field I would love to see this continue and increase. I would love to see people in each society who already have a heart to listen, and a predisposition to care, to go further and receive some basic counselling/listening/caring instruction. I believe that training such persons in "the second question" technique might prove a good start.

Counselling is a growth industry, particularly here in Australia. In the last five years, Counselling as an occupation has enjoyed an 11.5% employment growth. Recently this has escalated even more with the level of growth within the last two years has sky rocketed a massive 28.1%.[1]

As the industry's size grows so also does its legitimacy. Counsellors are filling a void that many other allied health professionals are not filling. According to Government figures, there are, in Australia, some 17,300 counsellors. This is a far cry from the approximate 5,000 as recently as 1991.[2] It is further anticipated that this trend will continue in this same direction in the future. This trend can, for example, be seen in the recent growth of appropriate professional bodies. The Australian Counselling Association alone currently has some 3,000 financial members and a further 4,000 subscription members throughout the country. Over five hundred persons joined the ACA in 2006 alone. Little wonder that the Australian Bureau of Statistics reportedly stated "the demand for counselling services is strong and growing."[3]

Several years ago many of us were watching a show about a place "where everybody knows your name." *Cheers* provided a safe place where the same old regulars would, week in and week out share their problems, indeed their lives with each other. While much that issued forth from behind the Bar would not constitute "good counselling" the need to share and to have someone listen (or at least feign listening) was obvious. People want others to care. We want to feel that we matter.

As counsellors we know the truth of this. We know the release that comes from sharing what is on our heart, and what is eating at us. We know that keeping it in is counterproductive. We know that repression is self-destructive behaviour. We know that people are beginning to understand this; hence the increasing demand for counselling services.

As we work together for people's empowerment, so let us also work together to equip those among us; not trained but in touch with those who may or may not come to see us professionally. Personally, I believe the "second question" needs to be asked. Let's do all we can to ensure it is.

The Australian Counselling Association alone currently has some 2500 financial members and 3600 subscription members throughout the country.

1 The Australian (Government) Job Search Website: www.jobsearch.gov.au

2 See www.jobsearch.gov.au

3 Cited in the Australian College of Applied Psychology's official website: www.acap.org

ACA

Counselling Australia's Contributor's Guide for 2007/08

Counselling Australia is now calling for articles and papers for publication in 2005. Counselling Australia is a peer reviewed professional journal that is registered and indexed with the National Library (ISSN 1445-5285). Counselling Australia is designed to inform and discuss relevant industry issues for practicing counsellors, students, and members of the Australian Counselling Association. Note publishing dates: The journal is published quarterly every March, June, September and December.

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

Editorial Policy

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

Counselling Australia is committed to valuing the different theories and practices of counsellors. We hope to encourage readers to submit articles and papers to encourage discussion and debate within the industry.

Articles for peer review (refereed).

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

Conditions

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

Deadline

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

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for Counsellors, Therapists, Psychologists, Social Workers & Allied Health Professionals

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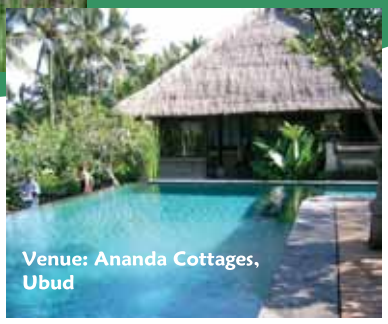

This course qualifies as Professional Development hours for your Professional Association. Also a percentage can be counted as group supervision hours for registration.

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Cost includes : 7 day course, all course materials and documentation. Airfares, Transfers, 7 nights Accommodation, Breakfast , Lunch and a choice of two blissful body treatments at Verona Spa Ubud.

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ACA Website

at

http://www.theaca.net.au

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