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ABORIGINAL FAMILIES, CULTURAL CONTEXT AND THERAPY

Abstract:

Aboriginal people will present issues that have influenced and affected the collective family group. The individual themselves may not have a direct experience with the said issues but the individual will present from a collective perspective. Therapists and Mental Health Professionals need to understand that you are assisting an individual who will speak of a collective experience, which needs to be understood as the affects of transgenerational trauma. In order to develop an understanding of this topic one needs to comprehend the complexities of Aboriginal Self which is outside of Western ideology. Australians First Nation peoples have had to endure the long-term negative affects of colonization that continues to give rise to further marginalization and exclusion. There is an ever-growing theory that suggests western societies including Australia have continued to operate in ways that feed historical injustice which reinforce and maintain minorities' low status. For example, Aboriginal mortality in Australia is more than 20 years less than mainstream population that is driven by the lack of access and equity to the standards and service that the wider population enjoys. Western medicine is symptomatology driven (e.g. substance abuse and mental health) rather than focus on causation. Mainstream system and western teachings are based on the principles of Western norms, ideology and the developmental stages of self. These western principles of self are limited as it fails to recognise, acknowledge, or include all aspects of Aboriginal self, which is outside of their cultural context.

Introduction

Aboriginal people developed an intelligent form of lifestyle, which allowed them to live in harmony with the land. Survival is depended on cooperation and coexistence with the forces of nature and one would think these included fellow humans. When Aboriginal people see the world, they focus on the qualities and relationships that are apparent, quantities are irrelevant. In addition, Aboriginal worldview provides for the unity and coherence of people, nature, land and time, thus seeing themselves as part of the natural order, rather than apart from it and having control over it. This is reflected in the understanding of themselves, the world and other people. In nature, Aboriginal society is an orderly, regular and the rhythm of life that led to a cycle of spirit-birth-initiation-marriage-death-rebirth; with their social life adapting to nature. The culture was finely tuned within a set routine to obtain the maximum results and to assist this process, everyone had a role and function within the clan.

Four Principles of Aboriginal Being

Wholeness:

Everything is connected; it is only possible to understand the Aboriginal being if we understand how all is connected. For example, to destroy the environment is to destroy

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ourselves through environmental and physical means because one cannot exist without the other.

Change:

Everything is in constant state of change; one season falls upon another, we are born, we live, and then die only to be reborn into the spirit world. With these changes comes the life experiences which create wisdom and understanding that sustains life. Therefore, we are not to fear changes but to be challenged by it, with changes come the growth process of life.

Change occurs in Cycles or Patterns:

It is not random or accidental; if we cannot see, how a particular change is connected, it usually means that our viewpoint is affecting our perception.

The Physical world is real, the Spiritual world is real:

These two aspects of Aboriginal reality are intertwined with one another, to violate the physical is to violate the spiritual and vice versa, as an Aboriginal person we must respect both realities. To pass on ill intentions (which work with the spiritual world) will manifest within the physical (world). There are separate lores (laws) that govern each; however, they affect one another. A balanced life is one that honours both. One needs to maintain balance within themselves because a person with a mean nasty spirit who is intent on hurting and depriving others will create ugliness in the physical meaning if your ugly on the inside it will manifest itself on the outside.

Land and Spirituality

Aboriginal people, when speaking of their land, will often use the term “my country.” This is a different concept from mainstream Australians, for when they make a similar statement of their land, it refers to ownership (legal title). Individuals did not own the land as in the western world sense; the land was entrusted to them to care for, as the land is the spiritual home of their ancestors, who roamed their land as told in the dreaming.

The Aboriginal belongs to the land and will refer to the land as “my mother’s country” or “my father’s country,” depending on whether the clan is patriarchal or matriarchal. The land is spoken of and seen as “Mother Earth,” from which all living things have derived and to which all will return after death. To understand this concept is to have a greater understanding of one’s connection and relationship with the land, which in turn defines one’s identity. Aboriginal people have and will continue to protect and defend their spirit land including sacred sites, rituals, totems and songs against destruction and /or misuse.

Aboriginal people are bound to their homelands, spiritually and practically as the well-being of their people, animals and plants are closely linked. Each tribe had a different totem, which was identified by an animal, or plant. Totems are sacred and therefore must be protected they are not to be damaged, injured, killed or consumed by clan members who identify themselves as belonging to a particular totem. It is believed that

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the totem is an ancestral being which is part of their dreamtime. Totems are linked to sacred sites and the Aboriginals spiritual, emotional, physical, social and environmental well-being depended on the maintenance of sacred sites. This ensured the maintenance, care and protection of Mother earth, who is the giver of all life as the land and its people are one.

The meaning of homeland in its deepest sense is based on the belief that their spirit and that of their ancestors have descended from the creation stories of that land. Aboriginal people have maintained a belief that is based on their awareness of family history through many generations of their people before them where their cultural roots are defined.

The Aboriginal culture is the oldest living culture in the world. Aboriginal people have been living in this country for more than 50,000 years and believe their creation and birth is of this country and no other. Archaeologists from around the world are finding more and more evidence to prove that the oral history, which has been held, passed on and maintained for many generations, is correct. It has been clearly demonstrated that Aboriginal people from the past to the present have a spiritual view of life, which intern has and will continue to shape their cultural beliefs and values.

Kinship Structures

Traditional Aboriginal social structures are based on non-industrialized societies as this society acknowledges the importance of lineage and maintaining a pure bloodline and in doing so developed the most complex kinship structure known to the Western world. Although this was the structure of traditional Aboriginal societies, the principles of kinship are still maintained today.

An Aboriginal family consists of immediate and extended members. Whilst some traditions have been lost due to forced colonisation, the family structure has been strongly maintained, which consist of biological kin (blood kin), affinal kin (related through marriage) and classified kin (one who has earned a particular role and stature within the family)). For example, a person who is not a blood relative can earn the role as a grandparent, parent, sibling or uncle and aunt etc, having equal stature within the family.

Interpersonal relationships whether traditional, semi-traditional or urban have been based on the kinship structure. The group's structures are derived in part from marriages, which gives rise to the family groupings and the recognition of common descent, which in turns gives rise to lineage and clan structures. Each member will define his/her social and family relationships with others in accordance of kinship structure. Kinship terminology is a guide for approved behaviour, which reflects the beliefs, values and protocols of the clan's social structure. In Aboriginal societies, one belongs to two family groups in the course of his/her lives, which are the family s/he is born into and the family they will marry.

As a result, the belief held within Aboriginal communities is that a person's greatest asset lies not in monetary value but rather in family relationships and community connections. The importance of family relationships is intensified by the difficulty that Aboriginal

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people experience in gaining validation from mainstream society and the role that family members play in promoting one another's well-being. Sharing and exchange within the kinship structure have allowed not only families to survive but to overcome incredible odds against them.

Since extended family tend to live close by to one another, if not in the same household for periods at a time, it is not unusual for multiple adults within the kinship system to participate in the rearing of the child. Parental child and three-generational households have been particularly valuable adaptations for parents who are overloaded with too many responsibilities and too few resources. A three-generational household can be a supportive structure for all involved if there is consistency among the adults who share the responsibilities. In this situation, an older family member usually the grandmother, shares the household and typically provides the necessary childcare to enable the other family members to attend school and work.

Often but not necessarily, the eldest child will assume responsibility for assisting the parent with house-hold, financial and child-care responsibilities. This role and responsibility can serve as a source of self-esteem and facilitate personal development as long as parental responsibilities are not abdicated and if these responsibilities do not interfere with the youth's own development. Another common example of role flexibility within Aboriginal families is when are sent to live with relatives because of a crisis or in some instances when the relative can provide the child or youth with a better environment. This is not viewed negatively by the child or the family. The length of such arrangements is not always predetermined as they may end up there permanently because of the emotional ties that are developed between child and family.

Aboriginal Culture of Today

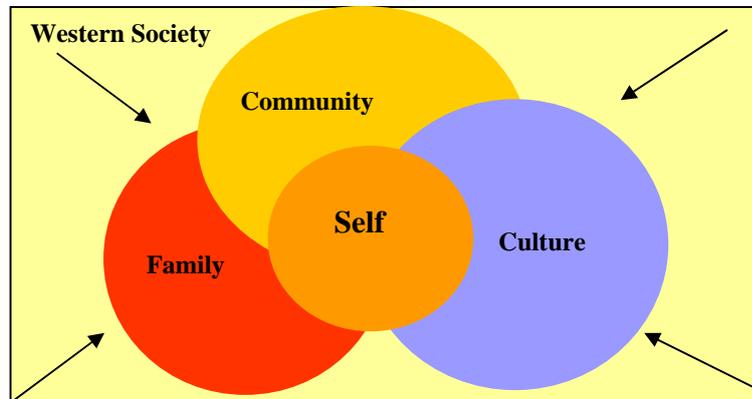
The Aboriginal culture is the combined result of traditional cultural practices, forced assimilation, acculturation to Australian mainstream with varied responses to oppression and dispossession which has produced a level of mistrust between community factions throughout Australia. This mistrust has lead to a level of competitiveness between the factions within Aboriginal communities.

This competitiveness is one of the factors that prevent communities throughout Australia from uniting and becoming one race in establishing a political force. In addition, an Aboriginal person is continually assessing others regardless of their Aboriginality and status (scrutiny is a natural repercussion of long-term oppression). In this regard, it is often difficult for an Aboriginal person to decide whom they can trust. Trust is conditional and it is not as simple as trusting one's own people.

There is a saying within the Aboriginal community that Aboriginal people vote with their feet; meaning that if they do not like something or someone, they will simply walk away from it or the person.

The Influencing Factors on the Aboriginal Communities

This diagram depicted below looks at specific realities that have impacted on and influenced the Aboriginal Communities beliefs and pattern of behaviours.



Influencing Factors

Western Society

Economy
 Police/Courts/Jails/Law
 Institutionalised Racism
 Hierarchy System
 Alcohol & Drugs
 Church & Religion
 Family & Friends
 School/ Work
 Hotels

Family

Kinship
 Belonging
 A Place
 A Role
 A Function
 Mother
 Father
 Brothers
 Sisters

Self

Physical, Social, Emotional
 and Spiritual Well-being
 Personality, Career, Sexuality,
 Self-esteem, Lived Experience
 Education

Aboriginal Community

Community Members
 Elders
 Dispossession & Oppression
 Shame & Trauma
 Family Breakdown
 Victimisation
 Western Culture
 CDEP or Unemployment

Culture

Traditional Lore & Practice
 Beliefs & Values
 Protocols, Kinship & Land
 Social Norms
 Structure in our Society
 Life Style
 Pace of Living
 History and survival
 Knowledge and Wisdom

Because of their strong spiritual beliefs and the constraints that racism has imposed on them, Aboriginal people place much more importance on one's character rather than educational or vocational achievements. For the average Aboriginal person work is highly valued because it allows independence in meeting basic needs and not because it fosters self-expression or status. Unfortunately, the self-esteem of many Aboriginal people has been lowered because of the lack of jobs within their communities and the discriminatory practices within mainstream society.

It is becoming increasingly difficult for young Aboriginal people to develop a sense of commitment towards work. Even though their aspiration may be as high as those of the mainstream counterparts their expectations for achievement are limited by the realisation that, in spite of a lifetime of hard work, many will remain stuck in poverty. Indeed, unemployment remains a serious problem within Aboriginal communities throughout Australia. Even those who are highly educated are still afforded fewer opportunities than their mainstream counterparts

Marital/Defacto Roles and Relationships

Male and female relationships are increasingly being shaped by economic factors and skewed gender ratios. There are a number of factors that contribute to the low percentage of men within the Aboriginal population, including infant mortality rate that is three to five times higher than mainstream society, higher rates of substance abuse, higher suicide rates, delays in seeking health care and incarceration. Because of limited job options and dismal odds against fulfilling the function prescribed for adult males in these communities or mainstream society, the role of Aboriginal men as fathers and husbands are particularly undermined. Those who fail to meet the required social standards face severe pressures from within their social structure.

Far too many men find themselves unable to provide for their families basic needs. Some feel forced to leave their household in order to ensure that their partners and children receive government assistance and others will attempt to seek employment outside of their communities. This institutional reinforcement of fathers' absence began during enforced colonisation when Aboriginal men were denied the privileges and responsibilities of active fatherhood. It's important to note that the absence of father/husband from the household does not necessarily mean a lack of contact between marital /defacto partners or father and child. It is typical for children to maintain contact with the paternal family even in the father's absence.

Aboriginal women have always played an active role in their families and community. Jobs have been available more often to them than to their men, especially in times of high unemployment. Consequently, the economic survival of Aboriginal families has frequently depended on Aboriginal women. Repeatedly racism is viewed as a greater oppressive force than sexism. Aboriginal women have been the doers within their community by necessity whilst being penalised for their creativity and strength by the perpetuation of the images of them as dominating matriarchs who emasculate their men. However, a husband or partner is likely to be respected and publicly as the head of home,

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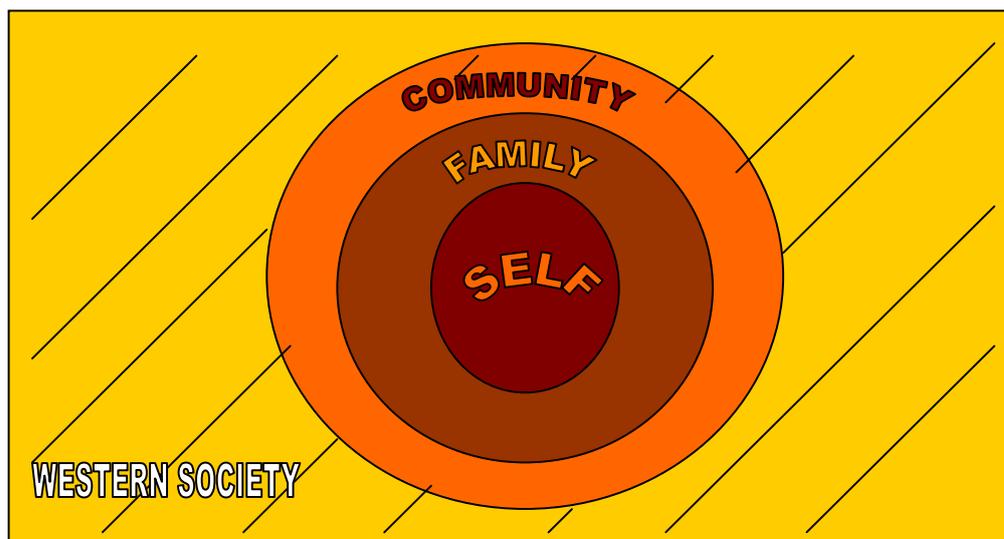
even if he is not working and even when his wife or partner does make more decision related to everyday household management.

Aboriginal women tend to place a higher value on the maternal role than that of the marital role. Aboriginal women tend to be younger at the birth of their first child and to have a shorter wait after they are married before having children. There is a greater likelihood of giving birth before outside of marriage and are likely to have larger families. Aboriginal women are choosing to have children outside of marriage which does not represent the devaluation of marriage but rather an adaptation for the shortage of marriageable mates.

Aboriginal Containmentment

Assessment of Aboriginal Self and Territorial Containmentment: As the non-Aboriginal professional continues to experience her/his self in any particular Aboriginal community, s/he will be better able to comprehend the “containment” that an Aboriginal person experiences from birth the Aboriginal “Self” is surrounded by territories of family, community and ecological system. However, all of these territories are contained by non-Indigenous society.

Aboriginal containmentment as depicted in the following diagram.



1. Aboriginal self is contained within the centre of one's family, to identify where one belongs, role, function and commitment to family and community.
2. Aboriginal self is seen as one place – belonging to self, family and community this cannot be separated or you have lost the centre of self.
3. Aboriginal self is contained within family and community which is surrounded by Western Society – one can not address one's own issues or concerns without needing to change or impact on what surrounds you (the greater society) for positive change to occur.

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4. The lines represent the boundaries or barriers that Western society has placed on Aboriginal self through institutionalized racism, etc.

For Aboriginal people in the twenty-first century, their greatest issue, and concern, which is implicit in their problems, and affecting them as a society and as individuals, stems from the loss of spirit? When we neglect or try to ignore our spirit, it doesn't just disappear but will manifest itself through symptoms of obsession, addiction and violence which in turn will lead to a loss of meaning for self and life, Moore (1992, p xi).

The current level of substance abuse, violence and sexual abuse, which is at an overwhelming proportion within Aboriginal communities throughout Australia is seen and understood by the community to be the negative affects of long term oppression. Oppression that was brought on by forced colonisation which was founded on institutional racism (White Australia Policy) that continue to implement and the enforcement of inappropriate government legislation and policies that continue to governed their lives.

As an Aboriginal person forced to grow up under a dominant society who has lived with oppression and exclusion which has lead to the ongoing destruction of Aboriginal families, communities and culture through family breakdowns, substance abuse, violence, poor health and well being. As long term oppression and exclusion has given rise to feelings of self-hatred, hopelessness, powerlessness, anger and despair that has been internalised by individuals which has lead to the continuous destruction of self, family, community and culture for many of our people.

As the majority (mainstream Australians) have shown little tolerance or recognition for the pain and sadness they have inflicted on minority groups expecting them to get over it and have no anger for being oppressed or excluded Mindell (1992, pp 109). He states that it is repressive of the majority to expect the abused minority (Aboriginal people) to remain quiet and not to subject the majority to negative statements. Because they cannot bear the noise and that the marginalised individuals suffer not only past abuse but also that they continue to suffer due to the lack of recognition and intolerance of the majority for their suffering.

A Collective Reality

The Aboriginal nation consists of Aboriginal tribes that are made up of clan groupings in which all are related and connected to each other. Each Aboriginal clan represents family groupings, which make up the collective. It is important to understand that an Aboriginal person will present from a collective reality and not that of the Western culture who define self and the world from an individualistic reality.

This means, Aboriginal people will present issues that have influenced and affected the collective family group. The individual themselves may not have a direct experience with the said issues but s/he will speak from a plural form as if they have had such an experience. A worker needs to understand that you are assisting an individual who will

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speak of a collective experience, which needs to be understood as the affects of transgenerational trauma.

Cultural Obligation

Cultural Obligation: is the acceptance and assistance of another, which is a reciprocal process, based on respect and honour. This is when one is expected to acknowledge and honour their obligated to give back (in kind) a service that has been given to them which can be an inherited or passed on to family member.

This does not mean that one should accept being abused or used by another. For example: it is not acceptable for another to come to your home and contribute nothing for one's keep. Traditionally, for one to do such a thing would bring great cultural shame and dishonour for self and family.

Aboriginal Healing conflict with Mainstream Therapeutic View

It is important to avoid any attempts by mainstream Australia to oversimplify the concept of culture. Every action of an individual of a culture will represent some aspect of what life means to them in that this meaning will have historical roots as it has been shaped and evolved over many years as cited by McLeod (1998, pp 162 - 163)

The western world holds a dualistic view in relation to the nature of reality, dividing the world into two entities – mind and body. Social relationships due to the belief of dualism have lead to the increasing division between self and object or self and others. Meaning self which is identified with mind, is set against and apart from the external world of things or other people, McLeod (1998, p 164). Aboriginal people do not hold a dualist concept, but one of the worlds in wholeness, believing that all things are connected to one another.

Through the authors many years of work within the mainstream health system, she has learnt that western health's approach to healing is symptomatic. As it treats, the symptom and not the causes by providing specifically identified service delivery such as drug and alcohol and mental health, which are based on a western medical model which fails to recognise another concept of spiritual self that is outside of mainstream religions or Christianity.

Aboriginal Spiritual Practice

The strong spiritual context of Aboriginal people has promoted their survival and ability to overcome innumerable odds they have endured over time. Aboriginal people place a great value on being strong; one is expected to manage life's stressors without buckling under pressure. Pain and suffering are seen as an expected part of life which service to only strengthen you and build character or test one's faith in a higher being.

For many, the church has been the most significant body with their community due to colonisation and the missionary movement which over time has been adopted and customised to better suit the Aboriginal cultural context. Active church involvement earns one's respectability and affords one an outlet for feelings; repeated messages are

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given by the minister, pastor and/or priest that reinforce a sense of personal values and social responsibilities and hope to reinforce the belief that adversity can be overcome. There are numerous opportunities for individuals to develop and display their talents and build a social network. Significant life-cycle events such as birth, marriages and death are likely to involve church-related service even for those who are not active members.

The emphasis on honouring the dead and the lives they have lived and their afterlife accounts for the importance attributed to funerals. Throughout their colonized history in this country, Aboriginal people have had a death rate that has consistently exceeded that of mainstream Australia. Frequently, these losses occur without the benefit of anticipatory mourning. Having an honourable fair-well at death is important regardless of cost. Funerals typically take place between three to seven days following death to permit everyone who wishes to attend the opportunity to make the necessary work and travel arrangements as attendance symbolizes respect for the dead and their family. As a family member, to fail to attend is a sign of disrespect for the dead and the family. Your lack of attendance would symbolize that you have forgotten the importance of your roots and that you have failed to concur with cultural practice. Thus, much value is placed on community acknowledgement of a death; people would begin to visit the family as soon as the loss is announced to honour the deceased's memory and to provide the necessary support of food and money to assist in this time of grief as family begin to arrive, including emotional support to the family.

Eulogies emphasize the desire to be remembered one's character and their commitment to others. Generally, the cultural values and practices give rise to healthy resolution for grief but for others who have experienced repeated losses will often experience a general loss of well-being including have a sense of powerlessness and despair. In these instances, problem solving and family relationships may suffer.

The Relationship between Aboriginal Poverty and Ill-Health

Health is the product of the inter-relationship between physical, socio-economic, and environmental factors, three critical factors that need to be considered relating to Aboriginal health:

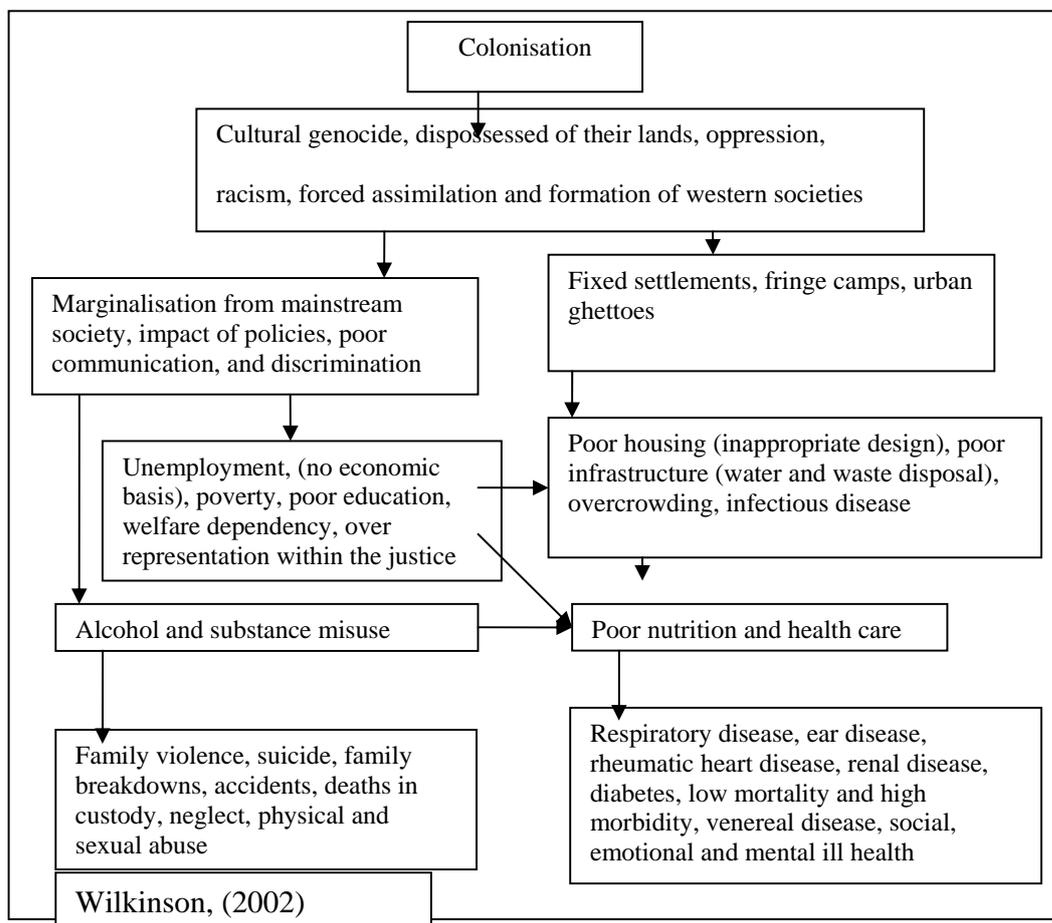
1. Poverty is the single most important determinant of health.
2. Aboriginal people residing in remote, rural, and urban settings throughout Australia are living in states of substantial poverty.
3. This poverty is directly caused by the process of colonisation.

The model depicted below as cited by Wilkinson (2002), which was proposed by Professor John Mathews (1998), suggests that the primary affect of colonisation is the loss of traditional lifestyle, loss of land, and loss of settlements. In truth, the impact of colonisation has had greater repercussions for Aboriginal people than what Mathew has indicated because he suggests it was lost what exactly does that mean. Ever after all these years for western society to still suggest that the Aboriginal people lost their lifestyle, their land, their culture, etc as if they (western society) played no part in this and are not responsible for forced colonisation, cultural genocide, the deaths, dispossession and

oppression of Aboriginal people who were forced from their land, etc. Aboriginal people did not just loose their traditional lifestyle, and for the many this included their language, culture and families, this was the impact of forced colonisation.

This in turn inevitably leads to marginalisation from society and, of course, displacement from traditional lands led to the formation of western society and that for Aboriginal people were and are typically very unhealthy. These settlements are typified by overcrowding, poor housing and infrastructure (water and waste disposal), and high levels of infectious diseases. Coupled with the inevitable unemployment that follows marginalisation and discrimination, poor nutrition occurs, alcohol and substance abuse becomes rampant as hope is lost, and a variety of diseases and social ills are the result. This model clearly links colonisation to poor health and increased mortality within the Aboriginal communities.

The links between colonisation and Aboriginal poor health and well-being



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These social factors and their impact on Aboriginal mental, spiritual and emotional health and well-being is not clearly understood or accepted by mainstream Australia. The belief that all Aboriginal families are poor and therefore dysfunctional is clearly a myth as there are an increasing number of Aboriginal families who are within the middle to high level income levels who also suffer with varying ranges of dysfunction because dysfunction is not income based. However, an Aboriginal family who are embedded in the context of chronic poverty and discrimination, the healthiest family may be limited in their ability to function at optimal level. Persistent stressors are likely to have adverse effects on individuals functioning and family interaction and relationships.

These families face triple the hardship being economically poor, politically bankrupt, and discrimination against their race. Low socio-economic Aboriginal families life-cycle seem to be more reduced than of those middle income families which is not clearly understood. Poor Aboriginal households are frequently headed by women and that of the extended family and their life-cycle is punctuated by frequent random events and associated stress produce. They have few actual resources available to assist them in coping with continuous stressors, even meeting their basic needs. The demand for flexibility and creativeness are endless. Their world view is shaped by over exposure to tragedy and suffering causing their anger to be directed at mainstream society or at family members or at themselves.

There are an increasing number of middle income families with the majority coming from working class or poor backgrounds but even within this large kinship structure there is diversity in education, life-style, employment and income. Although some may not have to struggle to meet their basic needs, they, too, are victims of racism which invades every aspect of their lives. Most have a few skills and abilities for addressing the obstacles they face in living and working in two worlds and even within families and the same generation, some may prefer to remain isolated while others identify exclusively with mainstream Australians while others attempt to integrate the two. But for all, much spiritual energy is required to sort out and respond to daily subtle and obvious racism which takes it toll emotionally.

For some Aboriginal individuals, the stress encountered results in a lack of connectedness in the Aboriginal or mainstream worlds but for others gain from their experience exceptional strength, flexibility and tolerance for diversity. The assets of most middle to upper income Aboriginal families are tied to their daily work as their hold on any wealth is tenuous, as they remain subjected to racial discrimination, particularly within the workplace. Similarly to mainstream women, Aboriginal women are subjected to the invisible ceiling above which they are unlikely to be promoted in their career regardless of there talent or qualifications.

Aboriginal middle income parents experience all the benefits and pitfalls of participation of cultural obligation in the reciprocal obligation process but more often than not middle income families have to over come many obstacles. They are likely to demand high achievements from their children because in comparison to their own childhood experience, their children are seen to be living privileged lives and are the purveyors of

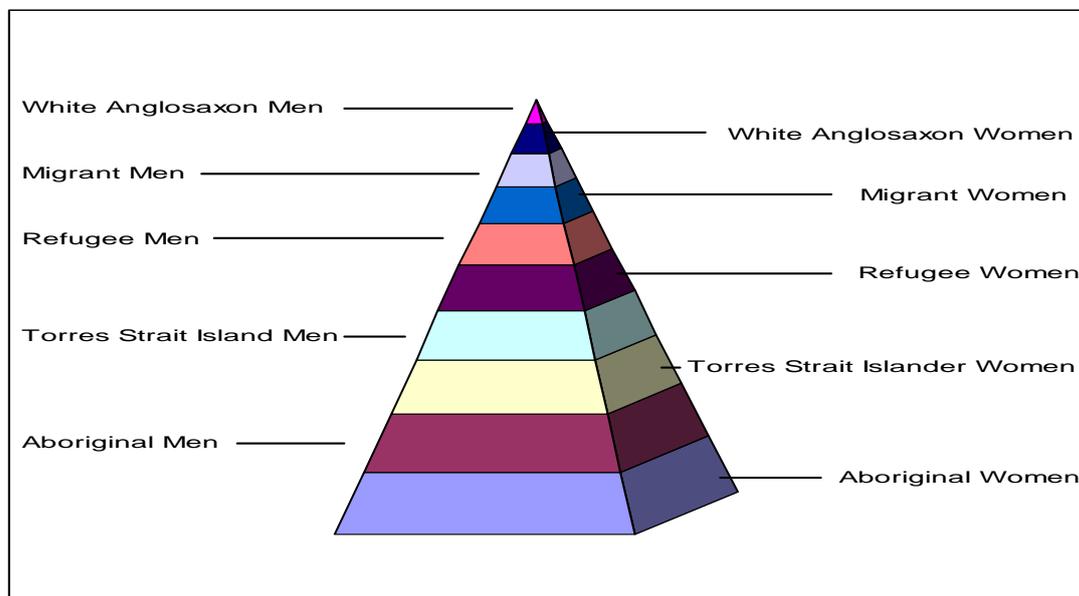
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the message at home that to be average is not acceptable to mainstream society, one has to be twice as good and often twice as qualified than white people in order to get ahead and maintain a middle income life style. Aboriginal parents are likely to be concerned about how to reinforce in their children a sense of positive cultural values, and how to proactively teach them about racism without creating feelings of anxiety, hostility or resentment. In some instances, children and adolescents from middle income families may have difficulties relating to more disadvantaged extended family members and school peers and when these cutoffs occur the price they pay is great because they end up lacking a sense of connectedness and continuity.

Racism and discrimination based on race and skin colour continue to be of today that significantly affects everyday lives, opportunities, hopes and aspiration regardless of economic status. Whilst some advances have been made since colonisation in incomes, education, employment and so on, but Aboriginal people continually remain at the bottom of the ladder, socially, economically and politically.

Hierarchical Scale

A Western belief is that the natural order of things is hierarchical. This diagram below depicts a Western world-view of Australia's population and where everyone sits on the Hierarchical Scale. This scale would be further broken down into Western classes of high – middle – and lower. As Aboriginals do not recognise class distinction it would remain the same.



Aboriginal Perspective of Cross Cultural Assessments

There is an assumption held by mainstream practitioners within health and education that Western assessment tools and techniques provide everyone with equal opportunity to participate and perform effectively. This assumption is incorrect as there are a number of reasons why an assessment tool is inclusive of some individuals and exclusive for others.

Western assessment tools and/or instruments used to assess Aboriginal adults, youth and children would be termed as biased, as the content is more familiar and appropriate for one group as compared to another group, as some groups could perceive items within this assessment or instrument to be irrelevant or culturally inappropriate (Whiston, 2000: 14, p316). For example, many non-Aboriginal health professionals have expressed their concerns and frustrations in providing assessments, diagnostic, counselling and treatment services for Aboriginal clients due to language and cultural differences so when faced with clients from a different cultural backgrounds, they have complained of the 'culturally confusing' factors, which obscured the "real" problem.

However, when providing assessments, diagnoses, counselling and treatment services to clients of their own language and cultural groups, they had no problem in finding the "universal categories" because 'culture' appeared tacit and was automatically subtracted from the clinical process. Littlewood, (1990) cited such treatment models and methods are implicitly racist as they suggest Western cultural norms are the universal standards on which all clients are assessed. Furthermore, an Aboriginal person's cultural background, beliefs and values are likely to be varied as they will have different but similar lived experiences and knowledge basis to draw from which will influence the assessment, diagnostic and treatment process.

In addition, culture defines self and all aspects of an individual; therefore, problems are likely to occur when the instrument is not inclusive of a specific culture (Whiston, 2000: 14, p 313). Moreover, it is clearly understood that members within Aboriginal communities will suffer the same mental illnesses as mainstream society, though culture will influence presentation and the treatment of such illnesses. However, the mental distress that exists within Aboriginal communities falls outside of Western mental health categories and is related to 'reality' factors of Aboriginal cultural beliefs, impact of forced colonisation, enculturation, institutionalised racism, and exclusion, Swan and Raphael (1995).

This will require health issues to be approached from an Aboriginal cultural context of wellbeing, which includes social, emotional, spiritual, physical, and environmental health, and in doing so, one must consider that the social, emotional health and psychiatric disorders encompass the affects of long-term oppression, racism, stress, trauma, grief, cultural genocide, and psychological processes. Whilst there is validity in identifying Aboriginal communities as a distinct group, one needs to acknowledge that there is no single cultural reality but rather a collective reality for Aboriginal people.

With over a decade and more of working with mental health services, the author has become aware of how little is known or understood by mainstream Counsellors and

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mental professionals in regards to Aboriginal people and their culture. There are documented cases of Aboriginal people being inappropriately assessed and diagnosed with a mental illness, due to the practitioner's lack of cultural knowledge and understanding that has failed to acknowledge culture specific factors.

The following case study serves as an example:

A young Torres Strait Islander male, aged 21 years was diagnosed as being catatonic on his arrival at the Accident and Emergency Unit and was admitted to the Psychiatric Unit for treatment and further assessment. This author was required to assess this patient and on arrival at the secure unit, the author found the patient lying on his bed. After entering the room and introducing myself, I spent the next hour speaking with the patient about the events leading to his hospitalisation.

He told me that he had broken up with his girlfriend and that he was attending university and residing at the Aboriginal Hostel as he was from up north and had no family here to support him. He said that he went out after being-paid and saw his ex-girlfriend at a club with her new man. On becoming upset, he drank until intoxicated spending all his money. Consequently, he had no money to pay his rent at the hostel and therefore no place to live.

Due to his feelings of depression in regards to the situation with his ex-girlfriend and having no place to live and not currently wanting to attend university, he decided to go to the hospital but felt too ashamed to tell the staff of his situation. He said that a hospital provided him with food, a place to sleep and a medical certificate that would cover his absence from University.

This case serves as an example of how social, environmental, economic, cultural, and personal factors may affect a person's 'mental health' status. In addition, the term 'well-being' has more meaning in the Aboriginal context than mental health. As stated by the National Aboriginal Community Controlled Health Organisation (NACCHO) in a position paper on Aboriginal Mental Health (September, 1993:14) cites, for Aboriginal people, mental health must be considered in the wider (Aboriginal concept of well-being) context of health and well-being. This requires health issues to be approached from a social, emotional, spiritual, physical, and environmental context and in doing, so one must consider the social, emotional health and psychiatric disorders encompass the affects of long-term oppression, racism, stress, trauma, grief, cultured genocide, exclusion, marginalization, and psychological processes.

Therapeutic Cultural Context

What made the difference for this client in regards to the author's intervention? The author believes the difference was made by the fact that she was an Aboriginal practitioner who possessed a competent level of cultural knowledge, understanding and the ability to relate with the client from his cultural context. It is important to understand that Aboriginal and Torres Strait Islander people do not have or come from an

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individualistic world-view but instead see themselves belonging too and identifying with a collective body.

Aboriginal people are generally hesitant about involvement in therapy because talking is not seen as an answer to most problems. When help is required the client is more likely to turn to older relatives or friends for a solution to the problem, as changes dictated by crises are rapidly consolidated into everyday life. Aboriginal communities are likely to have little understanding or have vague information about what therapy involves or how it can help them. Their expectations and fears are that they will be labeled negatively and blamed for the problems they are experiencing. It is helpful to identify and verbalize a genuine appreciation and acknowledge the families strength in wanting to address the problem. Aboriginal people generally will be concerned about whether the practitioner appreciates their history and social, cultural context. Therefore, they will be more responsive to language that supports their abilities to handle their own problems rather than language that emphasizes what the practitioner can do for them.

In times of stress Aboriginal family members will turn to their families for help due to their cultural expectations. When a family member is undergoing a crisis or having problems, others in the family are obligated to help, especially those who are in stable positions. More often when they do come to seek therapy it is because they have exhausted all other options and where someone in their community has recommended (word of mouth) you to them, they are aware that you are Aboriginal and therefore more understanding.

However, it is important to understand that when counselling an Aboriginal person, he/she will present from a collective world-view and not an individualistic world-view. This means the client will present issues that have influenced and affected the collective; a practitioner needs to understand that you are treating an individual who will speak of a collective experience this is vital and needs to be understood by the practitioner as the affects of transgenerational trauma. Families can be helped to distinguish between external and personal transactional barriers, channeling their anger and frustration into a proactive response which is empowering rather than being a reactive response which is disempowering.

Practitioners can expect that credibility must be earned as Aboriginal clients will be more concerned about cultural sensitivity, cultural relevance's and confidentiality and relevance of practitioners lived experience than about the practitioner's qualifications. It is important that the practitioner clarifies the therapeutic process, confidentiality, what records that are kept on clients files, who has access to files and if the file is made available for clients perusal. Practitioners are wise to introduce those who do come about the goals, processes and limitations of therapy. Most importantly the practitioner must establish a clear boundary and clarify their role as it is vital to the success of therapeutic process.

Aboriginal people are very private about their personal business and will only want those that are relevant to the situation to participate in the therapy process. A practitioner may

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lose family members who are participating within the therapeutic process if there is too much pressure placed on them to gain the participation of reluctant family members, before engagement has taken place. Participants are not likely to be convinced that therapy is a worth while process to undertake. They may ask personal questions of the practitioner in order to establish a connection in an attempt to feel more comfortable and to establish trust and rapport rather than be intrusive or to avoid their own problem. A practitioner meeting an Aboriginal family for the first time (especially if the practitioner is younger) must address the adults as Mr. and Mrs., and ask permission before speaking with the children.

For low socio-economic Aboriginal families within Aboriginal communities options in many instances are limited as a result of their larger social, economic and political constraints. Practitioners can gain credibility by acknowledging this reality and assist change by helping the family members to recognise and avoid involvement with forces that obstruct attainment of their goals. One must be sensitive to the practical and emotional impact of ongoing crises within the extended family and community. It is imperative that practitioners assist families to find solution that addresses survival issues, which ultimately detract from their ability to focus on emotional needs and relationship processes. However, practitioners also must be cautious not to lose sight of the repetitive processes that render the family vulnerable and likely to become unstuck. It is useful to focus on what strengthens the family's ability to be self-sufficient and effective in problem solving and exerting a degree of control over their lives.

The practitioner's aim is to assist but not replace the role of family members in recognizing and acting on choice, regardless of how limited they maybe. Metaphors extracted from the client's language can be helpful in making a point. One cannot underestimate the value of simply slowing things down and allowing members to explore and negotiate unresolved issues.

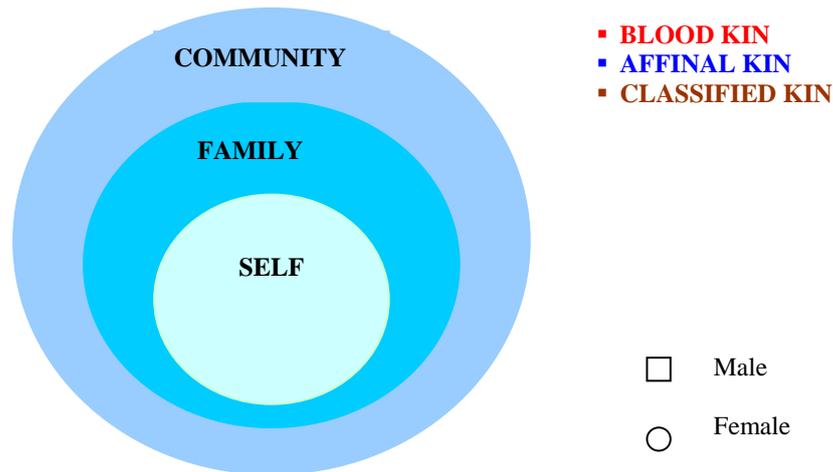
Furthermore, a practitioner when counselling an Aboriginal client will need to allow for longer session (no less than two hours) and it will also require more counselling sessions. The purpose of this is to ensure that a practitioner allows for the necessary time required to establish connection with the client as this will allow the client to unpack the extensive history (the trauma and stressors) of the collective experience in order to an understanding of how these issues have affected them. If sufficient time is not given to an Aboriginal client, it will disrupt connection with the practitioner, thereby preventing the practitioner from gaining access to core issues, which are central to self.

Genograms are widely used by mainstream practitioners when working with their clients and is seen as being valuable with the collection of family data. But for use within the Aboriginal community the genogram is culturally inappropriate as it does not encompass the Aboriginal kinship structure and therefore rendered useless.

Practitioners will need to be knowledgeable in the utilizing the kinship structure diagram within a therapeutic setting. The Aboriginal kinship consist of blood kin (related by blood), Affinal kin (related by marriage), classified kin (someone who has earnt the right

to take on the role and function of sister, brother, uncle, aunt, mother, father, grandmother or grandfather). It is recommended that you use different colours to identify each of the kin (blood, Affinal, and classified). Practitioners are to work with the client in identifying where each family member is located on the chart in relation to who is closer to self, who provides support, who do they trust etc.

**KINSHIP
STRUCTURE**



Throughout the author’s twenty years plus as a counsellor, she has developed culturally specific assessment tools keeping within the cultural context that are used to assist Aboriginal clients to understand the impact of colonisation and transgenerational trauma and its impact on self. For instance, the author assists clients to map their lifeline, which allows the client to identify all stressors and traumas that have affected their life. This is done from their earliest memory to their current age but most importantly; this enables the practitioner to assist the client in understanding the different levels of trauma and stressors enabling them to identify their need for healing.

My Lifeline

This tool provides the practitioner and the client an opportunity to map out the client’s entire life in detail. Lifelines are more informative than geno-grams and take into account events that are outside of family system. Clients are asked to identify on the line, the age they experience events of punctuations - trauma incident and turning points in their life. These events may be due to trauma (for example; sexual and/or physical abuse, loss and grief, man-made or natural disasters, acute and/or chronic stress etc.

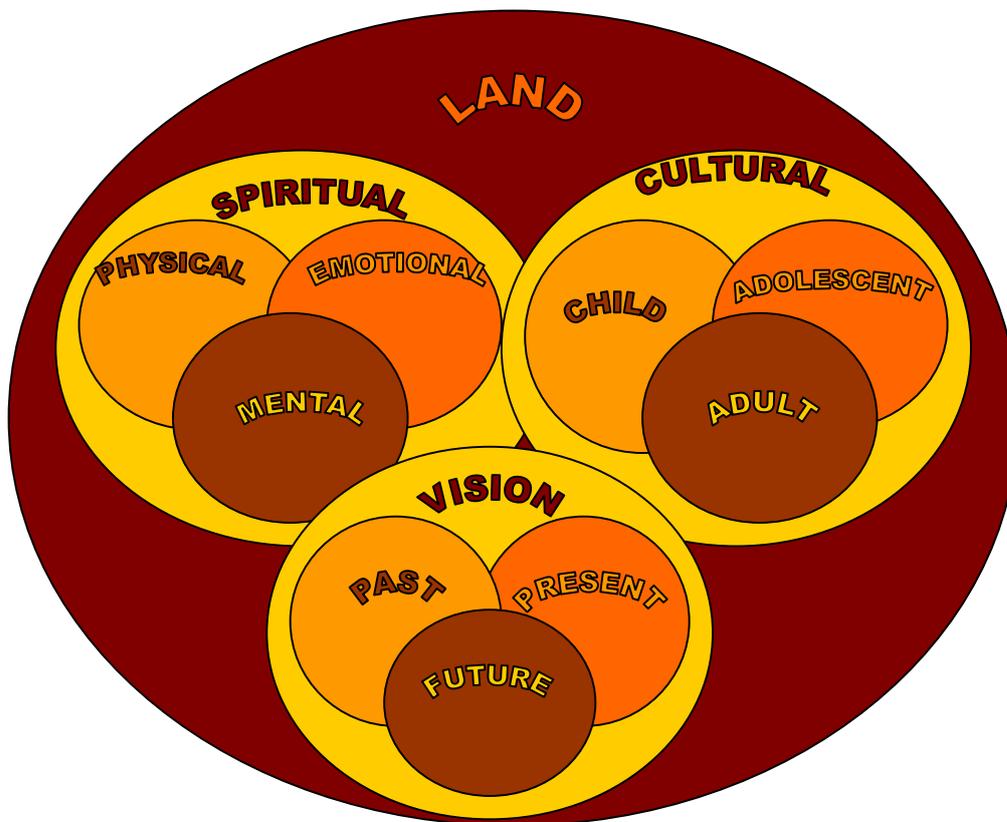


This tool provides a reference point for the client and the practitioner in identifying as to when change occurred, assisting the client to understand how this has affected them and influences their life and the choices they have made and why their life has taken the path

it has. Through the use of this tool the practitioner is able to identify affect and patterns which have shaped the clients lives and assist the client in change.

Aboriginal Self

Another tool that the author has developed is the model of “Aboriginal Self.” In order to develop an understanding of this one needs to comprehend the complexities of Aboriginal self which is outside of western ideology of self. Through the delivery of this model, the client is given the opportunity to develop a greater understanding of self and how the impact trauma and stress have affected self. The following diagram depicts a model of a healthy self, one who has healed.



1. The physical, emotional and mental components of self is encompassed within and founded on spiritual self. One cannot separate spiritual self from them emotional, mental and physical components of self as the spiritual being is the founding core of self. Any attempts to separate spiritual self form the physical, emotional and mental components of self will result in the distortion of the physical, emotional and mental components of self.

2. The child, adolescent and adult is encompassed within and founded on cultural self. Culture is the foundation on which the child, adolescent and the adult's identity of Aboriginality is derived, as this is one's own sense of knowing one's place and establishing their sense of belonging. Any attempts to separate cultural self from the child, adolescent, and adult developmental components self will result in the loss of Aboriginality creating a distortion within the developmental stages of the child, adolescent and adult components of self..
3. The past, the present and the future is encompassed within and founded on the vision (which was once called the dreaming) of self. The past represents the ancestral forbearers, lineage, kinship and historical factors that reinforce their sense of belonging from which a collective reality is derived. The past also represents the impact of colonisation which has given rise to transgenerational trauma. This is evident within communities throughout Australia in the current levels of substance abuse, violence, sexual abuse and child neglect which is at overwhelming proportion. These forms and levels of dysfunction are understood to be the negative affects of long-term oppression, dispossession and racism brought on by the enforcement of culturally inappropriate government legislation and policies that continue to govern their lives. For, without the past there is no present and without the present there is no future and without the future there is no vision for each generation.

For generations Aboriginal people and their children have been forced to grow up under a dominant society and living with the ongoing affects of oppression, dispossession and racism which has lead to the ongoing destruction of their families, communities and their culture resulting in family breakdowns, substance misuse, violence including poor health and well-being. As long-term oppression has given rise to feelings of self-hatred, hopelessness, powerlessness, anger and despair that has been internalised by the individual causing the continuous destruction of self, family, community and culture.

4. All components of self are encompassed within and founded on land as mother earth gives rise to the circle of life, spirit –birth-initiation-marriage-death- rebirth, there is no beginning and no end as it is infinite and a continuous cycle of life. It is important to note that each tribe had its own territory and this territory was not just a place for obtaining food or carrying out their daily tasks, it was regarded as their spiritual home in which their ancestors lived. Within these tribal boundaries were many sacred-sites giving the land a far greater importance and strong ties with the dreaming. Aboriginal people associated their well-being with particular animals and plant life as this represented the well-being of their ancestors. For Aboriginal people the rhythm of life, within nature and their society which once was orderly and regular with social life adapting to nature.

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Once the client has been assisted in their comprehension and understanding this model of self, the client is then asked to draw a picture that depicts their self now. This process further assists the client in understanding how their identified traumas and stressor have affected self, which in turn assists the client in identifying their need for healing. These two models are examples of culturally specific assessment tools that have been developed by the author.

Therefore, it is the opinion of this author that cultural knowledge and understanding of Aboriginal history, protocols and practices, beliefs, and values is vital in the development of effective assessment tools in relation to the therapeutic process. The current western assessment tools that have been designed, and delivered by non-Aboriginal professional, will never be culturally appropriate nor inclusive or accurate. To ensure reliability, validation and accuracy will require the skills of an Aboriginal professional who has been train in this field to design and deliver a culturally effective and accurate assessment tool to be applied to within the therapeutic process.

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Online counselling: With particular focus on young people and support

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Abstract:

The terms 'cyber counselling', 'online counselling', 'web based counselling' and 'online support', are used more frequently than ever before with far less reason for concern. Health support agencies are slowly resigning to the fact that technology is a part of more peoples' lives and that with or without agencies on board, people are turning to technology for many reasons which include: meeting new people, entering into intimate relationships, learning new skills, accessing support, accessing finance and shopping to name only a few uses of the household computer. Support is available in many forms, and the more choice people have, the greater the capacity health professionals have to meet the needs of a community from a population health approach.

Introduction

Online access to services to gain health information, as well synchronous (chat) and asynchronous (email) support of referral and counselling has been available for many years. The reputation of such modalities has been questionable as the western world has at times struggled to find a niche for therapeutic online support. From conception, the online world has lacked regulation and process, highlighting risks to the consumer and causing realistic concerns for researchers and professionals in the field. Government authorities, ethical bodies and key researchers have been leaders in ethical debates because of the lack of structure and governance protecting the consumer from the risks associated with online supports. Those leading the way are the ACA (American Counseling Association), BCA (British Counselling Association) and the NABCC (National Board of Certified Counselors) in the USA (Unites States of America). These bodies have created guidelines for providers of online support and have identified varying state legislations in the USA.

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Literally hundreds of questions have required answering, some of which include: Is the counsellor credentialed to be providing support? How does the service user know if the counsellor is credentialed? What are the training requirements to offer an online support service? Is the information safe from predators? Is the site secure? What quality of service provision can be offered via a keyboard and screen? Who is officially watching the process unfold? How can issues and concerns including ethical concerns be monitored? Although many questions still exist today, they are being addressed or have been addressed effectively. (Barak, 1999; Childress, 1998; Goss, 1999a; S. Hunt, 2002; Kennedy, 2005; N. Pelling, (under review) are a small sample of researchers and writers who have explored in detail the advantages and disadvantages associated with online counselling. One point that I would like to make is that online support is not going to suit everyone. As a counsellor in a government youth service, I noticed an increase in the number of young people as new clients failing to show to appointments. The counsellors were very well experienced and the service a professional and youth friendly government agency highly regarded by young people and the community. This led me to question whether the type of modality was meeting the needs and choices of young people, or could we as a community be delivering services more effectively. Yellowlees, (2000) reported that even psychiatrists agree that patients will determine the future and they will include online therapeutic supports as a part of that future. My current research is a quantitative study exploring whether young people would access an online counselling service if this were readily available to them and at not cost for the young person. The research is exploring values and choices of young people in both metropolitan and country South Australia. The research is currently in the data collection phase with a sample size of five hundred.

Regulation of online counselling

For many professionals and clients, the benefits of online counselling will outweigh the risks. There are definitely risks associated with online counselling that need to be carefully considered by any organisation and individual considering the use of the modality. Such risks have been explored by a number of authors who have advocated for online counselling to be regulated as a profession (Bloom, 1998; Murphy, 1998; N. Pelling, & Renard, D, 2000; Robson, 2000). The establishment of online counselling for me, is about increasing choice and service provision to the greater community to meet the changing needs of that community. I am an advocate for government services to be the leaders in the community, to become the role models for service reform and to establish policy and processes that reduce or eliminate risks associated with the service for the client. An example of risk is the problem of security of information. Secure and encrypted sites can be established to reduce the risk of hackers accessing private and confidential conversations between client and counsellor (Childress, 1998; Kmietowicz, 2001). Robson, (2000) explores the misuse of computer applications as well as the principal of fidelity, where the client trusts the counsellor and the information they have provided. I believe it is a community responsibility to provide educative information in schools and via government health web sites on the risks associated with online supports. Also, to provide sound advice on how to determine whether the counsellor is a part of an ethical body and has acceptable training credentials which meet state standards similar to the guidelines of the NABCC.

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Visual cues or lack of?

Communicating online is clearly not the same as having a verbal conversation and in person. The most obvious disadvantage is the inability to watch and read from body language. Young western people today (reference is made to young western people because research on numbers of household computers and frequency of use has occurred in western countries and homes (DeGuzman, 1999)) learn how to multi-task on the computer. Results from a study by Hunley, (2005), revealed that more young people today find it difficult to remain single-task focused and prefer to multi-task. It is not unusual for a young person to be writing an email while engaging on a chat site and working on their homework simultaneously. How effective they are at maintaining a consistent standard with their homework is questionable and would make an interesting research topic!

Debates related to the loss of visual cues in textual communication have occurred frequently over the last two decades (Barak, 1999; Bloom, 1998; Goss, 1999a, 1999b; Robson, 2000). Without visual cues both client and counsellor need to be proficient in expressing themselves textually as well as utilising colloquial language and descriptive immediacy. Both authors, (Barak, 1999; Weibhaupt, 2004 Oct) revealed that warmth and compassion can be expressed over the internet, and that over time, trust and receptivity can also be developed. Young people use a specific online language which can be accessed from www.netlingo.com. A community of young people decide how much of the language they will use. Generally, new language is introduced as it is needed to form an expression. The 'community' for young people may be a school or a neighbourhood group of friends for example. The KHL (Kids Help Line) in Queensland recently introduced online counselling to the service for young people (<http://www.kidshelp.com.au>). King, (2006), surveyed young people and their experience with email therapy and online counselling. The response from young people also suggested they use a specific language for online communications.

Choice of Modalities: Is there competition?

It is naive to assume that everyone benefits the greatest by speaking in person to person mode or from assuming that everyone is prepared to access person to person supports. It is unlikely there will be competition amongst modalities for clientele because people will be attracted to specific modalities for reasons that go beyond consumer availability and competition. Where consumer choice is limited, i.e. rural and remote locations; the modality is providing an additional option for accessing support. The choice still lies with the client. The client may decide to travel to a city and have a series of person to person sessions in a shorter period of time. The important question is whether or not people are making informed choices. We need to support health services to include information on their government websites, to include the risks associated with internet counselling as well as advocate the benefits of utilising technological supports. People can experience difficulty in determining credible vs questionable information on the internet (DeGuzman, 1999; N. Pelling, 2004). Saliency and credibility of information can be an issue due to the large volume of internet sites (Christensen, 2000). The source of the information is not always provided on the site (Kennedy, 2005), which is another reason

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why I advocate for government regulated sites and ethical bodies to lead the way in Australia to ensure that evidence based practice occurs.

Certainly, a benefit of online counselling using text is the ability for the client to review the session at a later date. This can be extremely empowering (Oravec, 2000). As computer systems and packages become more compatible, there will be the added advantage of speaking using a microphone and both counsellor and client being able to see one another via webcam, giving the client the option to vary the manner in which they use online technology. Such technology may be useful for people with disabilities who lack the dexterity, or for those who reside in a remote location and choose not to use text. The speed of correspondence can be much faster with online counselling (Gaggioli, 2001) and the client may have more flexibility in the planning of their sessions. An example of this is where the client has identified some strategies they want to initiate as a part of their change process. As a part of the client and counsellor plan, the counsellor can invite the client to send an email if they are experiencing a difficulty with the implementation of their strategies. The counsellor could say agree to respond to the client within twenty four or forty eight hours depending upon the counsellors other work commitments. A person to person counselling relationship can also have a place for the use of online technology in between sessions. There could be advantages within mental health organisations where client relapse is extremely high. Online counselling in isolation from other modalities is not recommended for crisis work (C. Hunt, Shochet, I., & King, R., 2005). However, online counselling can be the initial contact between counsellor and client and act as a point of referral.

A short history

Let's begin with Eliza, a household name amongst cyber supporters. Eliza was launched in 1966 and developed by Joseph Weizenbaum to study 'natural language' communication between a computer and a human and was based on Rogerian therapy (<http://en.wikipedia.org/wiki/ELIZA>). Eliza was not developed to be utilised in the role of a counsellor, however she was readily available to anyone who wanted to have dialogue with her. Eliza is concerned with: identifying key words; the discovery of minimal context; the choice of appropriate transformations and the generation of responses in the absence of keywords. The program was designed to time share and could handle a large number of users interacting simultaneously.

Centra is an online learning program, enabling users to access a virtual classroom from a computer. The program is moderated by a facilitator. One use of the Centra program could be to facilitate an online group counselling workshop. The added advantage of having a moderator ensures choice participation and regulates dialogue, allows for corrective behaviour input and group dominance can be regulated (<http://www.saba.com/centra-saba/>).

Health agencies began offering material via the World Wide Web (WWW) and people became more resourceful in the way in which they accessed health information. Young people at school learnt how to search the WWW for health information and the computer gradually became a more common household item. Programs such as 'Mood Gym' have

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become readily available and are recommended to be used in conjunction with a therapist (<http://moodgym.anu.edu.au/>). Mood Gym was developed by The National Australian University in Canberra and provides information, mood exercises and work books as online exercise all free of charge to the client.

Video conferencing is available in major health services in Australia and in the Department of Education and Children's Services in South Australia. Video conferencing can be helpful in maintaining client contact when the client resides in a rural and remote location. Hospitals in Australia generally use an IDSN2 connection and have access to an IDSN6 connection. Transmission speed of an IDSN6 far exceeds that of an IDSN2, and so does the cost. It is anticipated that broadband connection will supersede IDSN6 and is much more cost effective once installed. When trialling the technology for the purpose of this study, I was acutely aware of the distance between myself and the screen at the onset of the session. Eventually I lost the awareness of the technology and sensitivity toward the modality. The sessions became a rich blend of two worlds where the client readily divulged concerns and as the counsellor, I prompted for further exploration.

Where is online counselling in Australia today?

A small number of government agencies in Australia have started to utilise online counselling. Drug and Alcohol counselling online can be obtained via a Victorian based service called 'Turning Point' (<https://www.counsellingonline.org.au>). The service is offered free of charge to the client. The KHL which is based in Queensland offer both synchronous and asynchronous online counselling to young people aged up to eighteen years. One again, the service is free of charge for the young person.

Ethical bodies in USA have addressed ethical issues and developed 'codes of practice' for online practitioners (<http://www.counseling.org/>). In Australia, codes of practice seem to be developed by agencies as the services are developed. We are in the embryonic stages of embracing online counselling with a series of hesitations, however, Australia is slowly progressing. The benefits are obvious for people residing in rural and remote locations. Dr. John Court, the Coordinator of the Doctoral Program in Counselling based at The University of South Australia, has been instrumental in the development of a subject called 'cyber counselling.' The subject content in cyber counselling has been developed to further enhance the understanding of online counselling and technologies used to support such a modality in counsellors.

The potential exists for online support to be readily available to young people in schools across the country. We as a community are constantly looking for ways of improving health services for young people from a 'primary health care' approach and 'population model of health care'. Young people experience shyness and often paranoia at the thought of meeting a stranger in the role of 'therapist' for the first time. They can feel embarrassed and humiliated, as well as having to tackle the logistics of actually attending an appointment. Young people may have to travel to an appointment, negotiate time out from school resulting in the disclosure of their issue to an adult or parent. Their issue becomes more public than they may have wanted hence adding to their feelings of humiliation. I completely understand why young people may skip school to access

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support, especially if this is the only way they can engage and maintain confidentiality from others. If we expand the range of support options that our young population have, then we automatically improve our health system from a population/preventative perspective. The ability to access support prior to issues escalating for a young person, in a convenient manner where person to person contact is not a necessity, could be an attractive alternative for many. My current research in South Australia will hopefully identify the degree that young people between the ages of 16-18, would utilise such a service if it were readily available at no cost to the young person.

Rural and Remote

The issue of support for young people in rural and remote regions is not a new debate. Government agencies are too often required to demonstrate a commitment to country regions without a budget to match population needs. One of the benefits with online counselling is the ability for the modality to reach larger populations while using fewer resources. With the gradual enhancement in technology and compatibility, it will become more realistic for clients to choose whether they want to see the therapist via video conference using webcams and linking in with programs such as Centra. People who do not like to type or find this a distraction from the session, can use a microphone and talk instead.

Online counselling in Singapore

A very successful service in Singapore called 'metoyou' provides online counselling support to young people in schools as a part of Marine Parade Family Services (www.metoyou.org.sg). Metoyou were launched in 2000, and operate by charging the school for membership to the service. The students in the school receive a password and can access the service from 2.30pm-5.30pm Monday to Friday. If a student has a critical issue, they can send an email to the service outside of these times and someone will respond. This may however be in the form of a referral to another service that can support the person immediately if a crisis response is required in a person to person modality. Once a student has 'logged on' to the service site, they enter their nickname or username and their school password. This gives them entry to the 'waiting room' and here they select the cyber counsellor they wish to speak with. If their chosen counsellor is busy, they can select another counsellor. A 'cyber waiting room' could easily have access to games and health material while the client waits in the queue. Metoyou work with a volunteer model, where the counsellors receive 144 hours of training. An experienced counsellor is always present to oversee the service. The service offers a secure site and has clear record keeping management guidelines to adhere to. The model of service delivery seems to be a success and could be diversified for young people in Australia in a range of settings.

Conclusion

Research has been implemented in response to community concerns relating to online counselling expanding over two decades. Evidence from such research, suggests there is a niche for online counselling in our community. Emphasis needs to be placed on the regulation of online counselling with the introduction of clear policy and process as well as the introduction of state standards similar to the guidelines of the NABCC.

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Government agencies and ethical bodies in Australia have the opportunity to become the leaders in the development of this modality. Agencies as Turning Point in Victoria and KHL in Queensland have already incorporated online supports in to their services. Added benefits for young people include greater choice, increased anonymity and therefore the possibility of less shame and easier access. For young people residing in the country, their only other option may be phone counselling, or the need to travel great distances to see a service provider which may not be a possibility for them.

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Jackie M. Allen, Ed.D.

CAREER EDUCATION FOR SPECIAL EDUCATION STUDENTS

Abstract:

This article discusses the importance of career education for special education students. Special education students need career education as much or more than regular education students. The laws and procedures of special education and career development in the United States guide the development of state and local programs. In addition, national professional counseling associations provide models and standards of practice. The role of the school counselor is crucial in the development of comprehensive guidance programs that provide services for special education students. One aspect of the school counsellor role, the Individual Transition Plan process, is discussed in greater detail. School counselors advocate for special education students in special education meetings, at the school site, and in the community. The key to a special education student's success in K-12 and postsecondary pursuits and in transition to life and the world of work is often dependent upon the assistance the student and his/her family receive from the school counselor and student support personnel during the early years of education.

Introduction

...elementary schools are creatively integrating general and special education programs; parents are being given a legitimate voice in policy decision-making; and more disabled children are in regular schools than ever before. Yet there are still many obstacles to overcome before a truly equitable system is achieved.

Madelon Cloud (1999)

One of the remaining challenges for full integration of general and special education programs for special education students is the full implementation of career education programs into the curriculum for all children. Special education students, those students receiving accommodations in the regular classroom or program modifications with placement in special education classes, must be included in the mainstream of career counseling and career development programs from kindergarten through 12th grade. The future of many special education students depends on the participation of these students

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in post secondary training programs. School counselors need to work with the parents of special education students to increase awareness of the educational opportunities available for their children. Career education will prepare special education students for fulfilling and successful lives and instill in them the desire for life long learning.

The Needs of Special Education Students

In California there has recently been a renewed interest in Career Technical Education in part to meet the needs of employers and also to motivate students who are dropping out of school. Dean Gabriel Meehan asserts: "Face it, instant gratification is not going away. Provide students with interesting activities and hands on projects and it is guaranteed they will learn." (*The California School Counselor*, 2005). Certainly if the regular curriculum is in need of career education, the special education programs are even more in need of viable career education for their students. Special education students need normalizing experiences, and inclusion in career education programs is definitely a means of demonstrating to these students and their parents the value of considering their post secondary education and future. The American School Counselor Association (ASCA) National Standards for Counseling Programs and the *ASCA National Model for School Counseling Programs* (2005) call for academic, career, and personal/social counseling for all students.

Special education students may need extra help with exploring interests and determining strengths; what better person to provide that extra help than the school counselor with the aid of a career technician. Sacramento State University in California trains career counselors, teaching them how to utilize career resources, create career counseling programs, and train classified personnel to assist them with career programs for all students.

Robert Chope in his recent book *Family Matters* (2006) has made the case for the importance of the involvement of family members in the career planning process. Family members often know the strengths and challenges that their special education children face; parents need to be acquainted with available resources for post secondary training designed especially to assist special education students. Parents can also be enlisted to support maximizing the potential of their special education student. Preconceived ideas about the future of their special education student who has special needs and grief at the loss of a regular child are also areas in which counseling is extremely helpful for families of special education students.

Laws Guiding Special Education in the United States

In the United States four specific federal pieces of legislation dictate the parameters of funding and qualifications for special education: The No Child Left Behind Act (NCLB) of 2001, The Individual With Disabilities in Education Act (IDEA) 2004, Section 504 of the Vocational Rehabilitation Act of 1973, and the Carl D. Perkins Vocational and Technical Education Act. Reauthorization of the Elementary and Secondary Education Act providing funding for education became the No Child Left Behind Act of 2001. NCLB made schools accountable for student learning through the use of assessment with the goal to ensure that at-risk youth were "not left" behind academically. Accountability

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is measured through an annual yearly progress report (AYP) required by states in order to maintain federal support. At the local level schools were required to make local education plans (LEAP) for the implementation of scientifically-based programs and the spending of education dollars. Sanctions were imposed on local schools if test scores failed to improve and the consequences were cuts in funding, mandates for increased academic support services, replacing staff, or eventually restructuring, privatizing, or state takeover of school districts. An assessment rate of 95 percent student participation was required, and participation rates and assessment data could be averaged over a 3-year period for reporting AYP results. All students including those with disabilities are to be tested annually; provisions for assessment accommodations for special education students were to be included in the Individual Education Program documents. Alternative achievement standards were allowed for those with significant cognitive disabilities in approximately 2 percent of the total student population. For alternative assessment measures teachers could use observation, samples of student work, or criterion referenced tests of specific student competencies. Assessment must be in line with state curriculum standards (U.S. Department of Education, 2005). Although alternative assessment measures are permitted in a small percent of the special education population, there are concerns about testing disabled students. Dollarhide and Lemberger (2006) cited a 2004 public opinion poll of 1, 050 voters; 57 % disapproved of requiring the same tests for disabled students and nondisabled students.

Special education in part is funded through the Individual With Disabilities in Education Act (IDEA), reauthorized in 2004 (U.S. Department of Education, 2006). School districts are to initiate scientifically based early reading programs, positive behavioral interventions and supports, and early intervening services to address the learning and behavioral needs of children. IDEA 2004 has made some significant changes in rules and regulations for special education in the United States. One of the major changes is that states can no longer require districts to consider an IQ/achievement discrepancy as a criterion for learning disabled eligibility. Scientific, research-based intervention response is part of the evaluation procedures for severely learning disabled (SLD) students. Teachers are receiving additional training to become “highly qualified” to provide special education and inclusion in regular education classes.

Response to Intervention (RTI) is the new alternative to the discrepancy method used to determine if and how students respond to specific changes in curriculum and instruction. Problem solving models such as the “three-tiered model” are being used to provide a larger group of students with intervention to improve learning and test scores. Tier I is primarily early intervention for at-risk students in the general education classroom, using all available school supports and evaluating student progress. Tier II consists of more interventions and ongoing evaluation. For students who are not making progress consistent with standards, remedial services and instructional additions and/or modifications to regular classroom instruction are used. Tier III, after success has not been gained in the previous tiers, provides access to referrals for psychoeducational assessment for learning disabilities (Christo, 2006). More specific and intense remedial instruction through special education as well as regular classroom instruction with modifications are initiated at this level. Individual Education Plans (IEP) and Individual

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Transition (career) Plans (ITP) are written for special education students and constitute legal documents between the school district or other interagency service provider(s) and the parents. ITP plans will be discussed in detail later in this article.

Other options open to students with disabilities not eligible for special education classes are provided through Section 504 of the Vocational Rehabilitation Act of 1973. Accommodations within the regular curriculum are to be made for qualifying individuals. The requirements for eligibility for 504 accommodations are:

1. A mental or physical impairment which substantially limits one or more major life activities which include, but are not limited to caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.
 2. A record of such impairment as described above.
 3. The individual is regarded as having such an impairment as previously described.
- (U.S. Department of Education, 2003)

No extra money or legal protections are offered through this legislation. A student with a 504 plan, due to a permanent leg injury from a car accident, may have an accommodation for longer breaks between classes in order to walk from one class to another class.

For Career Technical Education, the Carl D. Perkins Vocational and Technical Education Act, Public Law 05-332, provides funding and guidelines through the Office of Vocational and Technical education for state basic grants. Career counseling and guidance are included in the funding and defined as:

... a comprehensive, developmental program designed to assist individuals in making and implementing informed educational and occupational choices. A career guidance and counseling program develops an individual's competencies in self-knowledge educational and occupational exploration, and career planning.

(U.S. Department of Education, 2005)

Professional Association Leadership

The National Career Development Association (NCDA), a division of the American Counseling Association (ACA), has teamed up with the Association of Career Resources Network (ACRN), federally funded through Carl Perkins monies, to update and produce the National Career Development Guidelines (NCDG) Framework (America's Career Resource Network, 2005). The framework is organized in three domains: Personal Social Development (PS), Educational Achievement and Lifelong Learning (ED), and Career Management (CM). The eleven goals are coded numerically and by domain. Three indicators (Knowledge Acquisition-K, Application-A, and Reflection-R) or learning stages are derived from *Bloom's Taxonomy* and no longer tied to an individual's age or educational level. An example of the NCDG Framework coding system follows:

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PERSONAL SOCIAL DEVELOPMENT

KNOWLEDGE ACQUISITION- PS1.K2 **Identify** your abilities, strengths, skills, and talents

APPLICATION- PS1.A2 **Demonstrate** use of your abilities, strengths, skills, and talents.

REFLECTION- PS1.R2 **Assess** the impact of your abilities, strengths, skills, and talents on your career development.

The American School Counselor Association, the largest division of ACA, developed standards for school counseling programs. The National ASCA Standards for School Counseling Programs include three developmental domains: academic, career, and personal/social. These standards have guided school counseling programs for almost 10 years. Recently the ASCA published *The ASCA National Model; A Framework for School Counseling Programs-Second Edition* (2005) and the *ASCA National Model Workbook* (2004) with the standards as a foundation for counseling programs, adding the 21st century emphasis on accountability and organizational structure. The theme of the ASCA model is systematic change in the way school counseling programs are organized, implemented, and evaluated. The basic themes of the model are counselor leadership and advocacy, system change, and collaboration. The delivery system, based on the Gysbers and Henderson model, advocates for school guidance curriculum, individual student planning, responsive services, and system support. The management system employs agreements; advisory councils; and use of data, action plans, and time calendars. Accountability is measured in student outcomes using performance standards, program audits, and results reports.

An example of an ASCA National Standard in the Career domain is:

Standard 4: Students will acquire the skills to investigate the world of Work in relation to knowledge of self and to make informed career decisions.
(ASCA, 2005)

In crosswalking this standard with the more extensive National Career Development Guidelines Framework domains and stages, the above examples of PS1.K2, PS1.A2, and PS1.R2 are essential skills for accomplishing ASCA Career Domain Standard 4. Thus the two professional association guidelines can be integrated into a comprehensive counseling and guidance program.

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School Counselor Role

Career education in the United States has a rich legacy of national and professional association regulations and guidelines. What then should be the school counselor role in providing career education for special education students? The school counselor as a service provider for special education students is both an integral part of a comprehensive counseling and guidance program and an important member of a student support services team (Allen & La Torre, 1998). ASCA (2004) in the revised school counselor role position statement recommends the following roles for school counselors:

- Providing assistance with transitions from grade to grade as well as post-secondary options
- Consulting and collaborating with staff and parents to understand the special needs of these students
- Advocating for students with special needs in the school and in the community
- Assisting with the establishment and implementation of plans for accommodations and modifications
- Advocates for students with special needs and is one of many school staff members who may be responsible for providing information as written plans are prepared for students with special needs.

Allen (2004) has outlined the program areas, roles, and functions of a school counselor in the career development domain of a comprehensive counseling and guidance program. The school counselor is a member of the integrated services team of student support personnel raising awareness of the team to career development needs of special education students. On the IEP team the school counselor is the case manager for career education and development, which includes the ITP process for the special education student. As coordinator of the comprehensive counseling and guidance program the school counselor coordinates the program, counsels students, provides career guidance lessons in the classroom, and evaluates the overall program including the career guidance components. In the school system the school counselor as staff member provides in-service presentations on the importance of career education, advocates for the rights of special education students for inclusion in the career education program, and leads and coordinates the career program throughout the school. The school counselor acts as coordinator and collaborator with community agencies developing linkages for career education, vocational training, and work experience programs.

Individual Transition Plan Process

As stated above the school counselor serves as the advocate for the special education students which means representation at Student Study Team Meetings, Individual Education Program planning meetings, 504 meetings, and Individual Transition Plan (ITP) meetings. Allen (2004) discusses the unique function of the school counselor in the Individual Transition Process. Under IDEA 2004 transition plans must be developed and in place by the time the special education child is 16 years old. The ITP like the IEP is a legal document. Key areas of the transition plan are:

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Employment Skills
Community Living Skills
Training/Education
Living Arrangements
Community Recreation/Leisure
Social Emotional Needs
Financial/Economic Needs

In preparation for an ITP meeting key questions that a school counselor might ask a student with the assistance of the parent include:

What are your strengths?
What skills do you need to develop to transition from school to adult life?
What kind of a job or career do you envision in the future?
Do you want to attend a college or community college?
Do you want to prepare for a job through career and technical training?
Do you want to continue to live at home or do you want to live on your own?
How will you earn money to support yourself if you live on your own?
What kind of recreation and leisure activities do you want to participate in?
Are you aware of special programs and resources for special education students?

The ITP meeting focuses on the needs of the special education student and the creation of a purposeful, organized process (the plan) to produce the desired outcomes that will enable the special education student to transition from school to employment and then to a quality adult life. Many educators as well as community specialists may meet to work with the family and student to review relevant data, summarize current functioning and previous goals achieved, develop transition goals and objectives based on identified needs and student preferences and interests, and decide on appropriate interagency linkages. ITP members include special education teacher(s), school counselor, parent and student (when appropriate), administrator, career specialist, regular education teacher(s), school, student support specialist(s), and community specialists that may be providing specialized services for the student.

When a high school student has completed an ITP that student should have a plan for transition to the work world and life. It must be stressed that this is not an end, but just a beginning. For the last two years of high school, the school counselor working with regular and special education teachers, family members, and other specialists must carefully monitor the progress of the special education student. Some students will leave high school ready to continue formal education, others will embark upon specialized training programs in shelters, some may choose to live at home, others may try independent living, or others may need residential placement depending upon their individual needs.

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Conclusion

There is no question that there is a need for career education for special education students. Federal and state laws and professional association guidelines define the career education path for special education students; the school counselor is the guide and mentor along the way. There are many programs designed to assist learning disabled students make their way in the world. Parents must be informed of these resources and programs, such as the special section on Programs and Services for Students With Special Needs in the *Life After High School* student guide (Allen & Hansen, 2006). Parents often need help to access this information that is so important in making their student's life more successful. The school counselor has an important role to play throughout the educational process and career education; it just very well may be the most important service a school counselor can provide for a special education child and their family.

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Additional Resources:

The Carl D. Perkins Vocational and Technical Education Act, Public Law 105-332
<http://www.ed.gov/offices/OVAE/CTE/perkins.html>

and Career Guidance and Counseling Programs
<http://www.ed.gov/about/offices/list/ovae/pi/cte/cgcp.html>

Web site for No Child Left Behind sponsored by the U.S. Department of Education.
<http://www.ed.gov/nclb/landing.jhtml>

National Career Development Guidelines (NCDG) Framework is found at
www.acrnetwork.org/ncdg.htm

Web site for IDEA 2004 News, Information, and Resources
<http://www.ed.gov/policy/speced/guid/idea/idea2004.html>



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Suicide Assessment: Strategies for Determining Risk

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Abstract:

Suicide constitutes an international health crisis. The World Health Organization estimates that approximately one million people per year commit suicide, and suicide is now among the top three leading causes of death for persons aged 15-34 in every country in the world. Counselors encounter suicidal persons in schools and agencies with alarming frequency and often express concerns about handling these clients. This manuscript overviews suicide risk factors and then discusses suicide risk assessment, as assessment is the critical foundation for both suicide prevention and treatment. The assessment of suicide risk is a difficult and complex task. Suicide risk assessment helps identify acute, modifiable, and treatable risk factors and helps clinicians to recognize when clients need more concrete methods to help clients manage their lives. Suicide risk assessment requires knowledge, training, and experience.

Suicide Assessment: Strategies for Determining Risk

According to the World Health Organization (WHO), approximately one million people each year commit suicide, more than all homicides and war-related deaths combined. Suicide rates are on the rise, increasing more than 60% in the last half century. In 1950, the worldwide suicide rate was 10 per 100,000, and it has now reached 16 per 100,000. If this trend continues, by 2020, there will be more than 1.5 million suicides in the world each year (World Health Organization, 2006).

Suicide represents a major health concern in Australia. The suicide rate for Australia is 13 per 100,000, higher than many industrialized countries, including the United States, France, Britain or Italy (WHO, 2006). More than 2,200 Australians a year commit suicide, averaging about seven suicide deaths per day. Suicide in Australia represents one-third of all injury deaths, and there are almost nine suicides for every homicide, and 1.5 suicides for every road accident death.

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In 2003, there was a very slight downward trend in suicide deaths in Australia, although it is too early to determine whether this represents an ongoing trend or is simply an artifact of the data (Australian Bureau of Statistics, 2006).

Mental health professionals in all types of career paths encounter suicidal persons in their practice. More than 30% of adults in the general population admit to feeling suicidal during at least one point in their lives (Goldney, Winefield, Tiggemann, & Winefield, 1989), and more than 70% of mental health professionals state that they have worked with at least one suicidal individual (Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001). Nearly one-quarter of counselors have experienced a client suicide (McAdams & Foster, 2000). In general, mental health professionals who experience a client suicide describe it as “the most profoundly disturbing event of their professional careers” (Hendin, Lipschitz, Maltzberger, Haas, & Wynecoop, 2000, p. 2022).

This paper is intended to assist clinicians in their efforts to recognize persons at elevated risk for suicide. Several of the major risk factors and warning signs associated with elevated risk are discussed, followed by an overview of suicide assessment protocols and techniques.

Suicide Risk Factors, Warning Signs, and Protective Factors

There are numerous risk factors for suicide, many of which have been articulated in the literature. In fact, a recent study found more than 75 risk factors in the suicide literature (Wingate, Walker, Joiner, Rudd, & Jobes, 2004), clearly suggesting a broad range of risk. Several major categories of risk factors are identified in the following paragraphs.

Suicide and Gender

For every completed suicide in Australia, there are approximately 30 suicide attempts, although this differs by gender. Just as in all developed countries, there are more suicide attempts by females in Australia and more completions by males. For every completion by an Australian male, there are five attempts. For every completion by an Australian female, there are 35 attempts. Thus, the gender breakdown in Australia is very similar to the U.S., where females are seven times more likely to attempt and males are four times more likely to complete suicide. For Australian males, the 2003 suicide rate was 17.7 per 100,000, and for females, it was 4.7 per 100,000 (Australian Bureau of Statistics, 2006). For the most part, this distinction is made because of the lethality of chosen methods, with males tending to use more lethal means for their suicide attempts.

Suicide and Age

Worldwide, suicide is the third leading cause of death among young people between ages 18-24. In general, among males, suicide rates increase with age, with men in the oldest age categories (over age 85) having the highest rates. In Australia, men over age 80 have rates that are six times that of women in the same age bracket, and males over age 65 account for 20% of all suicides. Additionally, the young adult years appear to hold a high level of risk for males, with a suicide rate of over 30 per 100,000 for males between 30-34 years old (Australian Bureau of Statistics, 2006).

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Psychiatric Disorders and Mood States

About 90% of people who commit suicide have a diagnosable mental or addictive disorder at the time of death, making this a central risk factor for suicide and suicidal behaviors. In fact, a psychiatric disorder is the strongest observed risk factor for attempted suicide in all age groups, and mental and addictive disorders provide the major context for suicide and suicidal behaviors. In adolescents, the major mental disorders that are associated with suicide are affective disorders, conduct disorder, antisocial personality disorder, and substance abuse. In adults, mood disorders (primarily depressive disorders & bipolar disorder), substance abuse, and aggressive behaviors are associated with elevated suicide risk. For example, persons with schizophrenia have 40 times the risk (Potkin, Anand, Alphas, & Fleming, 2003), and those with chronic alcoholism are at 60 times greater risk for suicide (Hufford, 2001) than those in the general population.

Although most mental health professionals understand the importance of screening for depression in suicide risk, most research indicates that hopelessness, rather than general depression, is an even greater risk factor for suicide. Whereas depression involves a strong negative affect, hopelessness is typically more about the lack of positive affect. Persons who are hopeless cannot generate images of positive outcomes for the future. Hopeless people attempt suicide because they cannot foresee an end to their psychological pain.

Impulsivity also has been linked to increased risk. Persons whose judgment is impaired through impulsivity – either by the use substances or because of an impulsive temperament – are more likely to attempt or complete suicide as an immediate reaction to an immediate stressor. Impulsivity is a key feature of several psychiatric disorders, including conduct disorder, some of the personality disorders, substance use disorders, and bipolar disorder. Impulsivity – whether occurring within the context of a diagnosable mental disorder or as personality trait that does not meet the criteria for a mental health diagnosis, significantly increases suicide risk. Taken together, hopelessness and impulsivity can serve as a very dangerous combination.

Cognitive Dysfunction

Individuals who have their thinking constricted by cognitive limitations may find themselves more likely to fixate on suicide as the only possible option. Thus, cognitive rigidity is a major risk factor for suicide. Cognitive distortions (e.g., over-generalizations, preoccupation with a single thought or idea, all or nothing thinking) are often present in those who attempt or commit suicide. A study of suicide notes of adolescents who completed suicide found a high incidence of cognitive constriction, including rigidity in thinking, narrowing of focus, tunnel vision, and concreteness. Other cognitive distortions that have been associated with elevated risk are limited problem-solving ability (inability to generate options or alternatives), an external locus of control (perceived inability to control one's destiny), impulsivity (inability to defer gratification of needs) and perfectionism (inability to tolerate perceived violations of internalized standards for behavior).

Environmental or Situational Stressors

Poor coping and/or problem-solving ability are exacerbated by environmental or situational stressors that push people beyond their ability to manage. Stressors such as job loss, divorce, financial concerns, and legal difficulties all have been linked to higher suicide rates (Weyrauch, Roy-Byrne, Katon, & Wilson, 2001). Among suicidal adolescents, there is a higher incidence of

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family dysfunction of all types compared to their non-suicidal peers. Common familial risk factors for adolescent suicide include coming from highly conflicted families that are unresponsive to the adolescent's needs, families with parental alcoholism or substance abuse, and families with physical or sexual abuse. Families of suicidal teens also have higher levels of medical and psychiatric problems (Garfinkel, Froese, & Hood, 1982). Social isolation and poor peer relationships are two additional environmental risk factors. Suicidal adolescents often feel alienated, both within the family and with their peers (Stillion & McDowell, 1996). They are more likely to have poor social skills, ineffective peer relationships, to be non-joiners, and to be generally unpopular. Finally, families who have had a suicide completion are at higher risk for another.

Warning Signs

Individuals who attempt or commit suicide often express their intent to others, either directly or indirectly. In fact, more than 90% of adolescents who commit suicide give clues (either verbal or other warning signs) before they attempt. About one-third of people who attempt suicide will have another attempt within the year, and about 10-12% of those who threaten or attempt go on to complete suicide, typically within 5-10 years of the first attempt (Runeson, 2001). Thus, recognizing warning signs for what they are when they occur can be an important component of suicide prevention.

There are many warning signs listed in the literature, but some of the most common include: suicide threats (direct or indirect), obsession with death, poems, essays and/or drawings that refer to death, dramatic changes in personality or appearance, irrational and/or bizarre behavior, overwhelming guilt or shame, changes in eating or sleeping patterns, changes in school or work performance, and giving away possessions (National Mental Health Association, 2006). It is clear that warning signs must be taken seriously and investigated to determine whether or not they are associated with elevated risk.

Protective Factors

Just as some behaviors or beliefs elevate suicide risk, others have a protective effect. Examples of protective factors include: appropriate and effective clinical care for persons with psychiatric problems, easy access to interventions, support for help-seeking, family and community support, and learned skills in problem-solving, conflict-resolution, and non-violent dispute resolution. However, only 38% of Australian adults with mental health problems access health care, with that care being provided primarily by general practitioners. Additionally, only one in four young people with mental health problems receive help, and even among those with most severe mental health problems, only 50% receive professional help (Parliament of Australia, 2006). Thus, although protective factors can clearly be important in reducing risk, there is little evidence that they are prevalent among those who need them most.

Suicide Risk Assessment

The assessment of suicide risk is a complex and challenging task that requires training, education, and experience. Mental health professionals who are new to the field or who assess suicide infrequently should always work under supervision. Even those with years of experience, however, find that consultation with peers is important. In fact, Edwin Shneidman (1981), often called the Father of Suicidology, cautioned that there is no instance in a therapist's professional

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life when consultation with a colleague is more important than in the case of a highly suicidal person. Because of the highly complex nature of suicide assessment, and the consequences of “false negative” assessments (e.g., believing someone is not suicidal when, in fact, they are), it must be underscored that this brief article does not contain all the necessary information to complete a comprehensive suicide risk assessment. It is merely an overview of some of the most essential information. Readers are referred to more comprehensive texts for more thorough discussions of suicide risk assessments (e.g., Shea).

A foundational principle of suicide assessment is that it must take into account the uniqueness of each individual. It may be tempting to review risk factors and warning signs, which are based on aggregate data, and then make individual determinations of risk. This is never appropriate. Risk assessment instruments and protocols focus on known risk factors. Although it is true that, in general, the more risk factors a person has, the higher their risk, clearly, clinical judgment must prevail. In other words, a person with very few risk factors and very low scores on assessments of suicide risk may, in fact, be at high risk. Another person with many risk factors may have protective factors (e.g., a relationship with the mental health professional, religious injunctions against suicide) that mitigate the risk. Thus, according to the American Psychiatric Association’s practice guidelines for suicide, suicide assessment remains “the quintessential clinical judgment” (Jacobs & Brewer, 2004, p. 373).

A comprehensive suicide risk assessment involves several different types of assessment as well as consultation, collaboration, and corroboration of information (Granello, 2006). A complete psychiatric history and examination of both demographic and individual risk factors are always part of a comprehensive assessment (Cochrane-Brink, Lofchy, & Sakinofsky, 2000). In addition, many mental health professionals use risk assessment instruments. There are many different informal checklists, interview protocols, and formal assessments that are available to assist the clinician in determining risk. However, the most common method to assess suicide risk is simply to ask. Sometimes beginning practitioners get so caught up in all the complexity of the risk assessment that they forget to ask the question (something like, “have you thought about suicide?” or “are you considering killing yourself?”). Other times clinicians let their assumptions, rather than their clinical judgment, interfere with assessment. Finally, there is evidence that a standard clinical interview, with one or two questions regarding suicide, may not be sufficient. In one study, as many as 44% of persons with past histories of suicide attempts answered “no” to a general gatekeeping question regarding past attempts and therefore would have been missed for follow-up questioning (Barber, Marzuk, Leon, & Portera, 2001).

Interview Protocols: A comprehensive suicide risk assessment interview does more than just ask a simple question. Clients are led through a series of topic areas that should include (at a minimum):

Suicidal intent – present/recent thoughts about killing oneself

Details of the suicide plan – the more specific, the more dangerous

The means by which s/he plans to commit suicide (gun, hanging, overdose, etc.). Be sure to consider the lethality of the means (a gun is more lethal than ingesting several over the counter aspirin)

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Accessibility of those means to the suicidal person (how easy is it for the person to obtain the means. In other words, saying they will shoot themselves is less of an immediate threat if they don't have access to a gun, versus someone who says, "I will shoot myself using my dad's pistol, which is in his dresser drawer and the bullets that are in the garage.")

History of suicidal thoughts and attempts (including parasuicidal attempts)

Stability of the current mood (e.g., did the person feel suicidal yesterday? Last week? This morning?)

Family history of suicide attempts or completions as well as family history of mental disorders

Client's mental state (through a mental status exam)

Assessment of warning signs and specific risk factors

Acronyms. Sometimes, counselors use acronyms to help them remember the basic components of suicide risk assessment. Commonly-used acronyms are:

S.L.A.P.

S – what are the *specific* details (S = specificity)

L – how *lethal* is the plan (e.g., guns, pills, rope) (L = lethality)

A – how *available* is the method of choice? Where is it? (A = availability)

P – what is the *proximity* to help? Who will find him/her? How long will it take to be found? (P = proximity)

P.L.A.I.D.

P – Previous attempts

L – Lethality

A – Access

I – Intent

D – Drugs/alcohol

P.I.M.P.

P – Plan

I – Intent

M – Means

P – Prior attempt

M.A.P.

M – Mental state for suicidality (thinking)

A – Affective state for suicidality (emotions)

P – Psychosocial state for suicidality (circumstances)

N.O. H.O.P.E. (Shea, 2002).

N – No framework for meaning

O – Overt change in clinical condition

H – Hostile interpersonal environment

O – Out of hospital recently

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P – Predisposing personality factors

E – Excuses for dying are present and strongly believed

Suicide Checklists

There are many checklists that are available to guide questioning around suicide risk. Again, just as with the acronyms, these checklists are intended only as a guide for the interview, not as a definitive suicide risk assessment. A caution is necessary: the “objective” scoring of some of the checklists can encourage inappropriate use. Remember, these are *general guidelines only*. Nevertheless, research has shown that clinicians who are trained in the use of suicide checklists have improved ability to evaluate risk than those who have not (Juhnke, 1994). Counselors have a variety of checklists to choose from, such as SAD PERSONS (Patterson, Dohn, Bird, & Patterson, 1983), Adapted SAD PERSONS for Adolescents (Juhnke, 1996), the Suicide Assessment Checklist (Rogers, Lewis, & Subich, 2002), and the Clinician Suicide Risk Assessment Checklist (King, Lloyd, Meehan, O’Neill, & Wilesmith, 2006).

Formal or Commercially Available Assessments

There are dozens of published standardized suicide risk assessments, and hundreds of unpublished questionnaires and assessments. Standardized assessments can be useful in providing adjunctive information that helps get a clearer picture of the situation. Research has shown that standardized assessments are especially helpful for professionals with limited psychiatric training (Patterson et al., 1983). However, at best they can only provide an estimate of suicide risk. Standardized assessments that are used for suicide risk assessment come in two major categories: those that measure suicidal risk directly and those that measure emotional states (e.g., depression, hopelessness, anxiety) that correlate with suicide risk. Some of the more common standardized assessments are listed below. For a more comprehensive review, see the National Institutes of Mental Health by Dr. Gregory Brown (nd).

Beck Scale for Suicidal Ideation (Beck & Steer, 1991)

Inventory of Suicidal Ideation (King, & Kowalchuk, 1994.)

Suicide Probability Scale (Cull & Gill, 1995)

InterSePT Scale for Suicidal Thinking – (ISST; Lindenmayer et al., 2003)

Reasons for Living Inventory (Ivanoff, Jang, Smyth, & Linehan, 1994)

Suicide Behaviors Questionnaire – Revised (Linehan, 1996)

Child-Adolescent Suicide Potential Index (Pfeffer, Jiang, & Kakuma, 2000)

Columbia Teen Screen (Shaffer et al., 1996)

When conducting suicide risk assessments, it is not necessarily important that all counselors select the same specific checklist, assessment, interview protocol, or acronym. What is important is that each counselor select a method of assessment that he or she actually will use. All of the assessment methods have overlap in their content because they are all trying to measure the same thing. What is most important is that counselors pick one (with advice and guidance from more seasoned practitioners, if applicable), keep a copy of it someplace where it is easily accessible, and use it. Whether it is an acronym written on a notecard that is taped to the desk or a formal checklist that is included in a file, the most important thing to do when assessing suicide risk is to conduct a thorough and comprehensive interview. The first step is to ask.

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Conclusion

Counselors who work with suicidal clients must have training, experience, and supervision to ensure that they have the necessary skills. Assessment of suicide risk is an important first step in working with suicidal persons, and assessing risk is a complex and challenging task. Clients who are at risk seldom fully understand their own risk level. They may not know whether they will be able to stay safe, and suicidal thoughts can change dramatically from day to day, hour to hour. The complexity of the task requires a careful and thorough assessment, ideally grounded in a strong therapeutic relationship, with consultation and collaboration with family members and other practitioners. Although knowing and understanding the risk factors is essential, suicide risk assessment of each person is unique and is based on clinical judgment. A real danger is that a formulaic plan for suicide risk assessment will lead to decisions that are inappropriate, or even deadly. Because of the likelihood that all counselors, regardless of setting, will encounter suicidal persons, everyone in the field of mental health is strongly encouraged to receive training and supervision to extend their knowledge in this very important area of clinical work.

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Motivational Interviewing: A Tool for Behaviour Change

Abstract

This paper will provide a brief overview of the counselling models used in Alcohol and Other Drug (AOD) Services and a brief overview of the Palmerston Association and the counselling approaches used by that agency with a particular focus on an intervention called 'Motivational Interviewing'. Although this paper is focused on the use of Motivational Interviewing with clients who have an alcohol or substance use problem, Motivational Interviewing (MI) as a tool can be, and was developed, for use with any client wishing to look at any form of behaviour change.

Palmerston

The Palmerston Association Inc was founded in Perth, Western Australia in 1980 and initially was known the Drug Research and Rehabilitation Association. The Association was (is) based in Palmerston Street North Perth and shortly after opening the name Palmerston was used and later became the name of the incorporated body. Initially Palmerston was founded to provide rehabilitation to illicit drug users. At the outset the intention was to establish a Therapeutic Community and in 1983 the Palmerston Farm had its beginnings. The farm is set on 10 acres approximately 30 kms south of Perth.

The Centre, the offices in Palmerston Street, provides a counselling service on site and the corporate and administrative support for all of the Palmerston branches. The various branches are as a result of the Western Australian Government outsourcing the Community Drug Service Teams to contracted NGO's. Since 1998 Palmerston have been responsible for the Perth CDST located in East Perth, the South Metropolitan CDST with offices in Fremantle and Mandurah and the Great Southern CDST based in Albany.

During the course of Palmerston's history the services provided by the Association have been extended beyond the original idea of provision of rehabilitation of illicit drug users to include counselling and support to people whose lives are affected by alcohol, substance misuse and gambling.

Palmerston employs over 60 staff providing in excess of 13,500 occasions of service per year serving over 3,200 clients. In addition the Farm, with an 85% occupancy rate, has 19

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beds available to men and women who wish to avail of the Therapeutic Community model of rehabilitation.

Presently Palmerston provides the following services:

- Palmerston Farm (TC)
- In Albany and Mandurah a GP service on site
- Individual, couple & family counselling
- Group work
- Parent support programs
- Court diversion programs
- Community Development & Education

Alcohol and Other Drug Counselling Models

Within the AOD (Alcohol and Other Drug) field approaches vary from organisation to organisation. The two predominant models upon which all the other theoretical approaches are based are Social Learning Theory and the Disease Model. These variances can move from a total abstinence approach (typically using a 12 Step model) to that advocated by a number of government and non-government agencies including Palmerston of Harm Minimisation.

The Disease Model was developed in the 1930's following the prohibition period and the formation of Alcoholics Anonymous (AA). This model is predominant in alcohol and other drug services in the USA. There are variations within this framework; however the essential concepts of the disease model have certain concepts in common. The concept of dependence is strongly linked with the disease model. Dependency occurs when a person spends increased time getting and/or using drugs. Within this model it is assumed that the person is not able to control the circumstances of his/her life as long as the substance is continued to be used.

Addiction is a primary disease or an illness that a person has. Based on a medical model, the person has an illness rather than other factors being central to the use/abuse of a substance. The 'condition' (drug use behaviour, dependency, addiction) is beyond the control of the person. In these approaches loss of control is seen as a key factor. A person is born with a disease (genetic influence) or develops it and once contracted it is for life. The consequence of the disease model approaches is that the only cure is abstinence.

Social Learning Theory (SLT) emerged in the 1960's to explain behaviour in a multiplicity of situations, including drug and alcohol use. SLT begins with the belief that all behaviours are influenced by internal and external cues: for example eating when hungry (internal cue) and when someone offers a piece of chocolate (external cue). Understanding the relationship between behaviours and particular cues helps us understand these behaviours. Different factors can act as cues for different people and for different kinds of behaviour: some act as cues for moderate use whereas others act as cues for heavy use. Similarly some can cue a reduction in use or stopping altogether.

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Some implications of SLT in working with clients with alcohol and other drug issues include the belief that drug use has real and expected consequences which are influential in defining whether and how often and in what circumstances the individual will use drugs. These consequences may include feeling 'high', feeling relaxed, the avoidance of discomfort, feeling sociable and so on.

Drug use is learned from a multiplicity of sources: parents, peers, the media, from observing others using and through experiencing the consequences associated with drug use. Modelling, which is vicarious or observational learning, is a key factor in the adoption of alcohol and other drug use behaviours. Learning occurs through both social and psychological cues.

The complexity of drug use, particularly the factors relating to the environment, is acknowledged in this theory. There is an interaction of factors: an individual is not driven by internal factors alone nor responds passively to environmental factors. The factors are interdependent. This complexity indicates the different reasons for use and the different responses required to assist people. A range of treatment options is required to match the needs of people; interventions work best when they are individually tailored.

Approaches to working with clients with alcohol or drug use advocated by the Drug & Alcohol Office in Western Australia are based upon Social Learning Theory and include: Stages of Change, Schafer's Model, Thorley's Balls, Roison's Theory and Motivational Interviewing.

The philosophy of Palmerston is that the client as s/he presents is seen as an individual with issues which may need addressing. As each client is an individual with his/her own specific needs we do not attempt to have a one case fits all approach. A constant challenge for the therapist is working with the client to encourage him/her to take charge of his/her own life. Often this means working with the client to understand their behaviour in the context of their life as it is lived now and how they have lived life in the past – both short term and over the long term.

Motivational Interviewing

A traditional view of motivation is that it is something that a person either has or doesn't have. There is a belief that for a person with a problematic behaviour that that person does not have the will power to change. They may be perceived as unmotivated, difficult or denying their problems. This view is often exacerbated when the behaviour is associated with drugs.

However a more accurate view of motivation is that everyone is motivated. It is more a question about the nature of the motivation. Are they motivated to continue, reduce or stopping their problematic behaviour?

Motivational interviewing is a style of counselling particularly suitable for clients who are feeling ambivalent about changing their behaviour. The counsellor practicing motivational interviewing utilizes Rogerian non-directive strategies - in a particular way

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and for a particular purpose - to encourage the client to explore their ambivalence and consider the possibility for change. In pursuing this goal, the counsellor will have a strong sense of purpose and may sometimes be directive and incisive.

Motivational interviewing prepares people for change. When successful, the client will be ready to actually change their behaviour, at which point a range of other approaches will be useful. It is particularly appropriate when the client is at the pre-contemplation or contemplation stages but can be used whenever someone is feeling ambivalent.

Motivational interviewing isn't a technique as such; rather at its best it is an interpersonal style that is a subtle balance of directive and client-centred components. There are however some specific and trainable therapist behaviours that are characteristic of a motivational interviewing style.

- seeking to understand the person's frame of reference (reflective listening)
- Expressing acceptance and affirmation (empathy)
- Eliciting and reinforcing the client's own self motivation, concerns, desires
- Monitoring the client's degree of readiness to change
- Affirming the client's freedom of choice and self direction

Within an MI approach working with a client to change his/her behaviour there are four general principles that a therapist will use: Expression of Empathy; Supporting of Self-Efficacy; Rolling with Resistance; Developing Discrepancy.

The expression of empathy is central to working with the client. Reflecting back to the client his/her feelings and thoughts not only helps build rapport, but in this process, helps mirror the clients experience in a way which allows him/her to fully experience their dilemma. Empathy involves seeing the world through the eyes of the client, thinking about things as the client thinks and sharing in the client's experience. When clients feel that they are understood, they are more able to open up to their own experiences and share their experiences with others. Having clients share their experiences allows the counsellor to assess when and where they need support and the potential pitfalls in planning the change process.

Importantly, when the client perceives empathy on the counsellor's part, they become more open to gentle challenges by the counsellor about lifestyle issues and beliefs about substance use. Clients become more comfortable fully examining their ambivalence about change and less likely to be defensive.

A client's belief that change is possible is an important motivator to succeeding in making a change. As clients are held responsible for choosing and carrying out actions to change in the MI approach, counsellors focus their efforts on helping clients stay motivated and supporting their sense of self-efficacy. There is no "right way" to change. The counsellor works with the client to plan for change in a way which fits for the client. The work is in helping the client to develop a belief that s/he can make a change. The

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clinician works with the client to identify the changes the client has already made and highlights the skills that the client has.

In MI the counsellor does not fight resistance but “rolls with it”. Statements demonstrating resistance are not challenged. Rather the counsellor uses the skills of reframing, rephrasing and working with the client’s momentum to further explore the issues. MI encourages clients to develop their own solutions to the problem that they themselves have defined. Rather than a hierarchy or an imposition of a new way of thinking, the client is invited into an exploration of their concerns and an examination of new perspectives.

When people perceive a discrepancy from where they are and where they want to be there is the possibility of change. Using this motivation to help clients examine the discrepancies between their current behaviour and their goals is MI. When clients perceive that their current behaviours are not leading toward some important goal they become more motivated to make important life changes. The counsellor’s role is to gently and gradually help the client see how some of their current ways of being may lead them away, rather than toward, their eventual goals.

What are the Steps in Using Motivational Interviewing?

There are a number of steps to follow in doing MI, such as looking at the two sides of the decision and at the conflict for the person. Prior to moving into a strict MI mode, it is important to clarify with the client the agenda around which there is ambivalence. At this stage use of open-ended questions and developing rapport is essential.

Once there is a sense of what the issue is the therapist works with the client to move on to explore what s/he likes about drugs or the positive aspects of drug use. Everyone has some positives that are important for both to understand as this may be the basis of the attachment to the drug and part of the conflict in giving up. This can be an engaging surprise for the client. It will only work if the counsellor is genuinely interested. It is also a useful strategy in reducing defensiveness. Some possible questions that can be asked area:

What are some of the things you like about ...?

People often use a drug because it helps in some way, how has it helped you?

What would you miss if you weren’t ...?

At this stage it is important to keep the person focused on what are the good things. What has s/he got out of using drugs or behaving in this way? Before moving on it is important to summarize the things the person has said.

Following on from looking at the positive aspects of the behaviour for the client the work moves on to the bad things or negative aspects of AOD use. Phraseology at this point is important. The not-so-good things can be a better phrase as it helps reduce defensiveness. Using a phrase such as not-so-good also makes it clear that you as the counsellor

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understand that the ambivalent place the client finds himself in is understood by the counsellor.

During this stage some possible questions could be:

You have told me some of the reasons you like What about the other side of the coin? What are some of the not-so-good?
What are some aspects you are not so happy about?
What are some of the things you wouldn't miss?

If the client speaks in generalities check out if it is a personal concern. At this time it is important not to get too caught up in a particular problem. The aim is to have the client explore their own thinking and feelings around the issues.

Once again summarize what the client has shared.

Making a clear summary of what the person has presented is important before moving on to the next step as it allows a reflection space for the client to respond and confirm what has been said and to clarify anything on either side. Both the counsellor and the client should now have a clear picture of the benefits and costs about the person's behaviour.

The third step in MI is to ask the client about their present life. The purpose of this step is to get an idea of their personal beliefs, attitudes, values and important life goals. The goals will be the pivotal point against which the costs and benefits are weighed. What sort of person would they describe themselves as? How do friends, parents, partners describe them and would the client agree.

After looking at the good/not so good aspects in the present contrast how they see themselves now and into the future. A question such as: How would you like things to be different in the future? Followed by a discussion around what may be stopping this is a useful strategy in bringing out barriers to change.

Over the time the counsellor and client have been working in the MI mode they have allowed space for the client to share and be heard, be recognized for the difficult situation in which he finds himself and to be at a point where a decision can be made, whether it is to change or not to change a form of behaviour.

The making a decision to change a long held behaviour is never easy. In a traditional MI manner of working a Decision Balance is often employed. This tool is a grid that allows the client to look at the good/less good and the pros and cons of changing behaviour. The decision is now up to the client to weigh up.

If the decision is to change, then a formulation of a short term goal and required action steps follows. The setting of goals – which goals; short term/long term – and the actions required is not part of this paper. There a number of useful strategies and techniques which are available in the counselling field to help the client set their agenda.

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The uses of MI vary, e.g. it can be a one-off targeted session such as in the use of this approach in a GP setting or can be an aspect or tool used by a counsellor in working with a client over a number of sessions.

Motivational Interviewing can be a useful tool to allow a client recognize and work through their ambivalence. As a tool it is available to any area of life in which behaviour is causing distress and can be used by a clinician coming from a varying number of theoretical backgrounds.

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Innovative counselling with anxious children

Abstract:

It is estimated that anxiety disorders can affect up to 18% of 6-17 year-olds (Costello & Angold, 1995). In addition, there are many children who are excessively anxious although they do not meet criteria for an anxiety disorder. Cognitive behaviour counselling techniques have been the therapy of choice for most anxious children in the last few years. This is usually because they have been the most researched and thus have an evidence-base. Kendall's *Coping Cat* program and variations such as the *FRIENDS* program, have found a 65% success rate in treating anxious children. However, for preschool and primary aged children other therapeutic counselling techniques using a wider range of child-friendly intervention can also be successful. Bibliotherapy, puppets, drawing, sandplay and games are also useful for counselling anxious children (Jalongo, 1993; Quakley, Reynolds, & Coker, 2004) as is the method of cross-age peer tutoring (Campbell, 2003).

Keywords:

anxiety disorders, children, cognitive-behavioural therapy, play therapy

It is estimated that anxiety disorders can affect up to 18% of 6-17 year-olds (Costello & Angold, 1995; Kashani & Orvaschel, 1990). In fact, excessive anxiety is the most prevalent type of disorder experienced by children and young people (Albano, Chorpita & Barlow, 1996; Verhulst, van der Ende, Ferdinand, & Kasius, 1997). Furthermore, the incidence of childhood anxiety disorders is thought to be increasing (Mash, 2006). Not only do many children have co-morbid conditions with anxiety but it has been proposed that anxiety and depression lie on a developmental continuum and that anxiety predates many other disorders (Dobson, 1985). Evidence suggests that childhood anxiety may play a causal role in the development of depression among young people (Cole, Peeke, Martin, Truglio, & Senczynski, 1998) and anxiety disorders have been shown to precede eating disorders in most cases (Godart, Flament, Lecrubier, & Jeammet, 2000). There is preliminary evidence to suggest that anxiety disorders may predispose children in the development of substance use

disorders (Burke, Burke, & Rae, 1994; Deas-Nesmith, Brady, & Campbell, 1998; Rodhe, Lewinsohn, & Selby, 1996) and that there is an increasing risk of suicide as a consequence of anxiety (Mattison, 1988). Students with anxiety disorders have been shown to have lower academic achievement (Ialongo, Edlesohn, Werthamer-Larsson, Crockett, & Kellam, 1994; 1995), peer relationship problems (Strauss, Frame, & Forehand, 1987) and impairments in general social competence (Messer & Beidel, 1994). Excessive school absenteeism and impaired peer relationships associated with anxiety lead to poor vocational adjustment (Hibbert, Fogelman, & Manor, 1990) and self-concept problems (Asher & Coie, 1990) as well as psychiatric disorders later in life (Kovacs & Devlin, 1998). Early intervention with children is therefore warranted.

Successful treatment approaches

Most published programs for anxiety disordered children that are evidenced-based are cognitive behavioural therapy (CBT) programs. Kendall's *Coping Cat* youth CBT anxiety program has strong empirical support with two large-scale randomised controlled trials (Kendall, 1994; Kendall et al., 1997). Barrett's adaptation of *Coping Cat*, *Coping Koala*, now referred to as the *FRIENDS* program also has strong empirical support (Barrett, Dadds, & Rapee, 1996; Barrett, Duffy, Dadds, & Rapee, 2001) with 57% of children in the CBT only condition compared to 26% of children in the waitlist condition being diagnosis-free at the end of treatment. Many other group CBT programs also evaluated by randomized control trials (Silverman et al., 1999; Spence, Donovan, & Brechman-Toussaint, 2000) have found that CBT intervention was superior to wait-list control. Additionally, these positive results seem to apply to children with co-morbid disorders (Kendall, Brady, & Verduin, 2001). Furthermore, most studies have found that group treatment is equally effective as individual treatment (Manassis et al., 2002). While evidence for these programs is strong, CBT has not yet not been compared extensively with other counselling therapies.

Despite these successes however, not all children who have undertaken CBT programs have benefited. In a systematic review of ten randomised control studies of CBT with children it was found that the remission rate in the CBT groups was 56.5% compared to 34.8% in the control groups (Cartwright-Hatton, Roberts, Chitsaben, Fothergill, & Harrington, 2004). While this is a significant effect, there are still 40% to 50% of children who still meet criteria for an anxiety disorder at the end of treatment. Long term follow-up studies have found that the benefits have been maintained and many children continue to improve (Barrett et al., 2001; Kendall, Safford, Flannery-Schroeder, & Webb, 2004). However, a third to half of the children who underwent treatment were not diagnosis-free long term (Hudson, 2005). Furthermore, most studies have not included children younger than 7-years-old (Cartwright-Hatton et al., 2004).

Why CBT might not work for all children

One consideration in explaining why CBT intervention programs for anxious children might not work with all children is the lack of incorporation of many developmental principles and processes, as these are just beginning to influence cognitive behavioural treatments with children (Mash, 2006). For example, age would seem to be an important consideration in the CBT treatment of anxious children. Most of the existing CBT programs have been designed for use in middle childhood (Dadds, Spence, Holland, Barrett, & Laurens, 1997). Effect sizes have been shown to be larger

for adolescents using CBT than for children, as adolescents function at a higher cognitive level and find it easier to learn the cognitive skills presented (Durlak, Fuhrman, & Lampman, 1991). Wurtele, Marrs, and Miller-Perrin (1987) also noted that young children may have difficulty in understanding some of the abstract concepts presented in cognitive behavioural therapy, while Campbell (1990) maintains that traditional CBT will never be appropriate for very young children.

Additionally, CBT treatments are highly verbal (Kendall, 1994), based on adult models and are often not suitable for young children whose vocabulary is more limited or for those children with a language-based learning disability (Manassis, 2000). Another consideration is the engagement of the child in the therapeutic process. This is important both for the child's learning and to prevent premature termination in counselling. It has been shown that child involvement in therapy indicates outcome, particularly in the later stage of therapy (Chu & Kendall, 2004). Thus, Hudson (2005) suggests a need to modify standard CBT programs for those children who are not benefiting from them.

One suggestion could be to incorporate other modalities such as play therapy techniques into the CBT framework. Traditional "play therapy" has been used with children because it is developmentally appropriate. Play therapy enhances communication by using both verbal and non-verbal techniques, engages children to learn and provides a safe environment for children to consider negative emotions (Reddy, Files-Hall, & Schaefer, 2005). In fact, play therapy was originally developed as a method to work with "nervous and neurotic children" (Carmichael, 2006). Often the "talking therapies" are not appropriate for children, or are not the best modality for some children or even for some adolescents. Other non-verbal methods such as stories, sandplay, puppets and painting could be incorporated into a CBT framework. Counsellors need to be creative in the engagement of anxious children and use innovative and dynamic therapeutic modalities within their preferred framework for working.

Using Stories

Bibliotherapy is not completely unknown as a CBT intervention, particularly with children. Bibliotherapy sometimes means the use of self-help books or manualised workbooks which have been shown to assist in reduction of flying phobia (Beckham, Vrana, May, Gustafon, & Smith, 1990), social phobia (Jerremalm, Jansson, & Öst, 1986) and test anxiety (Register, Beckham, May, & Gustafon, 1991). However, for counsellors, the kind of books that are used with children are more likely to be fiction books. Literature applied to a program using bibliotherapy helps to foster emotional and behavioural growth wherein selected readings portray true-to-life situations in relation to children's cognitive developmental levels (Jalongo, 1993; Riordan & Wilson, 1989). Through guided readings, children can discuss the implications of a story in a less threatening way than talking solely about themselves. Students are also able to consider their own thoughts and feelings about personal issues from the point of view of 'the other'. Stories help children learn that they are not alone, that others share similar problems to them (Christenbury & Beale, 1996; Nickolai-Mays, 1987). Reading about others can help children develop compassion and insight into their own and others' problems.

A common feature in children's literature is the use of animals as the non-specific, identifiable other that can keep a frightening idea from becoming terrifying (Livo, 1994). Animals in stories can create a distance from which children can view their own situations. However, a challenge for counsellors is in choosing material that is age-appropriate and relevant to students' emotional and developmental needs. Christenbury and Beale (1996) suggest that counsellors need to read the material first as a way to know what the story is about and as a way to enter the child's world to become an empathetic listener. Furthermore, chosen literature should be culturally sensitive; it should build a non-stereotypical knowledge base about life in a particular culture. Such literature describes the many commonalities of various cultures but also important differences (Freitag, Ottens, & Gross, 1999). Furthermore, bibliotherapy should not be used by itself but as one of many different techniques within a planned counselling framework.

There are many non-fiction books dealing with anxious feelings such as Crary's (1994) *I'm Scared*, as well as fiction books: From books for preschoolers such as Waddell's (1999) *Can't You Sleep, Little Bear?* and Varney's (1995) *Jelly Legs*, to books suitable for primary school students such as Browne's (1995) *Willy the Wimp* and Campbell's (2006a) *Cilla the Worried Gorilla*, to books suitable for secondary school students, such as Duff's (1999) *Duffy's Once Were Worriers* and Ruth Park's (1989) *Things in Corners*.

Sandplay

Sandplay therapy is one technique that presents as a potentially valuable tool for working with anxious children. Sandplay has been defined as a psychotherapeutic technique that enables clients to arrange miniature figures in a sandbox or sandtray to create a 'sandworld' corresponding to various dimensions of his/her social reality (Dale & Wagner, 2003). The process of sandplay therapy involves the use of one or two sandtrays and any number of small objects or figures from categories including, people, animals, buildings, vehicles, vegetation, structures, natural objects and symbolic objects (Allan & Berry, 1987). It is intended that these objects may represent people, ideas, situations, feelings and a potentially limitless range of other possibilities to facilitate children's expression.

Most commonly, the sandplay process consists of two central stages. The first involves the construction of the sand picture, where the perceived needs for the counselling session and the intentions of the facilitator guide the specific instructions given to the child (Pearson & Nolan, 1995). In general, the child is invited to create a picture in the sand tray, using any of the available miniatures. The ways in which the counsellor interacts with the child at this time and also their perspective on the purpose and meaning of the sand picture is largely determined by his/her therapeutic orientation. However, sandplay pictures are generally considered to be a projection of the child's internal experiential world and a representation of his/her worldview (Dale & Wagner, 2003). As such, they provide children with an opportunity to express the negative feelings and memories that exist in their unconscious and impact on their choices, feelings and behaviour (Pearson & Wilson, 2001). It is suggested that bringing these to consciousness is the first stage in disempowering them and allowing them to be released (Pearson & Wilson, 2001).

After the completion of the sand picture, if the child is comfortably able to engage in verbal communication, the second stage of the process involves their sharing of a story or narrative about the sand picture they have created. This stage of the process allows children to clarify personal meanings and to integrate new feelings and insights that may have emerged through the creation of the sand picture. Additionally, the counsellor may engage in interpretation of the child's sand picture based on knowledge of the meanings associated with particular symbols, in conjunction with information about the child's history and current circumstances.

Applying sandplay work to anxiety is similar to working with other emotional and behavioural problems. As the counsellor knows the problem then one can be a little more directive. For example, the counsellor could ask the child to make a picture with a selection of figures in the sand of the things that are worrying him/her. Thus sandplay provides both for emotional release and understanding and guided resolution.

Puppets

Puppets give children the opportunity to distance themselves from their problems and are thus invaluable in engaging anxious children in both assessment and counselling for anxiety. Puppets, like characters in a story, can serve as the unspecified other that children relate to in order to tell their own stories. Puppet interviews have been used successfully with children younger than 8 years old to determine their ability to make self-judgments (Verschueren, Buyck, & Marcoen, 2001) and their abilities to discriminate among thoughts, feelings and behaviours (Quakley, et al., 2004). In the study conducted by Verschueren and colleagues children manipulated the hand puppets, responding to interview questions as the puppets. In Quakely and colleagues' study, scenarios about problems the hand puppets had were read. The children were then asked to help resolve the puppets' dilemmas. Both studies involved children in interactive ways to have them reveal information about themselves. In Quakley's study, the puppets required the children to help them solve their problems, while in Verschueren's study, the children became the puppets. It can be argued that young children are still at an age of hands-on learning as an integral way of internalising concepts and so responded well to interaction with the puppets. This makes them ideal for including in work with anxious children.

CBT in play therapy or play therapy in CBT?

Others have considered using play therapy with CBT techniques incorporated such as the founder of cognitive play therapy (CBPT) Susan Knell. Knell's work incorporates CBT techniques such as modelling, generalisation and response prevention into a play therapy theoretical base (Carmichael, 2006).

CBPT is developmentally sensitive, flexible, promotes cognitive change indirectly through the use of play and relies more on experiential approaches than verbalisations (Knell, 1998). Knell advocates the use of puppets in modelling as well as art, music and books (Knell, 1993). Published case studies have demonstrated success with individual children (Knell & Moore, 1990) but as yet there is no other evidence-base for CBPT.

Although evidence for play therapy has not as yet been subjected to the same rigorous evidence base as CBT therapy for children's anxiety disorders (Labellarte, Ginsburg,

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Walkup, & Riddle, 1999) there have been two meta-analytic studies (Le Blanc & Ritchie, 1999; Ray, Bratton, Rhine, & Jones, 2001) which found moderate to large treatment effects (effect sizes of .66-.80) for play therapy in general compared to no treatment. Knell (2000) presented some case illustrations using CBPT for children with fears and phobias while Santacruz, Mendez and Sanchez-Meca (2006) found evidence for the effectiveness of play therapy with children with darkness phobia. They assigned 78 children with darkness phobia between the ages of 4 and 8-years-old to three experimental conditions of bibliotherapy and games, emotive performances and no treatment. The play therapies were applied by parents with both play therapy groups showing a significant improvement in darkness phobia compared to the children in the control group. These gains were maintained and increased at one-year follow-up.

Because of the scant evidence at present for play therapy for anxious children, it could be preferable to incorporate play therapy techniques into an evidenced-based CBT framework rather than incorporating CBT techniques into a play therapy paradigm. This concept has been researched by Miller and Feeny (2003) in a case study, which reported the treatment of a 5-year-old socially phobic girl using games as a technique whilst still adhering to the guiding principles of CBT. La Freniere and Capuano (1997) used an early intervention with parents for their anxious/withdrawn preschoolers combining some play therapy and CBT. Sessions focused on child-directed play, behaviour modification of problematic behaviour and education on the development needs of children. While children's social competence increased compared to the no treatment control group, all the anxious/withdrawn children improved after six months.

The Worrybusters program

A new program for anxious children called the Worrybusters program is CBT framed using different modalities which are developmentally appropriate, educationally sound and able to be flexibly delivered. The program consists of a selection of different activities designed for the counsellor to choose depending on their client's characteristics within a CBT framework. Modules of activities are provided for reducing physiological symptoms associated with anxiety such as feeling nauseous which is a common somatic response in anxious children. An example is the Woolly Mammoth story incorporating the explanation of familial traits of anxiety so that the child does not blame him/her self and 'tummy breathing' to assist in getting rid of the "butterflies". Another module consists of activities for understanding and challenging maladaptive cognitions such as writing on balloons, using Harry the Hand puppet to explain about "head, heart and hands" approach of thinking influencing behaviour and Wonga the Worry Wombat who worries about worries you can't do anything about. Another module supports activities for changing behaviour using exposure. Fiction books for the series, especially written on each of the childhood anxiety disorders, are incorporated into many activities.

This idea of a "modular" design has been investigated by Chorpita, Daleiden and Weisz (2005) and is an important difference from other manualised programs. First, it is important to cater for different client needs and in fact to cater for different children's preferences, as there is some emerging literature that client preference many influence how well treatment works (Lavori et al., 2001). In addition, there is evidence that matching intervention components to specific aspects of a children's

anxiety problem is more efficacious than providing a standardised anxiety treatment package (Eisen & Silverman, 1998). Furthermore, individual counsellors need to have the flexibility to choose from the menu of activities.

Cross-age tutoring

An innovative model of treatment delivery for the Worrybusters program is that of cross-age tutoring. Cross-age tutoring involves older students helping younger students learn new skills or concepts (Jacobson et al., 2001). Older students serve as role models who have first hand experience of what is confronting their young tutees (Gaustad, 1993). Gaustad suggests that, as students themselves, tutors are cognitively closer to their tutees than adult teachers and counsellors and so are more accurate in determining tutees' non-verbal behaviour and are better able to present concepts in ways more understandable to younger students. Consequently, tutor and tutee are able to establish strong bonds not generally realised by the usual teacher-student relationship.

According to Nugent (2001), the cross-age tutoring relationship appears to benefit both tutor and tutee academically, social and affectively. Social skills (Noll, 1997), self-determination in students who had severe emotional or behavioural disorders (Miller & Miller, 1995) and student's self concept (Ellis, Marsh, Craven, & Richards, 2003) have all found to be enhanced by cross-age peer tutoring.

A small pilot study (Campbell, 2006b) found that anxious adolescents who participated as tutors to anxious primary children using the Worrybusters program showed an improvement in anxiety symptoms, compared to a wait list control group. The parents of the anxious primary school students reported a significant improvement in anxiety symptoms in their children, however the children's self-reports remain unchanged from pre-to post-testing. A multiple base-line study involving three groups of anxious high school students tutoring three groups of anxious primary students using the Worrybusters program is currently being undertaken.

Conclusion

With the increasing number of children affected by anxiety disorders and the often severe consequences that can follow, it is important that programs for treating them assist as many children as possible. While at present there is strong evidence for the successful treatment of these children with programs based on manualised cognitive-behavioural counselling, there is still a significant proportion of anxious children who do not benefit from them. Cognitive behaviour therapies for children are still evolving and many clinicians and researchers are trialling new and innovative ways to help anxious children. Programs need to be developmentally appropriate, educationally sound and recognise and cater for individual differences. The incorporation of play therapy techniques into these programs could be one innovative way to improve these children's lives.

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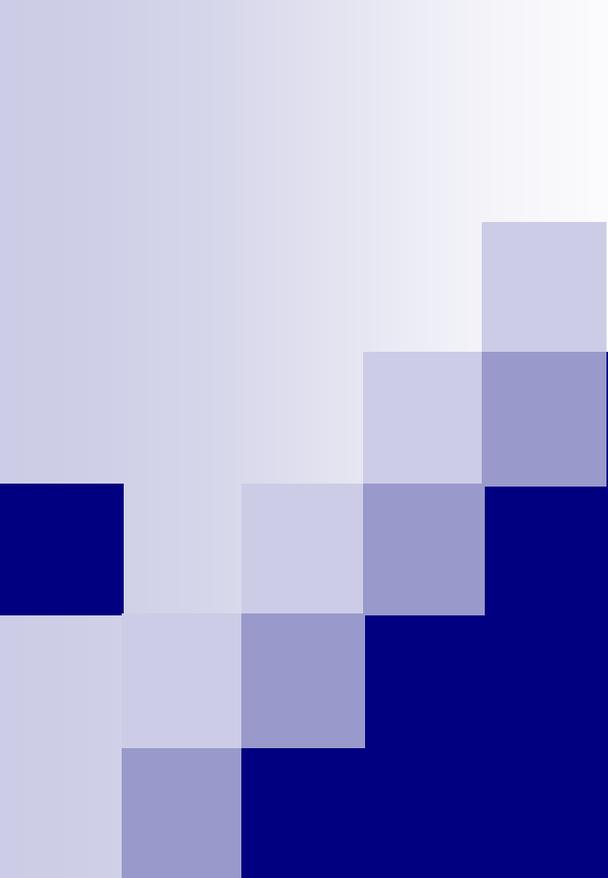
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Using Solution-focused thinking in career counselling

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Using Solution-focused thinking in career counselling

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Solution-focused counselling

- Pioneered by Steve de Shazer, Insoo Kim Berg and colleagues at Milwaukee Brief Family Therapy Center.
- Brief, constructivist, positively framed, future-oriented, collaborative inquiry that is respectful of client diversity and contextual differences.



Constructivist principles

- Everyone's reality is based on their understanding of, and participation in, their own experiences.
- Human behaviour can only be understood in the context of the client's whole environment and interactions within it.



Solution-focused thinking

- What is solution-focused counselling?
- What are constructivist principles?
- What is solution-focused thinking?
- The solution-focused career counsellor



Overview of a solution-focused strategy

1. Problem clarification and imagining the possible
 - Constructing well-formed goals
2. Building client self-helpfulness
 - Positive exceptions
 - Encouraging hope (WISHED)
3. Constructing meaningful feedback

Problem clarification and imagining the possible

Well-formed goals must be:

- The client's
- Small (but important)
- Specific, realistic, concrete, behavioural, observable
- The 'start' of something
- The presence of something



Techniques that help clients imagine the possible

- Direct questions
- Miracle questions
- Scaling questions

Direct Questions

- *What would you like to get out of today's career counselling session?*
- *How will you know that coming to see me about your [career concern] was a good idea?*
- *How will you know that you are where you want to be?*
- *What will be different for you when you [reach your goal]?*

Miracle Question

- Most useful when clients are 'stuck'.
- Helps clients verbalise their thoughts about 'if only...then'.
- Client envisions a preferred future that incorporates:
 - Work/career/leisure
 - Relationships
 - Financial
- *Suppose a miracle was to happen...what would you notice?*

Scaling Questions

- Can be used to focus the entire session.
- Help clients construct meaningful descriptions of their concerns, goals, strengths, motivation.
 - *What does that place on the scale look like?*
 - *Is there a point on the scale you would rather be?*
 - *What would be different for you at that point?*
 - *What would it take for you to move one point up the scale?*

Building client self-helpfulness with Positive Exceptions

- Help clients explore behaviour or circumstances that make problem less problematic.
 - *Have there been times when ...?*
 - *What did you do differently then (self helpfulness)?*
 - *What would others say was different for you (contextual meaning)?*
- Responses provide examples of client success, resourcefulness, strengths

Encouraging Hope (WISHED)

- **W**h qns (what, where, who where) NOT why?
- **I**nstead (to replace negatively worded goals)
- **S**uppose (to help clients imagine alternatives)
- **H**ow (to encourage self-helpfulness)
- **E**mphasise positive differences
- **D**raw or write, make visible all positives, possibilities.



Constructing meaningful feedback

- Compliments
- Bridging Statement (goal)
- Future oriented message

Relevant reading

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Glamcevski M. (2007) What are the necessary and sufficient elements of the counselling supervision relationship?, *Counselling, Psychotherapy, and Health*, 3(1), 104-114, May 2007.



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What are the necessary and sufficient elements of the counselling supervision relationship?

Abstract:

The supervision relationship is a dynamic process in which the supervisor and supervisee negotiate a personal way of using a structure of power and involvement that accommodates the supervisee's progression in learning. This structure becomes the basis for the process by which the supervisee acquires knowledge and skills ultimately for the empowerment of the supervisee, and to the benefit of the clients and supervisor. I propose that careful consideration of the fundamental principles within the supervision of counselling is required, regardless of theoretical, organisational or situational context. This requirement extends from a notion in the supervision literature, that a therapeutic relationship is the basis of development in supervision. Based on the Holloway's early work, empirical evidence and personal reflection, the fundamental elements in a supervision relationship are as follows: power and interpersonal structures, three identifiable phases (beginning, maturation and termination) and the need for a supervisory contract. Supervision is a formal relationship in which the supervisor's task includes imparting expert knowledge and making judgments of the supervisee's performance. Formal power, or power attributed to the position, rests with the supervisor, therefore the supervisory relationship is a relationship in which reciprocal power dynamics have a fundamental role. The supervision relationship develops through identifiable stages. After initial interactions, participants come to know one another better and are thus more accurate in their predictions about the other person's reactions to their messages. With decreased uncertainty, control strategies and communicative modes are utilised to reduce the level of conflict in the relationship, which in turn drives the progress through the stages of the relationship. Each supervisor and supervisee has expectations about the roles and functions in supervision. These expectations are idiosyncratic and organisational, some result from experience, while others are more personal and cultural characteristics. Thus there is a need for a supervisory contract to clarify expectations.

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Introduction

The exploration of the fundamental elements of supervision leads to the supposition that there are power dynamics within the supervision relationship. Literature pertaining to the models of supervision, and the trends in supervision research, demonstrate that significant changes occur within this relationship. Careful consideration of the fundamental principles within the supervision of counseling is required, regardless of theoretical, organisational or situational constraints. Based on the empirical evidence and personal reflection, the fundamental elements are as follows: power and interpersonal structures, three identifiable phases (beginning, maturation and termination) and the need for a supervisory contract.

Each supervisor and supervisee brings to the supervision relationship his or her own expectations about how the process will unfold. Some of these expectations result from previous encounters of supervision, including formal and informal relationships, as well as knowledge of supervision gained through anecdotal materials and literature (Carroll & Holloway, 1999). These experiences shape the process of supervision and provide a foundation for the development of the supervision relationship. The relationship structure subsequently influences participants' engagement in the process of supervision (Carroll & Holloway, 1999; Hawkins & Shohet, 2000).

The supervision relationship is a dynamic process in which the supervisor and supervisee negotiate a personal way of using a structure of power and involvement that accommodates the supervisee's progression in learning (Holloway, 1995). This structure becomes the basis for the process by which the supervisee acquires knowledge and skills, and ultimately for the empowerment of the supervisee. Both the supervisor and the supervisee are responsible for establishing a relational structure that is flexible enough to accommodate the supervisee's particular professional needs in an intense, collaborative learning alliance (Page & Wosket, 1994). However, the supervisor and supervisee roles differ. Within the structure of this professional relationship, the supervisor has the guiding role with respect to evaluation and support (Samuels, 1993).

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SETTING THE SCENE

Models in Supervision

Since the introduction of counselling to mainstream European (Western) societies in the 1950's, supervision has been the focus of considerable attention. Ekstein and Wallerstein (1958) produced one of the first texts to distinguish between the *practice* of counselling and the problem of *teaching* and *learning* counselling. In their seminal text, they focused on how to transmit these skills of counselling to another counsellor, unique in that they reviewed ways of supervising rather than counselling.

Much discussion on supervision was generated throughout the 1960's, 1970's and 1980's. At first, supervision models mirrored theories of counselling. The names of these models reflect counselling theories, such as client-centered supervision (Patterson, 1983), the social learning approach to supervision (Hosford & Barmann, 1983) and supervision in rational-emotive therapy (Wessler & Ellis, 1983). Although models are intended to aid in interpreting complex phenomena and in learning complex skills, the "counselling-bound" models of supervision provided few directions for either research or practice (Russell et al., 1984). Important knowledge from relevant disciplines, such as developmental educational and social psychology, were excluded due to the insular approach of such models.

Counselling-bound models have continued to be replaced by models that incorporate knowledge from related psychological sub-disciplines and that provide frameworks for empirical inquiry (Carroll & Holloway, 1999; Jacobs, 1996). Research on the process of supervision has revealed that supervisors do not practise supervision and counselling in the same way; a supervision interview has features distinct from a counselling interview (Hawkins, & Shohet, 2000; Carroll & Holloway, 1999; Russell, et al., 1984).

Recognition that supervision (teaching & training) of counselling is different from conducting counselling is reflected in cross-theoretical models of supervision that incorporate aspects of individual difference, social role theory, and instructional psychology (Page & Wosket, 1994).

Supervision Research Trends

In early seminal studies of supervision, researchers were interested in ascertaining whether the supervision relationship and supervisory process were distinct from the counselling relationship. Many analytical studies pertaining to supervision have focused on the relationship and process, using content analysis of the interactions within educational settings. The purpose of these studies has been to determine whether supervisors use different types, or different proportions of the same messages, in supervision interactions as opposed to counselling (Holloway & Wolleat, 1981; Lambert, 1974; Richards, 1984; Wedeking & Scott, 1976).

A comparison of supervisors' behaviour in supervision as opposed to counselling interviews demonstrates the different types of messages, or proportions of the same messages, found in supervision and counselling dialogues (Lambert, 1974; Wedeking & Scott, 1976). Verbal behaviours of both supervisor and supervisee have been described by researchers such as Holloway and Wolleat (1981), and Richards (1984). The combined results of these studies indicate that within the supervisory relationship the supervisor spends significantly more time providing information, opinions and suggestions than when counselling. Further, these research studies demonstrated that within the supervisory relationship, task oriented behaviour is utilised

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more than emotional support, or attending to the supervisee's emotional state. Studies have examined patterns of verbal behaviour across the span of the supervision relationship from conception to termination (Wedeking and Scott, 1976; Feltham, 1999), supervisor messages changed between the beginning and final stages of the relationship.

Analytical studies of interactional processes in supervision have contributed to our understanding of the sequence of events in supervision and the characteristics of the relationship as reflected in the verbal messages of the participants. The primary conclusions that can be drawn from the content analysis research are that (a) supervision and counselling processes are distinct; (b) there are significant changes in discourse during the relationship; (c) there is a predominant pattern of verbal behaviors that is analogous to teacher-student interactions and (d) the relationship structure of supervision has hierarchical characteristics (Holloway & Poulin, 1995).

THE FUNDAMENTAL ELEMENTS OF THE SUPERVISORY RELATIONSHIP

There has been considerable research on the relationship and process of supervision (Holloway, & Carroll, 1999; Russell et al., 1984). From empirically based literature, articles relating to philosophy and personal knowledge of practice, three fundamental elements in the supervisory relationship have been identified:

1. The power and interpersonal structure of the relationship.
2. The phases of the relationship and how these relate to the development of the participants.
3. The supervisory contract to establish a set of expectations for the tasks and functions of supervision.

Power and Interpersonal Structure

Supervision is a formal relationship in which the supervisor's task includes imparting expert knowledge, making judgments of the supervisee's performance and acting as a gatekeeper to the profession (Holloway, 1999; Page & Wosket, 1994). Formal power, or power attributed to the position, rests with the supervisor, therefore the supervisory relationship is a hierarchical one (King & Wheeler, 1999).

Hinde (1979) comments that power is in fact rarely absolute. Power is inevitably limited by the capacities of both individuals. It usually involves a limited influence of one partner on the finite probabilities of actions by the other. The controlled party usually limits the exercise of power (for example the worker can strike, or seek employment elsewhere). Additionally, one partner often has power in some contexts and not in others, as the power distribution is resultant of mutual negotiation. This factor indicates that power is a property of the relationship.

Hinde has suggested that power may take very different forms, depending on the personal and institutional resources available and the type of involvement of the individuals, which is not always given due consideration.

From an institutional structured perspective, power has been viewed as a vehicle of control and dominance. To be powerful is to wield influence and control resources and information (Dunlap & Goldman, 1991). In the helping professions, power has often been viewed negatively because the concept of control and dominance has seemingly been in opposition to the concept of mutuality and unconditional positive regard (Hawkins & Shohet, 2000). Early work of Follett

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(1924, 1951) however, introduced the idea of "power with," a concept that is pluralistic and representative of an ever-evolving process of human interaction (Holloway, 1995). This perception of power offers an alternative based on involvement and mutual influence. This "power" is more consistent with counselling and supervision, where the intent is to empower, rather than control, individuals.

Both participants determine the distribution of power or the degree of attachment to one another. Mutual perception, along with acceptance of the degree and distribution of influence potential in the relationship, are major determiners for the nature of the power dynamics in the relationship (Morton, Alexander, & Altman, 1996; King & Wheeler, 1999).

Although the relationship takes on a unique character that can be partially defined by power and involvement, the participants contribute their own history of interpersonal relationships. These interpersonal histories influence how the supervisor and supervisee ultimately present themselves in forming their new relationship. The power of influence is reflected by the action and thinking of the participants during the supervision process.

Phases of the Relationship

Research on the supervision process has described the structural characteristics of dialogue between the supervisor and supervisee. However, it has not examined the underlying evolution of the relationship. Process research has often overlooked the evolution of the relationship across time, despite considerable attention from social-psychological literature regarding the development of non-interpersonal to interpersonal relationships over time. Social-psychological literature has continually demonstrated that relationships, including super ordinate-subordinate and supervision, develop through identifiable stages (Bandura, 1986; Dodenhoff, 1981).

Certain factors have consistently been observed within developing relationships (Miller, 1976, Wiley & Ray 1986; King and Wheeler 1999). As a relationship evolves, the participants rely less on general cultural and social information and more on idiosyncratic information particular to the participant. Predictions regarding the other person's behaviors come from information that differentiates the person from other members of his or her corresponding social group. The other becomes unique in the eyes of the perceiver, and the relationship is said to have moved from a non-interpersonal to an interpersonal one (Miller, 1976).

As the relationship develops into an interpersonal one, uncertainty is reduced. After initial interactions, participants come to know one another better and are thus more accurate in their predictions about the other person's reactions to their messages. With decreased uncertainty, control strategies and communicative modes are utilised to reduce the level of conflict in the relationship.

Three principles identified by Morton, et al. (1996) have consistently been presented in literature, regarding the progression toward a more intimate relationship:

1. Change in the relationship occurs because of the need to increase or decrease the likelihood of attaining a reward;
2. The definition of relational change assumes a decision that change can be made by one or both persons in the relationship and

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3. Changes in the relationship are caused by changes in the content of communications between relational partners. People can escalate their relationship by providing information about themselves or seeking more information about the other.

Although some observations pertaining to supervisory relationships have been interpreted as reflecting a developmental shift in the supervisee, they might also be viewed as indicating a natural development in a relationship. Alternatively, they may be seen as an attempt to reduce uncertainty as interactional patterns become established i.e. a shift from one phase of the relationship to the next.

Despite the importance of being aware of phases in the relationship, it is equally important to note that a phase within the relationship does not itself determine the level of involvement of participants in the relationship. Individual differences have a major role.

Table 1.1 : Phases of the Relationship adapted from Holloway

Beginning phase	Clarifying relationship with supervisor Establishing of supervision contract Supporting teaching interventions Developing competencies Developing treatment plans
Mature phase	Increasing individual nature of relationship, becoming less role bound Increasing social bonding and influence potential Developing skills of case conceptualization Increasing self-confidence and self-efficacy in counselling Confronting personal issues as they relate to professional performance
Terminating phase	Understanding connections between theory and practice in relation to particular supervisees Decreasing need for direction from supervisor

Initially, supervision provides a general consistency for certain interactive behaviors. However, as the relationship develops it is individualised around the learning needs of the supervisee and the supervision approaches of the supervisor. Participants need to learn idiosyncratic, reciprocal rules within the this interactive process (Miller & Rogers, 1987). Rabinowitz's et al. (1986) found that regardless of the supervisee's level of experience, a constant need for support at the beginning of any new supervisory relationship. This is consistent with the view that uncertainty about role expectations is a part of the initial learning in a relationship. Thus, the beginning of a supervisory relationship is likely to involve clarifying and defining expectations for the participants

Empirical research provides strong evidence of phases in the supervision relationship, as summarised in Table 1.1. This representation of the relationship phases of supervision reflects the convergence of research findings of phases in supervision relationships (Carroll & Holloway, 1999; Hawkins & Shohet, 2000; Mueller & Kell, 1972; Rabinowitz et al., 1986). Mueller and Kell's

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(1972) conceptualisation of the beginning, mature and termination phases of the supervisory relationship provide the framework.

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The Supervisory Contract

Each supervisor and supervisee has expectations about the roles and functions in supervision. These expectations are idiosyncratic and organisational. Some result from previous experiences in supervision, while others are more directly related to the personal and cultural characteristics of both participants. Others may include characteristics of the professional group or organisation (Baker, Exum, Tyler, 2002; Hensley, Smith, Thompson, 2002). As with any working relationship, the clarity of these expectations directly affects the relationship and the establishment of specific goals (Baker, Exum, Tyler, 2002; Hensley, Smith, Thompson, 2002).

The supervisee generally has less evaluative or expert power, whilst the supervisor has a responsibility to ensure that the supervisee is clearly informed of the evaluative structure of the relationship. A supervisor must also identify the expectations and goals, the criteria for evaluation and the limits of confidentiality in supervision (British Association for Counselling, 1988; American Psychological Association, 1996). The supervisee is expected to clearly articulate his or her needs and expectations. Supervision contracts have been identified as decisive in establishing mutual understanding in the supervisory relationship.

Inskipp and Proctor (1989) have identified the contract as critical when establishing a way of being together in the supervisory relationship. Not only do the participants negotiate specific tasks, but they define the parameters of the relationship. The negotiation of norms, rules and commitments at the beginning of any relationship can reduce uncertainty and encourage involvement to a level of trust that will promote a higher quality relationship.

This confirmation of the supervisory contract sets up both content and relational expectations in the relationship and establishes the types of interactions in which the supervisor and supervisee will engage (Miller & Rogers, 1987). The supervisor, by initiating the contract, is dealing directly with the inherent uncertainty of the system, and the supervisee will receive an opportunity to participate in the construction of the relationship from the very beginning.

The supervisor must be alert to the dynamic character of the supervisory relationship and initiate discussion on renewing the goals and expectations. The supervisee's learning needs change as his or her experiences increase. Additionally, improved skills and interpersonal confidence will influence issues. Ongoing negotiation of topics and processes are built into the initial contract of supervision in conjunction with the quality of the relationship that is established by participants (Carroll & Holloway, 1999).

CONCLUSION

When defining supervision, it is imperative to consider the ongoing relationship between supervisor and supervisee, particularly the supervisee's acquisition of a professional role identity and the supervisor's evaluation of the supervisee's performance (Bernard & Goodyear, 1992; Bradley, 1989). It appears the relationship is inherent within the supervisory process. The supervision relationship appears to have fundamental elements that can be described in terms of contract, phases (beginning, mature & terminating), power and interpersonal structure within the relationship.

The supervisor is predominantly in the super ordinate position and the supervisee is subordinate i.e. there is a power imbalance. Due to the responsibilities, situational, organisational, theoretical

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and ethical constraints, the supervisory relationship is always a formal one in which the supervisor will have a greater share of the power.

The supervision relationship is partially defined by power and involvement, however the participants contribute to the uniqueness of the interpersonal relationship. These unique influences, ultimately effect how the supervisor and supervisee form their new relationship. As the relationship evolves, the participants use more idiosyncratic information and the other person becomes unique in the eyes of the perceiver. Consequently, the relationship shifts from being non-interpersonal to an interpersonal relationship, consisting of many individualised elements. This development occurs as the participants move through a series of phases.

Supervision is often seen as a developmental process because of the imparting of knowledge and skills acquisition. It focuses on an agreement about the goals of the supervisee, known as the contract, for each stage of professional development. The relationship is likely to develop into a peer exchange as the professional maturity of the supervisee evolves.

In working relationships, both the supervisor and supervisee are responsible for establishing a relational structure that leads to a collaborative learning alliance in which the supervisee acquires knowledge, skill and ultimately empowerment as a counsellor. The elements that appear to be fundamental in achieving this relationship include a contract that defines roles, expectations and goals. Phases enable the relationship to evolve from one level to another, whilst power dynamics allow interpersonal structures to develop within the supervision relationship, as well as protecting the ethical, structural, theoretical and professional elements of the supervisee's professional development.

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Who determines value?: Counsellors' fees in a third-party funding environment

Abstract:

Controversy over who decides the financial worth of counselling and psychotherapy is not new. The *Counselling and Psychotherapy Journal* aired discussion of this topic in 2003. It is fuelled by complex issues related to individual aspirations and collective professional allegiance, counsellors' views of marketing and the place of third-party funders in fee-setting structures. The impact of the latter, however, has featured very little in the discussion. In this paper, I use a case study to highlight the prominence of third-party funding and its impact on the value of counselling in New Zealand and suggest that considerations of such funding should be factored into any further discussions on the issue of counselling's financial worth.

Introduction

In 2003, the *Counselling and Psychotherapy Journal* published a number of articles the purpose of which was to encourage professional debate about how counsellors view the way private practitioners charge fees for their service (Feltham, 2003; Friery, 2003; Hawley, 2003; Martyn, 2003). Friery (2003) raised questions about whether it was ethical for counsellors to set their own fees for service when, clearly, there are wide discrepancies in their rates. While much of the article was thought-provoking, the underlying judgemental tone about 'greed' and the clear promotion of the services provided in his place of work, detracted from its usefulness. David Hawley (2003), in response to Friery, chose to ignore the call for a discussion of counsellor motives and, instead, considered how we value ourselves and the profession as expressed in the income we find acceptable. Both writers focused their discussions on the ways that counsellors set fees. Hawley (2003) suggested that counsellors should decide on a reasonable hourly rate by taking into consideration such factors as:

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The location of the counselling – whether there will be sufficient client base.

The location of the counselling – cost of rental.

The maximum number of clients to see – most professional bodies estimate 20 per week.

Allowance for time when clients are not in session – notetaking, letters of referral, accounting etc.

Whether the counsellor will institute a sliding-scale for some clients.

Holidays

Professional development.

Number of clients who may have their fees paid, or subsidised by third-party funders.

Similarly, Martyn (2003) listed individual factors that should form the basis of decisions about fair incomes but added a need to build parity with other professions, for example, nurses, lawyers, social workers and psychotherapists.

While these factors are clearly relevant when a counsellor is in private practice and is able to support his or her work without recourse to public funding, the issue that appears to be overlooked is that hinted at the end of Hawley's list – the impact of third-party funding. It is this impact that I want to explore in this paper.

Third-party funding

Friedson, (1994) argues that the presence of third-party funding for professional work highlights the tensions between the need to provide a conscientious service and the economic interest of service providers. Similarly, Ritchie (1990) notes that even if counsellors win the right to collect insurance payments, their professional autonomy is threatened when it is the insurance companies that decide what services they will pay for. Furthermore, Smith (2003), writing about members of the American Counseling Association, notes that the struggles of many counsellors for professional identity come, in part, in the form of challenges by managed care or third-party funders who don't want to reimburse them. Managed care (and by association, third-party funding) has a number of effects on counselling which include: a decrease in the number of health workers in private practice and an increase in the number working in group practices; a displacement of doctoral-level practitioners for master's-level psychotherapists; an increase in marketing strategies used by therapists; a decrease in use of DSMIV for diagnostic purposes; an increase in administrative paperwork and a curriculum change to incorporate cost-effective therapies (Miller, 2004). Added to this is the fact that when third-party funding is a necessary part of a counsellor's income, the value of counselling, or the price that may be charged for services is determined by the amount of subsidy available.

A case study

In 1995, as an extension of my research into the image of counselling (Miller, 2003) and the ways in which third-party funding influences New Zealand counselling (Miller, 1996), I initiated a survey of counsellors in private practice in Christchurch, New Zealand. This year signalled a time of growth in New Zealand counselling in general and, specifically an increase in the number of counsellors moving into private practice (ibid.,1996). In part, this latter increase was related to changes in government policies that decreased the availability of counselling offered in

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government departments and increased the opportunities for private practitioners to access employee-assistance funding and specific government funding. Examples of the latter included subsidies for counselling provided by the Family Courts, for couples seeking divorce, by the Children, Young People and their Families Agency (CYPFA), for families recognised as having difficulties, by the Department of Social Welfare (DSW), for people who live on a disability allowance, and by the Accident Rehabilitation and Compensation Insurance Corporation (ACC)¹ for people who have been made redundant because of an accident and people who claim to have been sexually abused. The latter funding arrangement is unique to New Zealand and has had dramatic influence on the fees set by New Zealand counsellors (see Miller 1996).

I used a two phase telephone survey to gather my data. Phase One began in 1995 when I used the counsellor advertisements in the Christchurch Yellow Pages to access participants. In 1995, there were 73 such advertisements for counsellors and counselling and mental health agencies. A short, confidential telephone interview was made with these agencies and their counsellors to determine the proportion of their income that came from third-party sources. Sixty (82%) questionnaires were completed. Of these 60, 29 (48%) contained data from counsellors in private practice: 17 (28.3%) were counsellors in full-time private practice and 12 counsellors were in part-time private practice. The remaining 31 (52%) responses were from people who worked in specialist agencies eg., pregnancy help, telephone counselling, sexual abuse survivors group, youth centres and agencies dealing with compulsive gambling. Each of these agencies was counted as one response, however part-time, often voluntary counsellors recorded in these agencies numbered 190.

Phase two was conducted in 2001 at which time the Yellow Pages in Christchurch contained 91 advertisements for counsellors and counselling and mental health agencies. When they were telephoned, 72 (79%) completed the telephone questionnaire which was the same as that used in 1995. Of this 72, 32 (44.4%) advertised under their own name and described themselves as full-time, and 34 advertised within a counselling agency and described themselves as part-time. Agencies were counted as one response, thus there were 40 of these incorporating 10 full-time counsellors and 157 part-time or volunteer counsellors.

During both surveys, counsellors were asked to indicate the proportion of clients whose counselling was funded by third-party funders. The majority of respondents indicated that less than 20 per cent of their funding came from any specific funding provider but there were some for whom more than 50 per cent of their funding came from third-party funding providers.

In 1995, 26 per cent of counsellors surveyed gained more than 5 per cent of their income from third-party funders, in 2001, 20 per cent received more than 50 per cent of their income from these sources (See Table 1). This level of reliance on third-party funding is lower than that recorded by two other surveys of New Zealand counsellors (Paton, 1999 and UCEN, 1994). Seventy-four percent (74%) of respondents to UCEN had ACC-funded clients, accounting for an average of 50 per cent of their income. For Paton, 36.8 per cent of respondents estimated that more than 50 per cent of their funding came from ACC –funded clients (See Table 1). The sample and data

¹ Although the name Accident Compensation Commission was changed to the Accident Compensation Corporation in 1980 and Accident Rehabilitation and Compensation Insurance Corporation in 1992, the letters ACC have continued to be used by the agency for its title.

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collection procedure for these two surveys were different than this present study. Paton (1999) distributed a written questionnaire (in 1994) to all members of the New Zealand Association of Counsellors who identified themselves as being in private practice and UCEN (1994) conducted a structured interview (in 1993) with a sample of 27 counsellors who had been in a salaried position before entering private practice. These surveys therefore included more full-time counsellors from throughout New Zealand. In Paton's study, 66 per cent worked more than 25 hours, and in the UCEN study, 63 per cent were working full-time.

Table 1: % of respondents who received more than 50% of their funding from third party funding providers

Funding provider	1995 % resp.	2001 % resp.	Paton 1996	UCEN 1998
ACC	15	10	36.8	74
CYPFA	1.3	2.0		
DSW	6.6	2.6	7.4	
Family Courts	3.0	4.1	12	
EAP	0	1.4	3.4	
Total	25.9	20.1	59.6	74

While the data in the present study reflect an apparently small level of reliance on third-party funding, when counsellors were asked if they received **any** third-party funding from ACC, the prominence of this funder in determining the value of counselling becomes clearer (Table 2). Most counsellors received some ACC funding in 1995 and this situation continued in 2001 (Table 2).

Table 2: Percentage of counsellors estimating the proportion of their clients who are funded by ACC.

	1995	2001
% funding	% Resp.	% Resp.
0 -10	57	67
10-20	8	12
20-30	7	7
30-40	12	1
40-50	2	3
50-60	5	6
60-70	3	0
70-80	5	1
80-90	0	0
90-100	2	3

Discussion

The results for my, and the two national studies, demonstrate the impact of third-party funders on the total income of New Zealand counsellors. All surveys conducted in the 1990s show that private practice counsellors in New Zealand were dependent on funding from third party providers and that the main source of third-party funding was the ACC. The ACC fee-for-counselling-service during the 1990s was set at \$NZ50.00 plus Goods and Services Tax (GST 12.5%) for each of up to 20 counselling sessions with a client. The total amount of funding paid out by ACC for counselling at that time was \$NZ 2.5 million in 1990, \$NZ 5.6 million in 1994 and \$NZ 7.4 million in 1996 (*ACC Injury Statistics 2001 (Second Edition)*). At this time, a small proportion of counsellors were earning more than \$60,000 per annum (Paton noted 10.8% of the group surveyed earned more than \$60,000 gross). The low subsidy provided by the main third-party funder was, I contend, having a determining effect on the value of counselling. Paton (1999) also noted that, since ACC funding is available for clients who have experienced sexual abuse, it is more likely that female counsellors access more of this funding. These female counsellors, therefore, received a lower total income on average.

In 2001, counsellors in private practice began to object to the constraints on their practice set by ACC. Two counsellors in this present study commented, in 2001, that they were not going to re-apply for ACC accreditation and two said that they had not sought this accreditation because they did not agree with the process. In 2002, ACC reported that there were 620 counsellors approved for funded work whereas there had been 750 approved counsellors before the latest re-approval process began (New Zealand Association of Counsellors Newsletter, September 2002: 26). Alongside this finding is a reduction in the total amount of funding paid out by ACC for counselling, from \$NZ 7.4 million in 1996 to \$NZ 6.7 million in 2001 (*ACC Injury Statistics 2001 (Second Edition)*), this despite the fact that the ACC fee-for-counselling-service was raised to \$NZ76.50 (including GST) per hour. Also, during this period, the New Zealand Association of Counselling conducted meetings with ACC personnel, and sought feedback from members on the process and payment structure of this funding (New Zealand Association of Counsellors Newsletter, September, 2002).

Each of these points highlights how difficult it is for New Zealand counsellors to set realistic fees for their service when so many private practitioners rely on the low third-party funder subsidies for work with many of their clients.

Conclusion

While previous debate about setting fees has centred on the practices of individual counsellors, it appears that the profession needs to keep alert to the impact third-party funders have on the value of counsellors as expressed in the income they receive. I have highlighted how during the 1990s, a very high proportion of New Zealand counsellors supplemented their income with funding from third-party subsidies. I have also demonstrated that, while, at the turn of the century, some counsellors started to limit their involvement with ACC, many still have some ACC and other third-party funded clients. The implication of this is that while private practice counsellors may try to set their own fee standard it is still the third-party funders who determine the value of counselling expressed in terms of income. The complexity of setting a fee

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that is reasonable, ethical, comfortable and achievable cannot be underestimated. If the profession is to debate the value of counselling, it must do this by canvassing members and challenging the fee constraints being set by all third-party funders.

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